United States v. State of Texas

Monitoring Team Report

Abilene State Supported Living Center

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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 a 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 February 14 through 18, 2011 the Monitoring Team visited ABSSLC. 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. The recommendation sections for some provisions include a subsection of additional suggestions for the Facility. These are presented in an effort to assist the Facility in prioritizing activities as the Facility staff work towards achieving substantial compliance with the provision.

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

As with previous reviews, the ABSSLC team approached the Monitoring Team's review with openness and cooperation. The Monitoring Team appreciated the significant effort that ABSSLC staff expended in providing requested documents, meeting with Monitoring Team members to share information, and generally ensuring that the Monitoring Team had access to information it needed. Moreover, both the ABSSLC Administration and State Office staff were receptive to the Monitoring Team's initial findings and recommendations, and appeared committed to make needed changes. This positive attitude regarding the need for continuous quality improvement should assist the Facility in its efforts to reach compliance with the Settlement Agreement.

As noted in various sections of this report, the Monitoring Team identified some areas in which the Facility had made progress. However, there were a number of areas, including some that had a direct impact on the health and safety of individuals, in which concerted efforts needed to be made to improve the supports, services, and protections provided to individuals. For example, concerns similar to those the Monitoring Team noted in previous reports related to the provision of medical, nursing, and physical and nutritional supports remained unaddressed. The adequate provision of such supports and their full integration with one another is essential to address the needs of individuals who are at high risk due to conditions including, but not limited to aspiration pneumonia due to dysphagia and/or gastroesophageal reflux disease (GERD), weight issues, constipation, and skin breakdown. As was discussed with State and Facility staff during the onsite review, the ABSSLC team should work to identify and implement the actions needed to effect required changes. In order for such change to be effective and lasting, methodical and thoughtful plans should be developed and implemented. An important component of this will be expanding the staff's knowledgebase and skills, as well as their philosophies regarding individuals' ability to benefit from treatment, grow, and develop. ABSSLC is encouraged to work closely with State Office staff as this process unfolds.

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

Restraints

- The trend analysis reports included not only an analysis on the data on restraints, but also recommendations for addressing some of the issues the analysis raised. The inclusion of timeframes and people responsible for the recommendations, as well as follow-up in subsequent reports showed development of a systematic approach to improvement.
- Refresher classes for staff who were assigned restraint monitoring responsibilities had been completed in an effort to ensure that they were properly equipped to monitor and accurately document restraints. This was responsive to the Facility's own data indicating some training was needed.

Abuse, Neglect and Incident Management

- Investigators were trained in investigation and in interviewing people with developmental disabilities. Investigations were completed using a standard format, were processed electronically, and, for the most part, were conducted in a timely fashion. Some documentation issues still needed to be addressed such as recording supervisory reviews and their content, and the review by Department of Family and Protective Services (DFPS) investigators of past investigations. However, based on discussions with DFPS and the Facility, these details appeared to be in the process of being corrected.

Quality Assurance

- The Quality Assurance/Quality Improvement Committee had been established to review quality management efforts and to strategize solutions to identified issues.
- Quality monitoring tools had been adopted based on the tools used by the Monitoring Teams. At the time of the review, the State had issued revised tools for some of the sections of the Settlement Agreement. The Facility was beginning to use the revised tools as they arrived. Guidelines for the use of the revised tools were not yet available, but were expected.

Integrated Protections, Services, Treatments and Supports

- The Facility had adopted the DADS Personal Support Plan (PSP) policy, but had not yet developed corresponding Facility policies and procedures.
- All Qualified Mental Retardation Professionals (QMRPs) had gone through initial training on the new process. Some of the PSP meetings the Monitoring Team observed showed limited improved facilitation skills, and a person centered focus. Improvement had begun to be seen in the area of identifying preferences of individuals. Incorporation of these preferences into the overall PSP continued to need work.

Integrated Clinical Services

- By creating a morning medical meeting each business day of the week that focused on those admitted to the Infirmary, progress had been made in developing an interdisciplinary integrated forum to discuss the health of the acutely ill individuals. Several disciplines were represented, including medical, nursing, psychiatry, and physical therapy. Further structure and expansion of the scope of these meetings is recommended to ensure the full potential of the meetings is realized.

Minimum Common Elements of Clinical Care

- A program focusing on prevention of aspiration pneumonia had begun to be implemented. In order to provide valid data for a database related to respiratory infections, the physicians were provided in-service training on correct identification of various types of pneumonia. However, all of these initiatives were in the early stages of implementation.

At-Risk Individuals

- The Facility recently completed a campus-wide webinar training program to begin implementation of the DADS At Risk Individuals policy. Teams had begun to implement the process with mixed results. Although, there were

several good examples or risk rating completed by the PSTs, with adherence to the risk guidelines included in the policy, there also were examples of teams who continued to complete the process in a pro forma manner, with little, if any review of relevant data.

Psychiatric Care and Services

- One significant recent positive change at ABSSLC had been the addition of a new full-time Psychiatrist. The Facility also continued to utilize two Consulting Psychiatrists. This brought the total amount of psychiatry time to approximately 1.5 full-time equivalents (FTEs), which was still not sufficient for the 222 individuals who received psychotropic medication. However, this represented a significant improvement since the last review. The Facility also was continuing its efforts to recruit additional full-time Psychiatrists.
- The addition of the full-time Psychiatrist also had made it possible for a Psychiatrist to attend the morning Medical Rounds in the Infirmary, which facilitated the psychiatric management of individuals admitted to the Infirmary, who also had a psychiatric illness. This also had fostered closer integration of the psychiatric and medical services in general.
- In the Psychiatric Clinics that were observed, there was a clear attempt to review every individual's psychotropic medications, with the goal of reducing those medications, when possible. The data compiled by the Pharm. D. also documented a related gradual reduction in the rates of polypharmacy, as indicated by the average number of psychotropic medications prescribed per individual.
- There also had been incremental progress in implementing the Desensitization Plans for dental procedures, although only a small number of Plans had been developed thus far. The dental staff also had implemented a number of environmental changes that were designed to make the Dental Office less intimidating to the individuals at the Facility.

Psychological Care and Services

- The psychology staff were clearly committed to expanding their understanding and skills in providing behavioral support to the individuals served. The majority of Associate Psychology staff were actively pursuing certification in Applied Behavior Analysis, with ongoing support and supervision provided by the Behavior Analyst on staff. Internal and external peer review continued. Behavior Analysts consulting to the Facility provided on-site training to professional and direct support professionals.
- A commitment to timely completion of functional behavior assessments was evident during the visit. A timeline had been developed with particular emphasis placed on those individuals who presented with more challenging behaviors or who had demonstrated a resistance to intervention.

Medical Care

- There was now a full complement of primary care practitioners, with caseloads that were adequate to address the clinical challenges and promote quality care. The Medical Director had a small caseload, allowing a majority of time to be focused on medical administration.

- The morning medical meetings showed the beginnings of a process with great potential. They should be expanded to include clinical review of individuals with acute care problems, but also include in-service training on new guidelines and discussion of complex clinical issues.

Nursing Care

- At the time of the review, ABSSLC continued to have an adequate complement of nurses. Thus, the Facility had not needed to use any agency nurses, and used voluntary overtime for situations when the Facility needed to augment nursing coverage due to issues such as sick calls, leaves, or vacations.
- Since the last review, the Facility had developed written procedures clearly outlining a formal system to ensure the reliability of the Facility's Infection Control (IC) data. A review of the newly implemented procedures addressing IC data reliability using the Drug Utilization Discrepancy Report revealed an excellent system that generated valuable data, which timely alerted the Facility to problematic trends. The next steps would be to develop formal plans of action addressing any problematic trends, and to incorporate this data into the Infection Control Committee Meeting minutes.
- Since the last review, the Nursing Department and the Pharmacy had been working together to review the medication administration system. In addition, the Facility had been working on identifying issues related to medication variances in order to implement interventions to decrease these errors.

Pharmacy Services and Safe Medication Practices

- The quarterly drug regimen reviews were having a significant impact on the actual practices of the PCPs, and had been an important tool used to assist in reducing the use of anticholinergic and psychotropic medications.
- The adverse drug reaction reporting system appeared to be in place. To add practical value, it was being used as a method to record any significant reaction, even if it did not reach the threshold of needing to be reported through the MedWatch system.
- Drug utilization evaluations had been scheduled a year ahead of time on a quarterly calendar. Follow-up studies were being completed to determine the impact of previous DUEs.

Physical and Nutritional Supports

- Since the last review, the Facility had developed two Physical and Nutritional Management Team (PNMTs). Team members had been assigned to each. The PNMTs consisted of the membership the Settlement Agreement required. As noted with regard to Section I and Section L, given the medical complexities of the individuals the PNMT supported, it would be important for a primary care practitioner (PCP) to be a regular consultant and/or member of the PNMTs.
- Competency-based training had been developed for Physical and Nutritional Management Plan (PNMP) Coordinators. This was an important and positive development. PNMP Coordinators played a key role in implementing PNMPs, as well as training and monitoring staff in the residences on the proper and consistent implementation of the plans. Although this was a positive development, PNMP Coordinators were not yet

consistently performing their duties. This was illustrated when staff were not implementing dining plans, but PNMP Coordinators did not intervene.

Dental Services

- The Dental Department now had a full complement of staff. There was a continuing focus on oral hygiene in the residences.
- Considerable effort and creativity had resulted in the development of an intricate and detailed system to identify causes of missed appointments. The refusal rate has dropped by approximately 50%, which was significant, but there was continuing need to improve.

Communication

- Working in conjunction with the Quality Assurance Department, the Speech Language Department had developed an action plan to further analyze the barriers to individuals' regular use of communication devices, and to begin to overcome some of these issues. Facility Administration, in collaboration with the SLPs, should continue to problem-solve and identify solutions to significantly increase staff compliance with the utilization of individual communication systems.

Most Integrated Setting

- ABSSLC was at the initial stages of implementing the new Community Living Discharge Plan (CLDP) process. Overall, the revised form was more comprehensive, included more information, and provided more direction to Personal Support Teams (PSTs) than did the previous form. The new process directed the PST to begin the CLDP process at the point of referral. This was an improvement from the previous process.
- Post-move monitoring had been completed in a timely manner for almost all of the individuals who had transitioned to the community. The Post Move Monitor's comments often provided a thorough description of the methods used to evaluate the item and the findings (e.g., interviews, document reviews and observations). Although teams had not always identified all of the needed protections, supports, and services, for those that were identified, the Post Move Monitor reviewed and commented on each one. The post-move monitoring identified some issues with regard to the provision of services at the community sites. Notes demonstrated consistent and thorough follow-up to ensure that issues identified were corrected.

Consent

- ABSSLC had continued to use tools it had created to attempt to prioritize a list of individuals in need of guardians. Until the DADS State Office defines the more formalized methods to be used to assess an individual's capacity to provide informed consent, ABSSLC had made efforts to identify individuals, with higher needs related to assistance with decision-making, using an objective process.

Recordkeeping and General Plan Implementation

- According to staff, all of the individuals at ABSSLC had Active Records and Master Records. The conversion of the records to the new Table of Contents was a substantial accomplishment, and demonstrated impressive teamwork on the part of the Records Department and the Home Clerks assigned to the Units.

- With regard to auditing records, progress continued to be made, but issues remained with regard to the reliability and validity of the monitoring data. The Facility also was still in the process of looking more formally at aggregated results of monitoring data, and developing and implementing actions necessary to correct deficiencies identified systemically.

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

Restraints

- In general, the Facility had systems in place for restraint reporting, monitoring, and review processes. However, concerns were noted in regard to the adequacy with which staff described the antecedent- and consequence-based interventions that were utilized prior to the implementation of restraint. It was not clear in all cases reviewed that staff implemented specific strategies from BSPs in an effort to reduce target behavior and prevent the use of restraint.
- Concerns also were noted with regard to restraint monitors being in place within the 15 minutes.
- Adequate processes for assessment, and review and modification of Behavior Support Plans were not being consistently implemented for individuals who were placed in restraint three or more times in any 30-day rolling period.

Abuse, Neglect and Incident Management

- Training for staff on abuse and incident reporting was in place, and all but two percent of staff were current on that training. However, work continued to need to be done to ensure that staff were competent in understanding signs and symptoms of abuse, their reporting responsibilities, and the reporting procedures.
- An area that continued to need improvement was the inclusion of adequate recommendations based on the results of investigations, and follow-through on those recommendations. DFPS investigations sometimes listed concerns, but not in the form of actual recommendations. Facility investigators made recommendations, but they more often related to the immediate protection of the individual, as opposed to systemic issues they encountered such as crowded environments, peers who did not get along, and a lack of meaningful activities. The process for translating DFPS concerns into recommendations on the companion Facility reports was not consistent, resulting in some concerns not be addressed.

Quality Assurance

- Trending of some basic quality indicators was being conducted in the areas of restraint, and unusual incidents, including Abuse/Neglect/Exploitation and Injuries. 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.

- 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.

Integrated Protections, Services, Treatments and Supports

- As noted in many sections of this report, comprehensive, thorough, and adequate assessments were missing in many areas, including but not limited to nursing, speech and communication, 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.
- The State and the Facility need to ensure that person-centered concepts are incorporated with the need to develop comprehensive, integrated plans. Many individuals require plans with multiple supports. The State, working in conjunction with the Facility, should figure out ways to have adequate, technical team discussions, while focusing on the individual and his/her preferences, strengths, etc.

Integrated Clinical Services

- The tracking and PCP review of consultation reports continued to need improvement. There remained a need for improvement in PCP review, and acknowledgement of agreement or not with recommendations included in consultation reports.
- The PNMT and the individuals it serves would benefit from a physician liaison to the team to provide support and direction from a medical perspective.

Minimum Common Elements of Clinical Care

- Clinical indicators often were not identified. For example, when psychiatric medications were prescribed, the target symptoms were generally not tracked. Tracking these symptoms would assist in determining the efficacy of the treatment. Likewise, medical treatment plans and nursing plans did not identify what clinical indicators would be tracked, by whom, or when. Many PNMPs also did not identify the functional outcomes to be measured.

At-Risk Individuals

- Significant concerns were noted with regard to the nursing care being provided in the Infirmary. This needed to be addressed as a priority to reduce the risk to individuals being treated in the Infirmary.
- Based on interview, Habilitation Therapies staff had attended initial meetings with the primary purpose of completing at-risk assessments for individuals, using the revised risk guidelines. The initial meetings did not consistently produce the desired outcome of accurately completing risk assessments. As a result, Habilitation

Therapy staff met with the Facility Director to propose providing training to PST members on the at-risk screening and assessment process. At the time of the review, a curriculum had been developed, but no plan was submitted with regard to the implementation of the training.

- The absence of an accurate database for Infirmary/emergency room/hospitalizations and an incomplete Communicable Disease Report for Aspiration Pneumonia and Pneumonia hindered the Facility's ability to identify individuals who met thresholds for specific categories of physical, nutritional and health risk indicators.
- Only three individuals identified at high risk with multiple risk factors had been evaluated by the PNMT, since the last compliance review.

Psychiatric Care and Services

- Although the format of the Comprehensive Psychiatric Assessment had been modified to more closely comply with the outline contained in the Settlement Agreement, the examples of newly completed Comprehensive Psychiatric Assessments still did not contain the information required to justify the psychiatric diagnosis.
- The co-identification of behaviors that were described in the Functional Analysis as being present on a behavioral basis, and also listed as "target" behaviors of the psychotropic medications, continued to be problematic.
- Systemic issues discussed in the prior report continued to be problematic, including the risk versus benefit analysis as it related to the utilization of psychotropic medication, and the corresponding Human Rights Approval/Guardian Consent process. The lack of empirical evidence to substantiate the efficacy of the psychotropic medications was an ongoing significant deficiency. Obviously, this documentation also was related intimately to an adequate analysis of the benefits of the medication in relation to the potential and/or realized side effects of the medication.

Psychological Care and Services

- Functional assessment relied heavily on staff interview and response to rating scales. Improved attention to direct assessment activities was needed. Using the information gained through assessment to develop enhanced Behavior Support Plans will be critical. Plans continued to lack depth with regard to training opportunities for replacement behavior, development of enriched daily schedules, and expanded access to a variety of reinforcers.
- The process for obtaining consents for revisions to Behavior Support Plans remained in need of change. Due to issues with obtaining consent, plan implementation was often delayed, resulting in a lack of appropriate services and supports to the individual served. Consideration should be given to developing a hierarchy of intervention restrictiveness to help streamline this process.
- Through observation, discussion with staff, and review of documentation, it was clear that collected data did not provide an accurate measure of individual behavior. Program implementation and data collection are directly related, and should be the emphasis for staff in the upcoming months. Both will be accomplished only through ongoing work with the direct support professionals.

Medical Care

- There continued to be a need an urgent need for a clinical guideline for GERD. In addition, further training was needed on such topics as the administration of fluids and medication through Jejunostomy (J-tubes), work-ups for GERD, identification of dementia, and critical thinking to prevent recurrent Emergency Room (ER) visits and hospitalizations.
- There were eight deaths in the past six months at ABSSLC. None of these had undergone a clinical mortality or administrative mortality review. As of the end of December 2010, there remained 16 death reports that were incomplete or outstanding. The clinical death review committee had not met on these cases, because the reports had not been finalized. Based on the Monitoring Team's reviews of the deaths that occurred over the last six months, a number of issues or questions were identified that required follow-up. The Facility's failure to conduct such reviews itself was limiting its ability to potentially proactively prevent other deaths in the future, and generally improve the healthcare treatment provided at ABSSLC. It is strongly recommended that ABSSLC conduct mortality reviews in a timely and thorough manner.
- Without a strong database, the medical Quality Assurance (QA) program was nonexistent or in the very initial stages of development.
- Since the last review, the Facility had implemented very few interventions to address the emergency response systems. The most promising change was having the Program Compliance Monitors (PCMs) present to record data at some of the Medical Emergency Drills. However, most of the problematic issues the Monitoring Team identified during the past reviews continued to be problems during the current review.

Nursing Care

- The Monitoring Team continued to identify numerous examples of a lack of clinical competence with regard to nursing skills essential to ensuring the health and safety of individuals at ABSSLC. In order for the Risk System, as well as other health care systems to successfully result in positive clinical outcomes, it is imperative that the Facility expediently addresses the nursing staff's overall lack of clinical competency.
- A number of significant issues continued to be found regarding the identification of changes in status and the nursing documentation addressing complete and adequate nursing assessments. There continued to be problems noted regarding the lack of adequate documentation when an individual began showing symptoms of a status change, consistent follow-up for symptoms, and assessments conducted prior to the transfer to an off-site medical center, as well as upon return to the Facility.
- There had been no improvement regarding the quality of the Nursing Assessments and Nursing Care Plans. The Facility had provided some training in these areas, but none of the training was competency-based.
- The Nursing Department's auditing data was not reflective of the problems the Monitoring Team found, especially regarding the quality of nursing assessments and documentation.

Pharmacy Services and Safe Medication Practices

- Chemical restraint review by the clinical pharmacist remained a challenge, because the pharmacy was not receiving the forms required for completion.
- The Quarterly Drug Regimen Reviews (QDRRs) that required a psychiatry signature were not being consistently reviewed and signed.
- Timely side effect monitoring screenings fell below acceptable threshold levels.
- Medication errors remained a challenge, especially with the important category of unreconciled errors.

Physical and Nutritional Supports

- Given the numbers of individuals at ABSSLC with physical and nutritional management needs, including a large number of individuals at high risk, the slow pace of the PNMTs completion of assessments and physical and nutritional support plans was concerning. The current caseloads of the PNMT members will continue to significantly impact their ability to address adequately their responsibilities as PNMT members for individuals at the highest risk levels within the Facility, as well as provide supports to individuals on their respective caseloads.
- Competency-based training on foundational physical and nutritional supports had not been developed, and was not being provided to staff responsible for the direct support of individuals the Facility served. Competency-based training also was not being provided on individuals' PNMPs. Given the Monitoring Team's observations that showed many errors in the implementation of PNMPs, and the risk at which this placed individuals, this was of continuing significant concern.
- A review of Facility reports, including those from Quality Assurance, did not illustrate that a mechanism was in place that ensured timely data was provided to the PNM Team for analysis leading to the identification of potential issues, and ensuring the provision of supports to individuals with the most complex physical and nutritional support needs.

Physical and Occupational Therapy

- The current staff-to-individual ratio list indicated the ABSSLC ratio for Occupational Therapists (OTs) was 1:223, and Physical Therapists (PTs) was 1:118. As a result, therapists were not active members of the PSTs, as evidenced by, but not limited to, their absence in annual PSP meetings, insufficient time to provide direct therapy, completion of comprehensive OT/PT Evaluations per established guidelines, development and integration of therapy recommendations into formal skill acquisition programs, development of instructional programs for PNMP Coordinators and/or staff, and the development of informal strategies to reinforce assessment recommendations.

Dental Services

- Review of several emergency visits indicated a need for the Dental Director to determine ways to hasten closure of acute painful problems. In addition, the Dental Peer Review Committee should develop outcome measures

that provide a reasonable estimate of time for closure of various acute dental problems, such as the time from finding a painful carious tooth to restoration with a permanent filling, etc.

- Sedation and mechanical restraint use remained a challenge. Ten individuals were selected for the development of desensitization programs, and were in various stages of completion of the development and implementation process. The Dental Department was attending PSTs for individuals with chronic refusals, or needing desensitization plans or other strategies to reduce the need for sedation.

Communication

- Based on the Monitoring Team's review, the current staffing ratio of approximately one SLP for 89 individuals was not sufficient to allow compliance with the Settlement Agreement. SLP staff had completed an analysis of the staffing needs of the department. The Facility is encouraged to address the results of this analysis.
- SLPs were completing evaluations that did not recommend direct and/or indirect therapy for individuals who presented with the strengths, potentials, and abilities for functional communication.
- The goal for an individual with an augmentative/alternative device should be to provide the supports necessary for multiple, intense opportunities for learning (formal and informal) to successfully utilize the device in a variety of natural environments. The integration of functional communication recommendations on a formal and/or informal basis within an individual's PSP and multiple environments is necessary to ensure a device becomes an integral part of how an individual communicates on a daily basis. This was not occurring at ABSSLC.

Habilitation, Training, Education, and Skill Acquisition Programs

- Assessment of individuals' needs remained incomplete or out-of-date. Resulting Actions Plans were, therefore, limited in scope. Training Documentation Reports continued to lack specificity with regard to the learning objective, the teaching strategies used to effect behavior change, the consequences applied to ensure the acquisition of new skills, and the plans designed to ensure skill maintenance and generalization. Opportunities for learning enhanced skills remained infrequent.
- Activities offered to individuals remained limited and often were not age-appropriate or individualized. Engagement levels across the residences and activity centers remained low. Training in integrated, community-based settings was limited to only a few individuals who took part in employment opportunities off campus.

Most Integrated Setting

- At the time of the review, individuals' PSPs did not include determinations by professionals with regard to whether or not community placement was appropriate. Such recommendations should be presented to the entire team, including the individual and Legally Authorized Representative (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.
- The Facility continued to be at the initial stages of identifying obstacles to movement to the most integrated setting appropriate to the individual's needs and preferences, as well as strategies to overcome such obstacles.

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

Consent

- At the time of the review, DADS Central Office was still in the process of finalizing a policy on guardianship and consent. In August 2010, the Monitoring Panel provided comments on the draft policy. According to Facility staff, at a meeting in January 2011 of all of the Human Rights Officers (HROs), assignments were made to re-draft portions of the draft policy and its attachments. It was anticipated that a final policy would be completed by July 2011. The State is encouraged to finalize this policy, as it will assist the Facilities to move forward with regard to the implementation of the Section U Settlement Agreement requirements.
- Since the last review, only one individual had obtained a guardian. The Guardianship Committee had approved another three individuals for funding to defray the costs of guardianship proceedings. In addition to seeking creative alternatives to identify guardians for individuals, 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.

Recordkeeping and General Plan Implementation

- Since the last review, State Office had provided the Facilities with guidance regarding the Individual Notebooks. Based on this guidance, ABSSLC had decided not to create Individual Notebooks, but instead provided a list of where information "referenced in the Individual Notebook" could be found. This is an area that requires further consideration. As indicated in the previous report, the Monitoring Team recognizes that this should be done in the least cumbersome, and most normative fashion. However, ABSSLC's current methodology did not appear to address fully the requirements of the Settlement Agreement.
- The Facility was continuing to develop and revise policies to address the requirements of the Settlement Agreement. However, based on documentation provided, the Facility had not, but should develop standardized processes for the dissemination of policies, and training of staff on new or revised policy requirements.
- Based on observations of team meetings, teams were not consistently using data, and other information contained within individuals' records, to make care, treatment, and training decisions. In addition, issues related to the timely and accurate filing of information, and the maintenance of complete data, had the potential to impact negatively on teams' decision-making ability. The Facility had identified some of these issues and was working to correct them.

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 ABSSLC Policy: Use of Restraints, dated 6/10; o ABSSLC Plan of Improvement, dated 1/31/11; o Restraint Checklist POR-MR-7, revised 12/10; o Administration of Emergency Medication Protocol (Chemical Restraint), POR-MR-9, revised 4/09; o Face-to-Face Assessment, Debriefing and Reviews for Crisis Intervention Restraint, Psychology Department, revised 12/09; o Procedures and Responsibilities of the Nurse During a Behavioral Crisis, Psychology Department, dated 12/09; o Procedures and Responsibilities of the Physician Related to Restraints, Psychology Department, dated 12/09; o Procedures and Responsibilities of the Restraint Monitor During a Behavioral Crisis, Psychology Department, dated 11/09; o Prevention and Management of Aggressive Behavior (PMAB); o Texas Department of Mental Health/Mental Retardation (MHMR): Restraint by Facility, 8/1/10 – 1/31/11; o ABSSLC FY11 Restraints Trend Analysis: From 11/1/10 – 11/20/10 to 12/31/2010; o Restraint Reduction Plan Minutes, dated 11/29/10, and 8/26/10; o Presentation Book C: Information on the Development of Desensitization Plans; o Settlement Agreement Cross Referenced with ICF-MR Standards: Protection From Harm – Restraints, revised 12/10; o The Restraint Checklist, Face-to-Face Assessment and Debriefing Form for each of the following individuals with emergency or programmatic restraints (Sample C1)*:* ▪ Individual #387 on 12/9/10 at 9:28 a.m., Individual #199 on 11/7/10, Individual #328 on 8/2/10 at 11:00 a.m., Individual #43 on 10/27/10 at 6:40 p.m., Individual #74 on 12/26/10 at 3:15 p.m., Individual #534 on 12/3/10 at 10:13 p.m., Individual #437 on 12/11/10 at 5:45 p.m., Individual #303 on 12/23/10 at 8:35 p.m., Individual #156 on 10/23/10 at 10/23/10, Individual #81 on 9/20/10 at 8:25 a.m., Individual #188 on 11/5/10 at 3:45 a.m., Individual #104 on 12/10/10 at 6:30 a.m., Individual #425 on 11/23/10 at 2:16 p.m., and on 12/20/10 at 8:57 a.m., Individual #231 on 10/25/10 at 12:12 p.m., Individual #79 on 9/23/10 at 4:52 p.m., Individual #149 on 9/19/10 at 7:10 p.m., Individual #94 on 10/17/10 at 5:45 p.m., Individual #252 on 11/19/10 at 5:15 a.m., Individual #160 on 9/4/10 at 12:27 p.m., and on 11/18/10 at 7:30 p.m., Individual #477 on 8/31/10 at 7:51 p.m., and on 10/4/10 at 9:12 p.m., Individual #260 on 9/14/10 at 2:10 p.m., on 10/9/10 at 6:05 and 6:10 p.m., and on 11/3/10

	at 3:04 p.m., Individual #469 on 10/23/10 at 1:10 a.m., Individual #102 on 10/4/10 at 8:25 p.m., Individual #324 on 9/17/10 at 5:21 p.m., and on 11/6/10 at 11:20 a.m., Individual #132 on 12/5/10 at 5:45 p.m., and Individual #357 on 11/1/10 at 9:50 a.m. For purposes of this report, the individual's number is used to identify the episodes of restraint, unless there were multiple restraints, in which case the date and time are included. o Sample #C2 included 23 staff hired between 11/1/10 and 12/31/10, drawn at random from the list the Facility provided in response to Document Request TX-AB-1102-III.11. Of the 23 selected at random, eight had resigned. The remaining 15 staff are identified by employee numbers as follows: Staff #218793, Staff #218803, Staff #219890, Staff #219955, Staff #219343, Staff #219048, Staff #219171, Staff #218831, Staff #218859, Staff #218878, Staff #219132, Staff #219958, Staff #218887, Staff #173953, and Staff #219960; o Sample #C.3 included the last nine episodes of medical restraint as supplied by the Facility in response to Request for Documents TX-XX-1102-II.8: Individual #304 on 12/14/10 at 1:00 p.m. and at 2:35 p.m., Individual #519 on 12/21/10 at 11:25 a.m., Individual #320 on 12/16/10, Individual #238 on 12/22/10 at 7:15 a.m., Individual #69 on 12/30/10 at 6:00 a.m., Individual #178 on 12/31/10 at 7:00 a.m., Individual #455 on 12/28/10 at 6:00 a.m., and Individual #192 on 12/22/10 at 7:15 a.m.; o Personal Support Plans (PSPs) for: Individual #115, Individual #429, Individual #438, Individual #505, Individual #91, Individual #46, Individual #444, Individual #245, Individual #9, and Individual #52; o Restraint Reduction Committee Meeting minutes, dated 11/29/11; o Dental desensitization plans for: Individual #307, Individual #242, Individual #104, Individual #140, Individual #144, and Individual #381; o Summary of Restraint from 8/10 through 12/10; o Restraint Records from 8/10 through 12/10 for: Individual #387, Individual #199, Individual #43, Individual #303, and Individual #510; o Behavior Support Plans for: Individual #178, Individual #501, Individual #387, Individual #164, Individual #199, Individual #123, Individual #43, Individual #74, Individual #184, Individual #105, Individual #476, Individual #242, Individual #6, Individual #509, Individual #371, Individual #76, Individual #303, Individual #347, Individual #276, Individual #505, Individual #104, Individual #286, Individual #49, Individual #201, Individual #318, Individual #293, Individual #330, Individual #153, Individual #140, Individual #247, Individual #313, Individual #231, Individual #274, Individual #301, Individual #198, Individual #332, Individual #405, Individual #486, Individual #149, Individual #8, Individual #471, Individual #94, Individual #539, Individual #370, Individual #525, Individual #83, Individual #469, Individual #5, Individual #102, Individual #148, Individual #388, Individual #146, Individual #510, Individual #132, Individual #339, Individual #357, Individual #11, and Individual #304; o Safety Plans for: Individual #387, Individual #43, Individual #74, Individual #231, Individual #486, and Individual #510;

	○ Personal Support Plan Addenda for: Individual #387, Individual #43, Individual #74, Individual #231, Individual #486, and Individual #510; and ○ Psychology Progress Notes for: Individual #387, Individual #43, Individual #486, and Individual #510. ▪ **Interviews with**: ○ Ron Manns, Psychologist (substituting for Cathy Hennington, Chief Psychologist); ○ Pat Smith, Admissions/Placement Coordinator (substituting for Sam St. Claire, Director of Quality Assurance); ○ Jason Fry, Psychologist; ○ Juan Herrera, QMRP Coordinator; and ○ Various staff in residential units. ▪ **Observations of**: ○ Ten residences, including #5961, #5962, #5971, #5972, #6330, #6350, #6370, #6460, #6480, and #6521; ○ Three PSP annual meetings for: Individual #234, Individual #196, and Individual #205; ○ Restraint Reduction Committee Meeting, on 2/7/11; and ○ Morning meeting of Unit 3, on 2/16/11.
	Facility Self-Assessment: The Facility's Plan of Improvement (POI) underwent major revisions with the result being an easier-to-understand description of the progress toward compliance with the Settlement Agreement. Based on a review of the Facility's POI with regard to Section C of the Settlement Agreement, the Facility found that it was out of compliance with six out of the eight provisions. The POI indicated the Facility was in substantial compliance with Sections C.1 and C.2. The Monitoring Team found noncompliance for all eight of the eight provisions. In the Comment/Status sections of the POI, the Facility reported conducting its own monitoring of restraints. The Facility was using a format similar to the one used by the Settlement Agreement Monitoring Teams. It had not been upgraded to include guidelines, and the numbering system on the December 2010 version did not correspond to the numbering system on the data tally sheets or on the summary graphs. As a result, it was not possible to validate that process. The Facility had established a plan to review restraint documentation, and had completed 95 monitoring tools since September 2010. The information included in the POI indicated percentages of compliance, based on the use of the monitoring tools. In the POI, the percentages provided appeared to be overall scores for each provision. As has been stated in previous reports, the monitoring review tools were not designed to provide overall scores. The items within the tools are not weighted. As the Monitoring Team has done in the report that follows, when conducting its own self-assessment, the Facility should review and report on data related to the individual indicators within each Settlement Agreement section. As foundation for the percentages, the Facility presented graphs of their findings, showing the overall percentage of compliance by item from the monitoring tools. As is illustrated in this report, the Facility's findings were not always consistent with those of the Monitoring Team. This could be due to a number of

	factors, including the difference in sample sizes, or that the Facility was evaluating the presence or absence of an item as opposed to the quality. For example, the Monitoring Team evaluated both the presence of information on restraint checklists and face-to-face assessments, as well as the quality of that information and its impact on the Facility's ability to adequately review restraints and take steps to prevent the need for their recurrence in the future. As it moves forward, the Facility should ensure that the quality of efforts as well as the quality of the documentation is evaluated thoroughly. In addition, the POI would be more useful if it included more specific references to the evidence supporting the listed status items. For example, with regard to Section C.5, the POI reported that a procedure to better track restraints had been developed and implemented. It would be helpful if the POI referenced the document that contained that tracking system. Where a policy has been changed as in relation to Section C.3, it would be helpful if the POI referenced the policy by name and cited the place in the policy where the change could be found. The inclusion of references to refresher training in relation to Section C.1 would have benefited from a reference to where that evidence could be found.
	Summary of Monitor's Assessment: In general, the Facility had systems in place for restraint reporting, monitoring, and review processes. However, concerns were noted in regard to the adequacy with which staff described the antecedent- and consequence-based interventions that were utilized prior to the implementation of restraint. It was not clear in all cases reviewed that staff implemented specific strategies from PBSPs in an effort to reduce target behavior and prevent the use of restraint. Concerns also were noted with regard to restraint monitors being in place within the 15 minutes. The trend analysis reports included not only an analysis on the data on restraints, but also recommendations for addressing some of the issues the analysis raised. The inclusion of timeframes and people responsible for the recommendations, as well as follow-up in subsequent reports showed development of a systematic approach to improvement. The addition in the report of identifiers for staff and individuals involved in large numbers of restraint was positive, as was the plan to prioritize review and focus attention on the individuals with large numbers of restraints. Refresher classes for staff who were assigned monitoring responsibilities had been completed in an effort to assure that they were properly equipped to monitor and accurately document restraints. This was responsive to the Facility's own data indicating some training was needed. The Facility's trend reports had documented an increase in restraints in October, and included analysis of the possible causes, the individuals, and the residences involved. The Facility was able to determine that the rise in use was not facility-wide, but concentrated on a few individuals and in four residences. This analysis was much more useful than the data alone, which indicated an upward trend in use. Adequate processes for assessment, and review and modification of Behavior Support Plans were not being consistently implemented for individuals who were placed in restraint more than three times in any 30-day rolling period.

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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.	Based on information the Facility provided in the data report: "Texas Department of MHMR – ABS, Restraint by Facility, 8/1/2010 -1/31/2011": ▪ 124 individuals were the subject of restraints; ▪ 703 restraints occurred; ▪ 327 of these were mechanical restraints; ▪ 216 of these were physical holds; and ▪ 160 of these were chemical restraints. Of the 703 restraints: ▪ 181 of these were emergency restraints; ▪ 105 of these were programmatic (per Safety Plan) restraints; ▪ 417 of these were medical/dental or protective restraints. Two individuals accounted for 255 of the 703 restraints. One, Individual #505, was in a wrist-to-waist restraint 199 times to protect him from seriously damaging his skin. The second, Individual #146 was in mitten restraints 56 times to protect him from damaging his skin. Individual #146 did not require restraint between 9/27/10 and 1/31/11, meaning that he appeared to have been successfully weaned from the restraint. A sample, referred to as Sample #C.1, was selected. This included 26 of the 38 individuals who had been restrained for emergency/programmatic reasons during the six-month period from 8/1/10 through 1/31/11. This represented 68% of the individuals restrained. Thirty-three records were examined, or 12% of the 286 records of emergency/programmatic restraints during this period. This sample was selected to ensure that some of the individuals with the highest numbers of restraint were included. <u>Prone Restraint</u> Based on Facility policy review, prone restraint was prohibited. Based on a review of the restraint records for individuals in Sample #C.1 involving 26 individuals, none (0%) showed use of prone restraint. Based on review of other documentation, including the Restraint Checklists, Face-to-Face sheets and Debriefing Sheets reviewed for Sample #C.1, prone restraint was not identified as having been used. In interviews with staff, no one had seen prone restraint used or had used it themselves, and staff appeared to understand that if an individual rolled into a prone position, they were to release the restraint immediately and restart in the proper position. This understanding was supported by comments on Restraint Checklists, indicating that individuals were released when they rolled into prone positions. Based on interviews with 12 direct support professionals, all were aware of the	Noncompliance

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		prohibition on prone restraint. However, some described it as restraint on the stomach, rather than as prone restraint. <u>Other Restraint Requirements</u> Based on document review, the Facility policies stated that restraints could only be used: if the individual posed an immediate and serious risk of harm to him/herself or others; after a graduated range of less restrictive measures had 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. Restraint records were reviewed for Sample #C.1, including the restraint checklists, face-to-face assessment forms, and debriefing forms. The sample was drawn from the data report: "Texas Department of MHMR – ABS, Restraint by Facility, 8/1/2010 – 1/31/2011." The data report included 703 incidents of restraint of all types, involving 124 individuals. Two hundred eighty-six incidents of restraint involving 38 individuals were listed as emergency or programmatic. (According to the psychologist who was interviewed for this review, the designation of "programmatic" was understood to mean restraints used as crisis intervention as specified in a Safety Plan.) Sample #C.1 included 33 incidents involving 26 individuals as listed above. The following are the results of this review: ▪ In 30 of the 33 records (91%), there was documentation showing that the individual posed an immediate and serious threat to self or others. Examples where this was not the case included: o For Individual #199 on 11/7/10 at 3:43 p.m., the form did not include information on the behavior that occurred just prior to the incident that was sufficient to allow a determination to be made regarding an immediate and serious threat; o For Individual #104 on 12/10/1 at 6:30 a.m., the restraint used was a horizontal hold, but it was categorized as "protective" which was inconsistent with the use of that hold. "Protective" restraints are usually mechanical restraints ordered to protect against opening of a wound or to prevent self-injury such as mittens or helmets. o For Individual #132 on 12/5/10 at 5:45 p.m., documentation was not available. ▪ For the 33 restraint records, a review of the descriptions of the events leading to behavior that resulted in restraint found that 31 (94%) contained documentation that indicated that there was no evidence that restraints were being used for the convenience of staff or as punishment. The exceptions were the records for Individual #199 where documentation was incomplete and Individual #132 where documentation was not available. ▪ In 29 of the records (88%), there was some level of evidence that restraint was	

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		used only after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner. However, in only 21 of the 33 records (67%), was the evidence considered sufficient. In the following four records, it could not be determined if a graduated range of less restrictive measures had been tried: o For Individual #132 on 12/5/10 at 5:45 p.m., the checklist and face-to-face documentation was not available. o For Individual # 387on 12/9/10 at 9:28 a.m. (there was a difference between the DFPS data sheet and the Restraint Checklist as to whether it was a.m. or p.m.), the Restraint Checklist was incomplete. There was no indication that a restraint monitor was called and no Face-to-Face assessment was completed. o On 10/4/10, Individual #477 was restrained twice in quick succession, once at 9:14 p.m., and again at 9:16 p.m. Two checklists were provided and one Face-to-Face to cover both episodes, making it difficult to determine exactly what happened. This was really one restraint episode with a failed release, and could have been recorded as such. o On 11/7/10 at 3:35 p.m., Individual #199 had an incomplete Restraint Checklist and no Face-to-Face, making it difficult to determine whether graduated steps had been completed. Of concern, in eight more of the 29 reports that had evidence, the evidence consisted of check marks in boxes provided or written repetitions of the checkbox language with no additional elaboration, making it difficult to determine if the graduated steps were actually attempted or whether they were considered and dismissed as not viable. The records where this was found to be the case were: Individual #43, Individual #534, Individual #79, Individual #160 on 9/4/10 and on 11/18/10, Individual #260 on 9/14/10 and Individual #324 on 9/17/10. Facility policies identified a list of approved restraints. Specifically, ABSSLC Policy: Use of Restraints, dated June 2010, at Section II.E.2 identified four mechanical restraints that could be used: helmet, mittens, boxing gloves, and wrist-to-waist restraints, and then only as part of an approved Safety Plan or Behavior Support Plan. The policy limited physical restraints to PMAB restraints, except "in rare cases when they cannot be safely applied," and then staff may take actions "believed to be immediately necessary to avoid imminent harm…" When Section II.E.2 was added to the ABSSLC Policy on Use of Restraints, it included the use of mechanical restraints as part of Behavior Support Plans. Since the definition of Behavior Support Plans covered positive interventions only, all use of restraint should be addressed in a Safety Plan. The policy should be amended accordingly. ▪ Based on the review of 33 restraints, involving 26 individuals in Sample #C1, all	

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		were approved restraints. An additional sample of 49 restraint records was reviewed. These restraints involved five individuals whose Behavior Support Plans were also reviewed. In every case, it appeared that restraint was used in response to a crisis that could not otherwise be effectively managed. As described, the individual was engaged in repeated aggression and/or self-injury that was posing a risk of harm. Comments on the records provided for each individual are provided below: ▪ Individual #387: Restraint checklists were completed for all but one occurrence. Twenty-six days after the restraint in question, a memo from the Chief Psychologist directed psychology staff to re-train the direct support staff member in restraint protocol. It appeared that restraint was applied in response to a crisis situation brought about through repeated aggression and/or self-injury. However the paperwork documenting the restraint had not been completed in full. ▪ Individual #199: Seventeen restraint checklists were completed addressing the use of bilateral wristlets to prevent eye injury across seven days. Time in restraint indicated a total of 3359 minutes. Documents indicated that checks were completed at half hour intervals. The restraint checklist documenting the use of a personal hold in September indicated the individual was upset because infirmary staff were not providing her points as outlined in her BSP. Psychology staff should ensure that all staff providing support to the individual are provided training on the BSP. ▪ Individual #43: As noted in the restraint report, a total of 11 restraints were applied between August and December of 2010. Documentation was found for all but two of these restraints. In every case, it appeared that restraint was applied in response to a crisis situation due to repeated aggression. ▪ Individual #303: There was significant discrepancy between the restraint report and the restraint documentation. This might have been the result of a typographical error, because the report indicated that four of the restraints initiated in October were terminated in December. Additionally, the restraint report noted one restraint each on 10/17 and 10/21. The restraint documentation indicated that on each of these days there were a total of three restraints. In every case documented, there appeared to be a crisis due to aggression, self-injury, and/or property destruction. ▪ Individual #510: Again, there was significant discrepancy between the restraint report and the restraint documentation. While the report indicated that eight restraints were implemented in September, the documents reflected one restraint in October and four restraints in December. The report of 12/3/10 provided no information regarding the events leading to restraint, or the strategies applied to avoid restraint.	

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		Although restraints were used in response to a crisis situation, the content of Behavior Support Plans remained in need of revision. As noted with regard to Section K.9, plans should be strengthened with regard to replacement behaviors (both identification and schedule for teaching), reinforcement for appropriate behavior, and individualized interventions that incorporate a range of consequences. A concern with regard to the use of restraint being used inappropriately was discussed with the Behavior Analyst while the Monitoring Team was on-site. Specifically, Individual #510's Safety Plan indicated that her wheelchair could be tilted when moving her from one area to another. The rationale was that this limited her ability to harm others. At no time should an individual's position in her wheelchair be changed for the convenience of staff. This should be removed from her Safety Plan immediately. Based on the combination of missing or incomplete restraint records, the lack of quality in reporting of interventions attempted before restraint was used, as well as concerns related to behavioral supports, the Facility was not found to be in compliance.	
C2	Effective immediately, restraints shall be terminated as soon as the individual is no longer a danger to him/herself or others.	The document, "Texas Department of MHMR – ABS: Restraint by Facility was reviewed. In 84% of the uses of restraint for emergency or programmatic reasons, the time in restraint was 10 minutes or less. In only three cases did it exceed 50 minutes. The Restraint Checklists involving the 33 episodes of restraint in Sample #C.1 were reviewed. ▪ In eight of the 33 records, chemical restraint was used and there was no information on release, because given the nature of chemical restraint, a release time cannot be determined; ▪ In the remaining 25 records in which release was applicable, 21 (84%) contained sufficient information to show that the individual had been released when he/she was no longer a danger to him/herself or others. The five where there was insufficient information included: o For Individual #387, the form was incomplete. o On 8-31-10, Individual #477 broke the restraint hold. When an individual breaks free from restraint through struggle, it is important to evaluate the problem with the use of that restraint, and determine if an alternate strategy should be employed. o Individual #328 was in restraint for four minutes, determined to be calm and quiet, and then held for another minute before being released. o On 11/19/10, Individual #252 was released twice unsuccessfully and then the final release was recorded as "according to his Safety Plan." However, the box for safety plan was not checked, so it was not clear	Noncompliance

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		whether or not he had a safety plan. As discussed with regard to Section C.7.e, concerns were noted with regard to the quality of individuals' Safety Plans. For individuals with Safety Plans, these were the documents that identified the criteria for release. As examples related to Section C.7.e, these criteria were not always identified in observable ways. In the four records where there was insufficient information, it appeared that in two, the issue was related to the documentation (Individual #477 and Individual #252). The Facility should ensure that restraint checklists are accurately completed in the future. It is essential that individuals be released as soon as they are no longer a danger to themselves or others, and that there be adequate documentation to substantiate that this has occurred.	
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 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.	The ABSSLC Policy and Procedure Index was revised in January 2011 and marked as current as of 1/12/2011. In the index, the Restraint Policy date was listed as June 2010. The Restraint Policy was adopted from the State policy on restraint, and had been amended to include the list of permitted restraints at ABSSLC, as described above with regard to Section C.1 of the Settlement Agreement. Review of the Facility's training curricula, entitled Prevention and Management of Aggressive Behavior (PMAB), revealed that it included adequate training and competency-based measures in the following areas: ▪ Policies governing the use of restraint; ▪ Approved verbal and redirection techniques; ▪ Approved restraint techniques; and ▪ Adequate supervision of any individual in restraint. A review of the list of staff, (Sample #C.2), including their start dates and the dates on which they were determined to be competent with regard to the required restraint-related topics, showed that out of 23 staff, 23 (100%) had been trained on restraint and its related topics as required for their position. Based on interviews with 12 direct support professionals: ▪ Nine (75%) were able to describe the basic policy governing the use of restraint; and ▪ Ten (83%) were able to describe approved restraint techniques. Staff's ability to describe restraints depended somewhat on whether restraints were in regular use within their unit. However, all staff that are responsible for the potential use of restraint should be competent in it, and able to describe the basic policy provisions, as	Noncompliance

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		well as the list of approved restraints. As noted above with regard to Section C.1 of the Settlement Agreement, 67% of the restraint records reviewed included adequate documentation that restraint was only used after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner. The documentation was not as useful in some cases, because there were no notes describing how or in what order the measures were applied. While the training on the use of restraints appeared to be comprehensive and staff were being retrained in pre-service and annually, not all staff were able to respond to basic questions about the restraint policy and not all knew which restraints were approved. As noted above, in only 67% of the records reviewed was documentation sufficient to show that the intervention was the least restrictive. As a result, the Monitoring Team did not find compliance on this provision.	
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.	In 30 of the 33 records (91%), there was documentation showing that the individual posed an immediate and serious threat to self or others. Examples of the concerns noted are included with regard to Section C.1. In a review of 58 Behavior Support Plans, there was no evidence of the use of programmatic restraint. The plan for Individual #313 did review the use of restraint in a crisis situation. While this individual was on the list for the development of a Safety Plan, it appeared that at the time of the visit, a plan had yet to be written. Despite the fact that many individuals at ABSSLC had risk factors that would have contraindicated the use of restraint, ABSSLC did not have a "Do Not Restrain" list, according to their response for Request for Documents TX–AB–1102 –II.19. The following provide examples of individuals for whom consideration should have been given to including them on a "Do Not Restrain" list: ▪ Individual #8's Annual Medical Summary indicated: "great hesitancy" to authorize use of restraint. However, the Restraint Risk Assessment indicated there was no contraindication to the use of restraint. ▪ Individual #52's medical summary indicated that restraint was contraindicated due to osteoporosis. ▪ Individual #115's the medical summary indicated "try not to use restraint," due to osteoporosis. ▪ Individual #46's PSP indicated there was a specific contraindication to restraint. In an effort to reduce the use of chemical and mechanical restraint for dental procedures, staff at the Facility had identified 10 individuals who were considered most in need of	Noncompliance

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		services. This represented a small percentage of the individuals for whom chemical or mechanical restraint had been used. Dental desensitization plans were developed for those individuals who the Dentist had identified as priorities. Six of these plans were provided for review, only two of which were dated (Individual #307 and Individual #381). The author was identified in four of the six plans, but none of the plans were signed. In every case, desensitization activities were scheduled to occur once per week. Consideration should be given to increasing opportunities for exposure and practice, because this schedule is likely to be insufficient in changing behavior. In all but one case (Individual #104), the identified reinforcer was verbal praise. Consideration should be given to using more powerful reinforcers (paired with praise) to help individuals become more comfortable with what has been identified as a highly non-preferred activity. Lastly, while training steps were clearly identified in five of the six plans, the criterion for movement through the steps was not specified. The sixth plan (Individual #104) did include steps, but these were less clearly outlined than in the other five plans. The plan for Individual #307 was stopped, because it was determined not to be necessary. This would suggest that there might be other individuals who may tolerate dental procedures without the need for sedation.	
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 justification, the physician may order an alternative monitoring	Review of Facility training documentation showed that there were training curricula on the application and assessment of restraint. In addition to the PMAB training, which was competency-based and required demonstrations of competency and was required for staff in positions where they might need to use restraint, there was a curriculum called "Restraint for SSLC Facilities." It could not be determined if this training was competency-based. Although it identified the skills staff needed to perform their responsibilities, it was not clear from the materials provided how competency would be judged. Based on review of training records, found in the Presentation Book for Section C, on 9/30/10,18 staff at the Facility completed training on Restraint Debriefing: Timely Responding and Accurate Completion of Form. On 11/04/10, nine staff attended "Re-training on Debriefing for Restraints," and on 12/2/10, as part of a Psychology staff meeting, 21 staff (17 had attended the 9/30/10 training) attended Retraining on Restraint Debriefing. It was not clear what the curriculum for these trainings were except that a copy of the Policy and Procedure manual section on "Procedures and Responsibilities of the Restraint Monitor During a Behavioral Crisis," dated November 2009 was included with the sign-in sheets for the trainings. Sign-in sheets included a section for a determination of competency for each staff, but that section of the sheet was not completed. Based on the lists provided, it appeared that 30 staff had attended some training on the restraint monitoring process. However, it was not clear that all of these staff had demonstrated competency, and, if so, how this had been determined.	Noncompliance

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	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.	Based on a review of 33 restraint records (Sample #C.1), a face-to-face assessment was conducted: ▪ In 28 out of 33 incidents of restraint (85%) by a trained staff member. Records that did not contain documentation of this included: Individual #387 (no form), Individual #94 (no form), Individual #132 (no form), Individual #199 (no form) and Individual #425 on 12/20/10 (where the signature of the monitor was not legible). ▪ In 24 out of 33 instances (73%), the trained staff member began the assessment of the restraint, no later than 15 minutes from the start of the restraint. Records that did not contain documentation of this included: Individual #534 on 12/3/10 at 10:13 p.m., Individual #252 on 11/19/10 at 5:15 a.m., Individual #437 on 12/11/10 at 5:45 p.m., Individual #425 on 11/23/10 at 2:16 p.m., and on 12/20/10 at 8:57 p.m., Individual #94 on 10/17/10 at 5:45 p.m., Individual #387, Individual #132, and Individual #199 on 11/7/10 at 3:43 p.m. ▪ In 28 instances (85%), the documentation showed that an assessment was completed of the application of the restraint. Records that did not contain documentation of this included: Individual #387 on 12/9/10 at 9:28 a.m., Individual #199 on 11/7/10 at 3:43 p.m., Individual #132 on 12/5/10 at 5:45 p.m., Individual #260 on 9/14/10 at 2:10 p.m., and Individual #94 on 9/4/10 at 12:27 p.m. ▪ In 23 instances (70%), the documentation showed that an assessment was completed of the circumstances of the restraint. Records that did not contain documentation of this included: Individual #534 on 12/3/10 at 10:13 p.m., Individual #252 on 11/19/10 at 5:15 a.m., Individual #437 on 12/11/10 at 5:45 p.m., Individual #425 on 11/23/10 at 2:16 p.m., and on 12/20/10 at 8:57 p.m., Individual #94 on 10/17/10 at 5:45 p.m., Individual #260 on 11/3/10 at 3:04 p.m., Individual # 387, Individual # 132, and Individual #199 on 11/7/10 at 3:43 p.m. ▪ In explanation of the previous two bullets, while assessments had been done of the application and circumstances of restraint, at times, the quality of this assessment was not adequate. They did not always focus on the cause of the behavior that led to the restraint and to the possibilities for preventing the restraint in the future. For example: o In the restraint involving Individual #324 on 11/6/10 at 11:20 a.m., the Restraint Checklist description read: "...displayed aggression and SIB toward staff hitting them and attempting to bite staff. She was biting her arm and picking at sore …layed (sic) in the recliner and began to attempt to knock it over rocking heavily and screaming." This information explained why she needed to be restrained, but did not explain what preceded her aggression and SIB. The Face-to-Face sheet recorded "I do not know," in response to the question about what might be tried to	

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		prevent restraint. o In a restraint of Individual #324 on 9/17/10, the explanation was much more useful. It read in part: "…was upset about not having sauce on her meat, so she became aggressive…" This records what was happening just before her behavior became aggressive and provided information that could be used to avoid future restraints. However, the Face-to-Face sheet did not provide any ideas about preventing restraint, such as posing the question: "Can she have sauce with her meat? If not, what steps could staff take to diminish the likelihood of challenging behaviors when she requests sauce and/or her peers are served sauce with their meat?" ▪ The sample did not contain any episodes where the physician had authorized an alternative monitoring schedule. Based on a review of 33 restraint records for 26 individuals for restraints that occurred at the Facility (Sample #C.1), there was documentation that a licensed health care professional: ▪ Conducted monitoring at least every 30 minutes from the initiation of the restraint in 20 of the 33 instances of restraint (61%). Records that did not contain documentation of this included: Individual #324, on 11/6/10; Individual #102, on 10/4/10; Individual #81, on 9/20/10, Individual #425, on 11/23/10; Individual #477, on 8/31/10, and 10/4/10; Individual #387, on 12/19/10; Individual #357, on 11/1/10; Individual #437, on 12/11/10; Individual #328, on 8/2/10; Individual #149, on 9/9/10; Individual #163, on 11/7/10; and, Individual #156, on 10/23/10. ▪ Monitored and documented vital signs in 27 of the 33 instances (82%). Records that did not contain documentation of this included: Individual #81, on 9/20/10 (none recorded); Individual #477, on 8/31/10 (none recorded); and Individual #387, on 12/19/10 (none recorded). Individual #104, on 12/10/10; Individual #160, on 11/18/10; and Individual #437, on 12/11/10 had respirations noted as "refused." To obtain respirations, the individual's cooperation is not required. ▪ Monitored and documented mental status in 29 (88%). Records that did not contain documentation of this included: Individual #81, on 9/20/10; Individual #477, on 8/31/10; Individual #387, on 12/19/10, and Individual #437, on 12/11/10 had mental status noted as "refused." To obtain a mental status, the individual's cooperation is not required. Sample #C.3 included the last nine episodes of medical restraint as supplied by the Facility in response to Request for Documents TX-AB-1102-II.8, including: Individual #304 on 12/14/10 at 1:00 p.m. and at 2:35 p.m., Individual #519 on 12/21/10 at 11:25 a.m., Individual #320 on 12/16/10, Individual #238 on 12/22/10 at 7:15 a.m., Individual	

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		#69 on 12/30/10 at 6:00 a.m., Individual #178 on 12/31 at 7:00 a.m., Individual #455 on 12/28/10 at 6:00 a.m., and Individual #192 on 12/22/10 at 7:15 a.m. All of these restraints were chemical. For these individuals, the physicians' orders as referenced on the Restraint Checklist were reviewed, as well as documentation of monitoring on the Restraint Checklist. The following represents the results of this review: ▪ In nine out of nine episodes of medical restraint (100%), the physician did not specify a schedule of monitoring. The ABSSLC Restraint Policy section II.M did not require monitoring of a chemical restraint every 15 minutes in the absence of an order for an alternate schedule, as it did for chemical restraint used for crisis intervention. ▪ In each of the nine episodes, (100%) the Restraint Checklist included monitoring by a nurse or the dentist. Each case varied depending on the procedure, and the chemical restraint. Some monitoring was every 10 to 15 minutes, and some was at the start of the procedure and at the conclusion.	
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.	A sample (Sample #C.1) of 33 Restraint Checklists for individuals in non-medical, that is emergency or programmatic (in accordance with a Safety Plan), restraint was selected for review. The following compliance rates were identified for each of the required elements: ▪ In 28 (85%), continuous one-to-one supervision was provided: o Checklists for Individual #387, Individual #199, Individual #104, Individual #79, Individual #160, and Individual #132 did not include information about "Level of Service;" ▪ In 33 (100%), the date and time restraint was begun was documented; ▪ In 33 (100%), the location of the restraint was documented; ▪ In 10 (30%), information was documented about what happened before, including the change in the behavior that led to the use of restraint. The seven cases where there was sufficient information about what was happening before the behavior that led to restraint included: Individual #437, Individual #43, Individual #231, Individual #149, Individual #260 on 10/9/10 at 6:05 p.m., Individual #324 on 9/17/10, and Individual #303. An additional three included some information, but left an open question: Individual #79 was upset about her foot, but there was no indication regarding what it was about her foot that was upsetting; Individual #106 on 9/4/10, and Individual #260 on 9/14 were both upset about not being able to choose their staff. What was not reported was why they couldn't choose their staff: absence, unavailability, past history, etc. In the 23 remaining cases, the behavior that caused staff to apply restraint was usually clear, but what triggered that behavior was not present. For example, Individual #74 was restrained when he had an "outburst for no apparent reason." What needed to be discovered was what was going on with him just before the outburst. For comparison, Individual #324 on 9/17/10 was restrained after an	Noncompliance

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		outburst that began with her wanting sauce on her meat. In that case, it was happened directly prior to the episode. ▪ In 24 (73%), the actions staff took prior to the use of restraint were noted to permit adequate review per Section C.8. However, in some cases the information was sparse. While notes can be helpful, they do not add valuable information when they merely repeat the information in the check box. For example: o Individual #199 was hitting staff. The Restraint Checklist included two checkmarks to indicate interventions attempted and nothing more. o Individual #328 was punching staff and yelling. Boxes were checked for verbal prompt and redirection, and "Environmental change" was written in. o Individual #43 was displaying aggressive behavior. Boxes for verbal prompt and redirection were checked, and the same information was written on the form. In the 24 restraints for which the information was adequate, the completed forms offered information beyond the checking of boxes to provide a clearer picture of what was happening and what was not working. For example: o Individual #534 was aggressive toward two peers. Boxes were checked for most of the list interventions, and included some additional descriptive language regarding the interventions attempted in the description of events leading to restraint. o Individual #156 was biting, head-banging and throwing himself to the floor. Boxes for verbal prompt and redirection were checked, and a note was entered indicating what was tried first and second and what his reaction was. o Individual #104 was aggressive and destructive. Most interventions were checked and notes were added to describe approaching him in a calm tone, and offering him an opportunity to get a cigarette after he took his medication. ▪ In 32 (97%), the specific reasons for the use of the restraint were identified. For Individual #132, the Restraint Checklist was incomplete. ▪ In 33 (100%), the method and type (e.g., medical, dental, crisis intervention) of restraint was documented; ▪ In 33 (100%), the names of staff involved in the restraint episode were listed; ▪ Observations of the individual and actions taken by staff while the individual was in restraint were noted, including: o In 30 (91%), the observations documented every 15 minutes and at release. The exceptions were: Individual #387, where the Restraint Checklist was incomplete; Individual #79, during which the person with chemical restraint was only checked every 30 minutes by the nurse; and Individual #132 where the person with chemical restraint was checked	

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		only once by the nurse. o For the 27 episodes of physical or mechanical restraint, in all (100%), the specific behaviors of the individual that required continuing restraint were documented; and o There was one case where the physical restraint lasted more than 30 minutes. On 11/6/10, Individual # 324 was in horizontal restraint from 11:20 a.m. until 12:15 p.m. During these 55 minutes, she was released twice for 10 minutes and once for nine minutes, but the restraint had to be reinstituted. There was no meal offering, but the restraint did not last past the lunch hour. It appeared that the individual had opportunities to exercise restrained limbs, and to eat as near meal times as possible. Fluids were not offered, but the circumstances might not have permitted it. Opportunities to use a toilet or bedpan were not provided, but there was no indication that it was necessary in this relatively short period. ▪ In 22 of 33 restraints (67%), the documentation identified the level of supervision provided during the restraint episode as one-to-one. In 11 of the episodes where there was no indication that one-to-one supervision was provided. Of those 11, seven involved chemical restraint. ABSSLC: Restraint Policy required that the level of supervision for individuals with chemical restraint be increased to one-to-one until the individual had been determined by a licensed health care professional to be medically stable. In the remaining four episodes, there was no indication of level of supervision on the Restraint Checklist. ▪ In 25 of 26 restraints that were not chemical (96%), the date and time the individual was released from restraint was on the Restraint Checklist. In five of the 25 episodes the release date was not entered on the correct place on the form, but could be determined from the event codes. Seven episodes of restraint were chemical and no release date could be given, since the release is when the drug wears off. One episode, for Individual #387, did not have the required information. ▪ In 25 of the 33 instances of restraint reviewed (76%), the results were present of assessment by a licensed health care professional as to whether there were any restraint-related injuries or other negative health effects. Records that did not contain documentation of this included Individual #102, on 10/4/10; Individual #160, on 11/18/10; Individual #477, on 8/31/10; Individual #387, on 12/19/10; and Individual #163, on 11/7/10. The records for: Individual #324, on 9/17/10; Individual #260, on 10/9/10; and Individual #324, on 11/6/10 did not include appropriate documentation regarding the specific descriptions of injuries.	

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		In a sample of 33 records (Sample #C.1), restraint debriefing forms had been completed for 28 (85%). For Individual #387, Individual #199, Individual #132, there were no debriefing forms provided. Individual #94, and Individual #260 on 9/14 had Administration of Emergency Medication Protocols (Chemical Restraint) completed, but no debriefing forms. A sample of nine individuals subject to medical restraint was reviewed (Sample #C.3), and in four (44%), there was evidence that the monitoring had been completed as required by policy for use of chemical restraint. ▪ Monitoring varied by individual from at least every 15 minutes in four cases to more than 15 minutes in five cases. Episodes showing monitoring intervals of more than 15 minutes included: Individual #304, Individual #320, Individual #69, Individual #455, and Individual #192. Since 60% of these episodes did not appear to be monitored at the required level of every 15 minutes, medical procedures should be checked to determine if the restraint policy is clear, or if the alternate schedule of monitoring is being specified somewhere other than on the Restraint Checklist. If it is recorded elsewhere, it might be useful to note the schedule on the Restraint Checklist next to the date and time of the order. Sample #C.4 was selected from those who had chemical restraint as an emergency or programmatic restraint in Sample #C.1. This included the following individuals: Individual #43, Individual #79, Individual #94, Individual #260 on 9/14/10, 10/9/10, and 11/3/10, and Individual #132. This sample of five individuals who were the subject of seven episodes of chemical restraint was reviewed. Although in all cases, a psychologist had been contacted, in none (0%) of these episodes was there unambiguous documentation that prior to the administration of the chemical restraint, the psychologist had assessed whether less intrusive interventions were available, and whether or not conditions for administration of a chemical restraint had been met. However, in all cases, the nurse had contacted the physician to obtain an order for chemical restraint. According to a Psychologist, substituting for the Chief Psychologist, the usual procedure was for the nurse to act as the intermediary between the physician and the psychologist, asking the psychologist for any ideas about what else might be tried and the physician about whether a chemical restraint would be appropriate. With that process in mind, a review of the seven episodes revealed that in four, the psychologist was in the area where the episode was taking place or had been called by the nurse prior to the issuance of the physician's order. In two episodes: Individual # 260 on 9/14/10, and on 11/9/10, the physician was called at the same time or later than the psychologist. In one episode, Individual #132, the Restraint Checklist was not available. As illustrated throughout this section, a number of issues related to authorization prior to the use of chemical restraint, as well as individuals' supervision while in restraint, follow-	

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		up after restraint, and documentation of the restraint episodes continued to exist. As a result, the Facility remained out of compliance with this provision of the Settlement Agreement.	
C7	Within six months of the Effective Date hereof, for any individual placed in restraint, other than medical restraint, more than three times in any rolling thirty day period, the individual's treatment team shall:	According to the restraint review provided by the Facility, during the six-month period prior to the on-site visit, a total of 30 individuals were placed in restraint more than three times in any rolling 30-day period. A sample of six of these individuals (20%) was selected for review to determine if the requirements of the Settlement Agreement were met. The six individuals reviewed included: Individual #387, Individual #43, Individual #74, Individual #231, Individual #486, and Individual #510. The following documents were reviewed: Behavior Support Plans, addenda to the individual's Personal Support Plan, and where available the Psychology Monthly Progress Note, and Safety Plan. The results are discussed below with regard to Sections C.7a through C.7.g of the Settlement Agreement. For six of the individual reviewed (100%), the individuals' teams met to discuss the restraints.	Noncompliance
	(a) review the individual's adaptive skills and biological, medical, psychosocial factors;	While there was no indication that an adaptive behavior assessment had been completed in response to frequent use of restraint, the Addenda for two individuals (33%) reflected discussion related to adaptive behavior. For Individual #231 the team discussed teaching her money and time management skills. Due to her weight issues, the team also recommended training objectives to address healthy eating and physical activity, and to learn about a healthy diet. The team discussed a variety of training objectives for Individual #486. In six cases (100%), the individual's team engaged in discussion regarding biological, medical, and/or psychosocial issues. Below are specific examples: ▪ Individual #387: The team reviewed better ways for staff to communicate with him and offer him choices. ▪ Individual #43: The team discussed his psychiatric decompensation, and made a referral to the state hospital. Staff also noted that the individual had difficulty following visits with his family. Psychology staff should have provided guidelines regarding preventative strategies following family visits. ▪ Individual #74: This individual had experienced an assault by a peer in early January of 2010, which negatively impacted his behavior. Staff were directed to provide counsel as needed. Consideration should have been given to enrolling this individual in regularly scheduled counseling provided by a professional therapist. ▪ Individual #231: This individual's difficulty with her prescribed reduced diet was frequently discussed. Support to the individual was reviewed.	Noncompliance

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		▪ Individual #486: This individual was noted to suffer from allergies, yet it appeared that no steps were taken to provide medication on a regular schedule. This same individual was noted to have difficulty following visits from his mother, or when receiving support from particular staff. Consideration should have been given to outlining preventative strategies that could be implemented following family visits. Whenever possible, staff should have been directed to ensure that this individual was working with preferred staff. ▪ Individual #510: Addenda to her Personal Support Plan reflected frequent discussion regarding her poor eating habits, and her need for dental care. The former was addressed repeatedly, and the latter resulted in several dental procedures while the individual was sedated.	
	(b) review possibly contributing environmental conditions;	Contributing environmental conditions were addressed for two of the six individuals (33%). As noted above, Individual #74 had experienced significant trauma. In response to this, he had been given his own bedroom. Individual #510 displayed difficulties with food consumption as noted above. In an attempt to improve this situation, staff had offered a change to the location and timing of meals. During the review of the Facility, it was apparent that the lack of interesting and varied materials often led to problem behaviors. Individual #387 was observed wandering around his home, without any activity provided. He began to engage in repeated aggression, resulting in directions from staff to stop. The lack of interesting materials and activities for him to access certainly contributed to his problem behavior. However, this was not being consistently considered and/or addressed as a contributing factor, in general, or for individuals requiring more than three restraints in a rolling 30 days.	Noncompliance
	(c) review or perform structural assessments of the behavior provoking restraints;	For three of the individuals reviewed (50%), the individual's team had completed a functional behavior assessment. A summary of the assessment results with accompanying recommendations for intervention had been written for Individual #74, Individual #486, and Individual #510. Specific feedback regarding these assessments can be found with regard to Section K.5 of the Settlement Agreement. Functional behavior assessments were scheduled to be completed for the other three individuals between February and September of 2011.	Noncompliance
	(d) review or perform functional assessments of the behavior provoking restraints;	See Section C.7.c above.	Noncompliance
	(e) develop (if one does not exist) and implement a PBSP based on that individual's particular	Each of these individuals did have a current Behavior Support Plan. In all cases, operational definitions were provided for identified target behaviors. In three of these BSPs, or 50%, an operational definition of the replacement behavior was provided. In the	Noncompliance

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	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 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;	other three plans, broad statements regarding the individual's response were given. All of the plans did include descriptions of preventative strategies and behavior contingencies to be followed. Specific comments regarding BSPs are provided with regard to Section K.9 of the Settlement Agreement. Two additional concerns are addressed below: ▪ Individual #387: This individual's plan called for a sensory diet, presumably to help him "… calm and self-regulate." Staff were also directed to provide frequent opportunities for movement as "children with autism seek movement because it tends to help ground them." Neither of these suggested characteristics were operationally defined, nor was there research literature to support either of these claims. This same individual was to be guided to a quieter place where he could listen to music (an identified reinforcer), if he was displaying tantrum behavior and could not calm. This might result in a strengthening of his tantrum behavior. ▪ Individual #486: Although concerns regarding eye poking behavior are addressed with regard to Section K.9, it is important to raise these again as the team noted in January of 2011 that this behavior could cause serious injury. However, it had been removed from his BSP, because he would stop when told to stop. This should be added to the target behavior of self-injury on this person's BSP. Safety Plans were provided for all six (100%) of the individuals reviewed. In four plans, the type of personal restraint was identified, the maximum duration of the restraint was noted, and criteria for terminating restraint were listed. The Safety Plans for Individual #43 and Individual #510 specified the type of chemical restraint to be used, so release criteria was not applicable. Specific release criteria are described below: ▪ For Individual #387 and Individual #74, release from restraint was to occur immediately when the individual was no longer a danger to self or others. ▪ Release criterion was the same for Individual #231, with the exception that her plan noted that five minutes of "calm" behavior would indicate the absence of danger. A definition of "calm" behavior (e.g., no longer yelling in protest, no longer physically resisting restraint) would have enhanced this release criterion. ▪ Individual #486 was to be released as soon as he was no longer a danger, or sooner if he requested that his helmet should be removed. ▪ The Safety Plans for all four individuals noted that release should occur if the individual showed signs of physical distress or experienced a medical emergency, or when an evacuation or evacuation drill occurred. While all the plans also defined situations in which restraint should be used, most (67%) referred to a situation in which three criteria were met: a) the individual was attempting to or actually hurting self or others; b) the listed less restrictive procedures had been	

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		exhausted; or c) these procedures were not considered feasible. Two plans offered greater specificity than others. It is important to note that these criteria must be used within the context of the "danger to self or others" requirement: ▪ Individual #43: A request could be made for chemical restraint if this individual did not cease engaging in aggressive behavior after five minutes of attempts to "redirect" him. Redirection should have been defined in observable terms. ▪ Individual #231: Her plan specified that if she were still aggressive after five minutes, a physical restraint could be applied. Although this five-minute criterion provided more specific information, the intensity or frequency of her aggression should have been identified (e.g., five hits in five minutes). Safety Plans typically followed the same format, with advice to staff to first direct the person to an area away from others, to change staff, to not crowd the individual, and to remain calm. One plan raised concerns, which were discussed with the Behavior Analyst at the time of the visit. More specifically: ▪ Individual #510: Staff were advised that this individual's wheelchair could be tilted when moving her from one area to another. The rationale was that this limited her ability to harm others. At no time should an individual's position in her wheelchair be changed for the convenience of staff. This should be removed from her Safety Plan immediately. Due to issues related to the quality of individuals PBSPs and Safety Plans, the Facility remained out of compliance with this provision.	
	(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	At the time of the monitoring visit, the Facility staff were just beginning to monitor the implementation of treatment plans. Strategies to ensure high levels of treatment integrity will require ongoing support and training of the direct support professionals as they carry out their job responsibilities. Feedback regarding the draft monitoring tool is provided with regard to Section K.12.	Noncompliance
	(g) as necessary, assess and revise the PBSP.	Based upon a review of the Psychology Monthly Progress Notes and Personal Support Plan Addenda, it appeared that there was only one instance (17%) where the Behavior Support Plan was revised in response to worsening behavior. Blocking pads were recommended in an attempt to reduce the incidence of self-injury and restraint for Individual #486. It was recommended this change be made to the individual's Safety Plan. Changes to the Behavior Support Plans were not recommended in other cases, but should	Noncompliance

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		have been. For example: ▪ Individual #231 was observed to have worsening behavior when waiting for, or returning from a family visit. Strategies to support her during these times should have been included in her Behavior Support Plan. ▪ Individual #510 had a replacement behavior designed to teach her to ask for a break. However, under the teaching guidelines, staff were advised to provide her with a break even if she did not display the communicative response. During the review, staff reported that she often threw her communication book and rarely used this for its intended purpose. Given her increasing rates of aggression, it would have been appropriate to revise her Behavior Support Plan to better address replacement behavior, reinforcement for appropriate behavior, and more individualized strategies for intervention.	
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.	According to the ABSSLC: Restraint Policy, the process for reviewing restraints started with the restraint monitor who was to arrive at the site of the restraint within 15 minutes of the start of the restraint. The restraint monitor determined if the restraint was necessary and applied correctly, reviewed the Restraint Checklist and completed a Face-to-Face and Debriefing form (one document). The restraint monitor interviewed staff and the individual restrained in order to complete the document. The nurse was called, and in addition to other responsibilities during the restraint, examined the individual for injury at the conclusion of the restraint. If injuries were noted, they were treated, an injury report was filed, and the physician notified. The nurse completed the medical section of the Restraint Checklist. The restraint monitor took the Restraint Checklist and the Face-to-Face/Debriefing Form to the Psychology Department for review, and the Psychologist took it to the Unit Meeting on the following day. The Unit Team discussed the restraint and noted their review in the minutes of the meeting. The Unit Director took the form to the next Incident Management Review Team (IMRT) Meeting, where information about the restraint was reported, discussed, if necessary, and any needed instructions given to team members. The Unit Director noted the dates of the Unit and Incident Management Team reviews on the Debriefing form, and any additional actions to be taken, and returned the form to a clerk for data entry. Depending on the circumstances of the restraint and the determinations of the Unit and Incident Management Review Teams, a Personal Support Team (PST) meeting might be called, and an addendum added to the Personal Support Plan. At the end of each month, the Quality Assurance staff issued a summary of the data	Noncompliance

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		collected through this process, and the Psychology Department prepared a trend analysis of the data. At their monthly meetings, the Restraint Reduction Committee reviewed the summaries and trend analyses to determine where to apply efforts at reduction from both an individual and a systemic perspective. The trend analyses included information about individuals experiencing high levels of restraint, and possible causes of the increase in behavior. They identified specific individuals, which made the information easier to use. This was a significant improvement since the last review. The Committee's minutes also included updates on recommendations made in the previous month. In November for example, recommendations were updated for four individuals, and two recommendations about tracking and trending initiatives. Four new recommendations were added and assignments given. This was an excellent process that, if pursued with determination and in conjunction with the new Personal Support Plan process, should result in reductions in restraint use. Documentation related to a sample of 33 incidents of non-medical restraint was reviewed (Sample #C.1). In 28 (85%), this post-review of restraint occurred within three days of the restraint episode, according to the information supplied on the Debriefing Form. An additional sample of the ten most recent episodes of restraint was provided by the Facility. The Restraint Checklist and the related minutes from the Incident Management Review Team were provided. In each case the Incident Management Team minutes recorded the episodes without further comment, making it difficult to determine if adequate review had occurred, and action taken. • In all (100%), the circumstance under which it was used was determined. On 2/16/11, a member of the Monitoring Team observed the Unit 3 Team Meeting, and learned that detailed discussion of restraints employed in the past 24 hours took place. Minutes might not capture the discussion, however. Moreover, the Restraint Reduction Committee minutes were reviewed for 8/26/10 and 11/29/10. The November report contained the speculation that the rise in restraint use in October could be tied to "the cameras coming to campus" without further elaboration. Although some positive activity was occurring with regard to the review of restraints, improvements continued to need to be made with regard to the timeliness of the reviews, as well as the documentation of the reviews and resulting actions at the unit level. The Restraint Reduction Committee should continue to focus on identifying the potential causes for restraint, and developing and implementing plans to reduce the use of restraint.	

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

1. The Restraint Reduction Committee should continue with an emphasis on discovering the underlying causes for individuals with the most frequent use of restraint and promote accurate descriptions of antecedent behavior on Restraint Checklists.
2. As is discussed in detail in Section K of this report, improved Functional Behavior Assessments and Behavior Support Plans need to be developed. This will help to reduce the use of all types of restraint. More specific recommendations for the Facility's consideration are contained in Section K of this report.
3. Immediate attention should be given to those individuals for whom restraint, particularly chemical restraint, is employed frequently. This should include a review of the individuals' Behavior Support Plans, with revisions made accordingly. Ongoing review of data is essential, and should occur as part of the systems developed to reduce the overall use of restraint.
4. Monitoring instruments should include guidelines to ensure inter-rater reliability, and numbering of associated forms and graphs should match.
5. Training should be provided to direct support professionals to ensure that they are prompting the use of replacement behaviors and other coping strategies and documenting their use adequately, when appropriate, on restraint checklists.
6. Desensitization plans should be individualized. Assessments should be conducted to identify individual-specific preferences, current coping skills/deficits, and likely effective supports. Once identified, these elements should be incorporated into plans and implemented across settings, including opportunities to practice coping skills in the natural setting (dental office).
7. Progress on desensitization plans should be regularly documented and summarized. Such information should be summarized in Monthly Behavioral Services PSP Monthly Reviews (i.e., along with other behavioral data) or in Monthly PSP Reviews (i.e., along with other skill program data). In addition, efforts should be made to ensure that all documentation accurately and consistently reflects the implementation of these plans.
8. The Facility should ensure that restraint monitors are in place within the 15 minutes the Settlement Agreement requires.
9. The Facility should ensure that a licensed health care professional monitors and documents vital signs and the 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.
10. The Facility should ensure that nursing assesses and appropriately documents any restraint-related injury.
11. The quality of the documentation of the events preceding the restraint should be improved to provide an understanding of what happened to initiate the chain of events that resulted in restraint, as well as the specific actions staff took.
12. The quality of the Restraint Debriefing and Face-to-Face forms should be improved. Specifically, improvements are needed with regard to completing the forms accurately, and filling in all information.
13. In order to ensure that staff have adequate knowledge and skills related to restraint, supervisors should quiz staff often on the restraint policy, and on proper use of restraints.
14. Since the Restraint Checklist, Face-to-Face sheet and Debriefing all require handwritten information, it is important that the information be legible. Staff should be reminded to write legibly.
15. Safety Plans should be brief, with clear descriptions of the behavior that will result in restraint. Guidelines for implementation should be individualized. Information that can be found in other reports should be eliminated unless it is informative to the staff member in addressing the crisis situation and is necessary to ensure safety.
16. The Unit and IMRT's review of restraint episodes should be 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. These reviews, the corresponding recommendations, and any follow-up should be well documented.

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 ABSSLC Policy #021: Protection from Harm-Abuse, Neglect and Incident Management, dated 6/18/10; o ABSSLC Policy #002.2: Incident Management, dated 6/18/10, revised 1/14/11; o ABSSLC Plan of Improvement, dated 1/31/11; o ABSSLC: Stopping Abuse is Everyone's Business, undated; o Documentation of training of Qualified Mental Retardation Professionals (QMRPs) on the use of the resource guide, dated 1/14/11; o List of abuse cases from 7/1/10 through 12/31/10, provided in response to Document Request: TX-AB-1102-III.18.a; o List of unusual incidents from 8/1/10 to 12/31/10, provided in response to Document Request TX–AB–1102–III.18.b; o ABSSLC Unusual Incidents Trend Report –FY 2011, 9/1/10 to 11/30/10; o ABSSLC Injury Trending, for 9/1/10 through 11/30/10; o ABSSLC Allegations of Abuse/Neglect/Exploitation Trend Report, FY11: 11/1/10 to 11/30/10; o Reassignments list provided in response to Document Request TX-AB-III.34; o Employee Listing, dated 1/26/11; o Job Data Change, effective date from 11/1/10 to 12/31/10, reported dated 1/10/11; o Individual Training Records for 23 employees in Sample #C.2; o Adult Protective Services (APS) Mental Health and Mental Retardation (MH&MR) Investigations Instructor Led Advanced Skills Development ILASD, dated March 2009, Modules 1, 2, 3, and 4; o APS MH&MR Investigations Instructor Led Skills Development (ILSD), dated October 2009, Modules 7, 8, and 10; o List of serious injuries investigated from 1/1/10 through 12/19/10; o Reassignments list in response to Document Request TX-AB-1102–III.34; o Abuse, Neglect, and Exploitation training curriculum, dated 6/5/06 o Sample #D1 included a sample of 31 DFPS investigations of abuse, neglect, and/or exploitation with the Facility investigation reports that were related. This sample included the following DFPS investigation numbers: #38212421, #38294736, #38048720, #38038680, #38477185, #37376561, #37990303, #38496955, #38254301, #38497721, #38287790, #38272461, #38277195, #38285763, #38349543, #38476499, #38284265, #38404435, #38182701, #38480668, #37668942, #38345042, #38473138, #38410714, #38187901, #38469719, #38277404, #38284214, #37707240, #38472232, and #38431676; o Sample #D2 which included a sample of 10 Facility investigations. Some of these were

	investigations that DFPS had referred to the Facility, while others were investigations the Facility completed related to serious incidents. This sample included the following Facility investigations numbers: #2537, #2378, #2525, #2339, #2338, #2388, #2419, #2512, #2466, and #2502; and o Personal Support Plans for Individual #115, Individual #429, Individual #438, Individual #505, Individual #91, Individual #46, Individual #444, Individual #245, Individual #9, and Individual #52. ▪ **Interviews with**: o Linda Hinshaw, Facility Director; o Jolene Willis, Assistant Director of Programs; o Luee McCreary, Incident Management Coordinator; o Patricia Smith, Admissions/Placement Coordinator, substituting for Sam St. Clair, Quality Assurance Director; o Ron Manns substituting for Cathy Hennington, Director of Psychology; o Tracyl Gandee, Settlement Agreement Coordinator; and o Various staff and individuals receiving services. ▪ **Observations of**: o Ten residences including: #5961, #5962, #5971, #5972, #6330, #6350, #6370, #6460, #6480, and #6521; and o Three PSP annual meetings for: Individual #234, Individual #196 and Individual #205.
	Facility Self-Assessment: The ABSSLC Plan of Improvement indicated the Facility was in substantial compliance with 16 of the 22 provisions in Section D of the Settlement Agreement. The Monitoring Team found the Facility to be in compliance with nine out of 22 provisions. The Facility's determinations were based on data collected through the QA monitoring process, as well as work toward addressing the recommendations the Monitoring Team made after its August 2010 visit. The Facility had established a plan to review incident management and investigation documentation, and had completed 93 monitoring tools since September 2010. The information included in the POI indicated percentages of compliance, based on the use of the monitoring tools. In the POI, the percentages provided appeared to be overall scores for each provision. As has been stated in previous reports, the monitoring review tools were not designed to provide overall scores. The items within the tools are not weighted. As the Monitoring Team has done in the report that follows, when conducting its own self-assessment, the Facility should review and report on data related to the individual indicators within each Settlement Agreement section. This will assist the Facility in identifying those areas within each section that require further attention in order to achieve and sustain compliance. In addition to collecting data on indicators, the Facility addressed the Monitoring Team's recommendations from the last visit. As a result, a resource guide for individuals and their families was in place, and QMRPs were being trained on its use, a process for supervisory review of investigations had been designed and was ready for implementation, the responsibility for investigating choking incidents was placed with the Incident Management Coordinator instead of the therapist, and nurses responsible for the completion of

	investigations were being scheduled for Labor Relations Alternatives (LRA) investigator training.
	Summary of Monitor's Assessment: The systems for reporting and investigating unusual incidents were becoming established as part of the day-to-day management of ABSSLC. As with most maturing systems, requirements such as calling in reports of abuse, summoning the nurse to examine an individual when he/she was injured, placing alleged perpetrators on temporary reassignment, calling in the Crisis Intervention team, and reporting to law enforcement were becoming routine activities. Investigators were trained in investigation and in interviewing people with developmental disabilities. Investigations were completed using a standard format, were processed electronically, and, for the most part, were conducted in a timely fashion. Some documentation issues still needed to be addressed such as recording supervisory reviews and their content, and the review by Department of Family and Protective Services (DFPS) investigators of past investigations. However, based on discussions with DFPS and the Facility, these details appeared to be in the process of being corrected. Training for staff on abuse and incident reporting was in place, and all but two percent of staff were current on that training. However, work continued to need to be done to ensure that staff were competent in understanding signs and symptoms of abuse, their responsibilities with regard to reporting, and the reporting procedures. Some investigation reports raised concerns about staff not reporting abuse. It was positive that the investigation process identified this as an issue, and the Facility took steps to retrain staff involved. However, this coupled with interviews with staff in which some staff were not able to accurately describe the reporting process, and another who indicated it was not his job to report, raised concerns regarding the adequacy with which staff were reporting incidents and allegations. The Facility should evaluate reasons for staff failing to report and/or not understanding their reporting responsibilities, and address the underlying issues. An area that continued to need improvement was the inclusion of adequate recommendations based on the results of investigations, and follow-through on those recommendations. DFPS investigations sometimes listed concerns, but not in the form of actual recommendations. Facility investigators made recommendations, but they more often related to the immediate protection of the individual as opposed to systemic issues they encountered such as crowded environments, peers who did not get along, and a lack of meaningful activities. The process for translating DFPS concerns into recommendations on the companion Facility reports was not consistent, resulting in some concerns not be addressed.

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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	The Facility's policies and procedures: ▪ Included a commitment that abuse and neglect of individuals would not be tolerated; and ▪ Required that staff report abuse and/or neglect of individuals.	Noncompliance

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	neglect of individuals and that staff are required to report abuse or neglect of individuals.	In practice, the Facility's commitment to ensure that abuse and neglect of individuals was not tolerated, and to encourage staff to report abuse and/or neglect was illustrated by the following examples: ▪ The Facility produced a brochure entitled ABSSLC: Stopping Abuse is Everyone's Business, undated, aimed at educating individuals and their Legally Authorized Representatives on the signs and symptoms of abuse and how to report it. At the time of the review, QMRPs had just been trained on this process. ▪ The Facility provided evidence that checks of living units were being conducted to assure that posters were posted, which were aimed at individuals, explaining their rights and how to report abuse. The following are examples of concerns related to the Facility's commitment to ensure that abuse and neglect are not tolerated and/or to encourage staff to report abuse and/or neglect: ▪ Abuse investigations had revealed instances where staff had failed to report abuse. According to one report, #38182701, this was evident on the video surveillance tape of the incident. The DFPS report of the incident, while raising the concern, did not make a recommendation for staff retraining. However, the ABSSLC incident report did make a recommendation regarding re-training, and it was carried out. However, no disciplinary action was taken with regard to staff that not only did not report abuse, but also did not take action to intervene or protect the individual. A zero tolerance for abuse requires the Facility to take decisive action when staff fail in their responsibilities to report abuse. ▪ Likewise, concerns were noted with regard to a lack of appropriate disciplinary action for staff for whom allegations of abuse and/or neglect were confirmed. This is inconsistent with a commitment to not tolerate abuse and neglect.	
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)	According to Policy #021,III.1-5, staff who discover or learn about abuse, neglect or exploitation were required to report it within one hour to DFPS and to the Director by phone. This was consistent with the requirements of the Settlement Agreement. With regard to serious incidents, the Facility policy #002.2.III.A required staff to report	Noncompliance

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	for deaths, abuse, neglect, and exploitation to the Facility Superintendent (or that official's designee) and such 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.	serious incidents within one hour. The process required staff to report to the Director or designee who notified the Incident Management Coordinator for follow-up. This policy was consistent with the requirements of the Settlement Agreement. According to Facility data provided in the document entitled "All ANE 2/1/10 to 1/1/11," the following numbers of serious incidents occurred at the Facility since July 1, 2011: ▪ Total abuse allegations - 108, including: o Substantiated - 20; o Unsubstantiated - 72; o Inconclusive - 7; and o Pending – 9. ▪ Total neglect allegations - 69, including: o Substantiated - 18; o Unsubstantiated - 31; o Inconclusive - 0; o Administrative Referral - 3 o Pending – 9; o Combination of substantiated, unsubstantiated – 7; and o Combination of substantiated, inconclusive – 1. ▪ Total exploitation allegations: none. The number of unusual incidents as defined in ABSSLC Policy #002.2 totaled 51. The following numbers were taken from the list of Unusual Incidents 8/1/10 to 12/31/10, provided in response to TX-AB- 1102 – III.18.b. ▪ Deaths – 7; ▪ Serious Choking Incidents – 3; ▪ Life threatening illness or injury – 0; ▪ Life threatening medication error – 0; ▪ Serious Injury -29; ▪ Sexual Incidents – 6; ▪ Suicide Threats – 0; ▪ Theft by Staff – 0; and ▪ Unauthorized Departures – 6 Based on other information provided to the Monitoring Team, it did not appear that some of this information was accurate. For example, in weekly reports the State sends to the Monitoring Team, a number of suicide threats had been reported during this time period, such as threats made by Individual #199 on 11/18/10, and 11/21/10; Individual #357 on 11/6/10; and Individual #444 on 12/10/10. It was unclear why there was this discrepancy, but it called into question the overall reliability of the data.	

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		A comparison of the Unusual Incidents Trend Report –FY 2011: 9/1/10 – 11/30/10 with the above data revealed that credible suicide threats appeared in the trend report, but not in the list of investigated incidents. The trend report showed credible suicide threats in August (1), in October (2) and in November (2). The November numbers did not match either the above data or the trend reports. On further examination of the data, it appeared that the list of unusual incidents from 8/1/10 to 12/31/10, supplied in response to Document Request TX-AB-1102-III.18.b, did not include all investigations. On a list supplied (TX-AB-1102-III.16.c), suicides threats were included as incidents with investigation file numbers. The cause of the differences needs to be identified and corrected. Based on an interview of 12 staff responsible for the provision of supports to individuals, 11 (92%) were able to describe the reporting procedures for abuse, neglect, and/or exploitation. Several staff referenced their badges to obtain the reporting number and it was noted that two staff were not wearing their identification badges, but immediately went to retrieve them, when this was pointed out. Based on an interview of 12 staff responsible for the provision of supports to individuals, 10 (83%) were able to describe the reporting procedures for other serious incidents. Two samples of investigations were selected for review. These included: ▪ Sample #D.1 which included a sample of 31 DFPS investigations of abuse, neglect, and/or exploitation with the Facility investigation reports that were related. This sample included the following DFPS investigation numbers: #38212421, #38294736, #38048720, #38038680, #38477185, #37376561, #37990303, #38496955, #38254301, #38497721, #38287790, #38272461, #38277195, #38285763, #38349543, #38476499, #38284265, #38404435, #38182701, #38480668, #37668942, #38345042, #38473138, #38410714, #38187901, #38469719, #38277404, #38284214, #37707240, #38472232, and #38431676. ▪ Sample #D.2, which included a sample of 10 Facility investigations. Some of these were investigations that DFPS had referred to the Facility, while others were investigations the Facility completed related to serious incidents. This sample included the following Facility investigations numbers: #2537, #2378, #2525, #2339, #2338, #2388, #2419, #2512, #2466, #2502. Based on a review of the 31 investigation reports included in Sample #D.1: ▪ Twenty-eight (90%) included evidence that allegations of abuse, neglect, and/or exploitation were reported within the timeframes required by Facility policy. Three exceptions were case #38038680, #37668942, and #38345042, where the	

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		individual was the likely reporter, or there was lack of clarity about when the alleged episode took place. However, according to one report, #38182701, several staff witnessed an incident, and failed to intervene to stop the abuse. This was evident on the video surveillance tape of the incident. Not all staff reported this incident. In another case, #38480668, a staff member was discovered to have failed to report the incident, and admitted to the investigator that he did not want to get involved. ▪ All (100%) included evidence that allegations of abuse, neglect, and/or exploitation were reported to the appropriate party as required by Facility policy. Based on a review of 10 incident reports included in Sample D.2: ▪ Ten (100%) showed evidence that serious incidents were reported within the timeframes Facility policy required. ▪ Ten (100%) showed evidence that serious incidents were reported to the appropriate party as required by Facility policy. Both DFPS and the Facility relied on reports of unusual incidents and allegations to be phoned to their hotline (DFPS) or their switchboard (the Facility). Key information was gathered from that call such as the names of people involved, location, date, and time. That reporting process is standard. However, the initial call information was then entered into the DFPS or Facility computer as part of the investigation information. Several initial reports were checked to determine if the information was being correctly entered, and in all cases it appeared to be. Based on the issues with the reliability of the data, as well as staff not consistently reporting incidents/allegations, this indicator in not in compliance.	
	(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	According to ABSSLC Policy #021.III, the Facility outlined in detail the steps the Facility was required to take to protect the individuals involved in allegations of abuse, neglect, and exploitation, including stopping the abuse, securing medical help, and reporting the incident. According to the policy at X, a staff member alleged to have been the perpetrator of an allegation of abuse will be placed on temporary work duty reassignment. Based on a review of 31 investigation reports included in Sample #D.1, in three cases, including #38287790, #38285763, and #38476499, the perpetrator was unknown and the individual in each case was moved to the Infirmary for the night to ensure their safety. In 25 of the reports, the alleged perpetrators were removed from direct contact with individuals immediately following the Facility being informed of the allegation. With regard to the remaining three: ▪ Case #37376561 involved an individual who had been a resident of a privately operated group home. An alleged incident occurred at that group home, prior to	Noncompliance

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	the employee poses no risk to individuals or the integrity of the investigation.	the individual's move onto the campus of the Facility and was under investigation when the individual moved to ABSSLC. When she arrived at ABSSLC, an X-ray of her hip was ordered due to her history of osteoporosis. The X-ray revealed a healing fracture. ABSSLC reported the possibility that she had been abused, and DFPS joined the two investigations. There was no alleged perpetrator at ABSSLC, and it was not clear if the alleged perpetrators at the private facility had been removed. ▪ In case #38477185, the perpetrator was unknown, and monitoring was put in place; ▪ In another case, #38480668, one staff member was removed who was alleged to be actively involved in the abuse. A second staff member was discovered to have failed to report the incident, and admitted to the investigator that he did not want to get involved. He was not immediately removed, but he was terminated five days later. Based on a review of 31 investigation files included in Sample #D.1, a total of six cases were confirmed as abuse or neglect, and three were confirmed in part. Documented disciplinary action was as follows: ▪ Case #38254301: employee terminated; ▪ Case #38277404: employee terminated; ▪ Case #38431676: action pending; ▪ Case #38272461: cleared to return; ▪ Case #38349543: cleared to return; ▪ Case #38182701: cleared to return: ▪ Case #38489668: one staff terminated, and one, disposition unknown; ▪ Case #38048720: cleared to return; and ▪ Case #37376561: disposition of staff at private facility unknown. In cases where the employee returned to work, it was not clear what retraining was provided, or other actions taken to ensure that the employee posed no threat. Based on a review of the 31 investigations, it was documented that adequate additional action was taken to protect individuals in 31cases (100%). For example: ▪ As noted above, individuals were sometimes moved to the Infirmary for safety, if the perpetrator was unknown; ▪ A room reassignment was made within the home; ▪ Additional monitoring of the home by supervisors from other homes was ordered; or ▪ Staffing levels were increased for the alleged victim. The following are example in which it did not appear that appropriate immediate action	

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		was taken: ▪ In case #37376561, where the individual was staying with a private provider at the time of the abuse, it was not clear what, if any, action was taken. While staff were being removed from direct contact at the outset of an investigation, it was not clear how decisions were made to return them to direct contact, and whether those decisions included discipline when warranted. As a result, the Facility remains in noncompliance.	
	(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.	According to ABSSLC Policy #021.II, all staff were required to attend competency-based training on preventing and reporting abuse and neglect. This was identified in the policy as course ABU0100. This was consistent with the requirements of the Settlement Agreement. The Facility provided a copy of a 2006 version of the training, which appeared from the context to have been updated sometime in 2008. However an undated copy of the training with color formatting was available. Both contained essentially the same information. The training curriculum for new employee orientation as presented was reviewed, and it appeared to be the same for annual refresher training. The results of this review were as follows: ▪ In relation to the requirement that training be competency-based, the Settlement Agreement defines "competency-based training" as "the provision of knowledge and skills sufficient to enable the trained person to meet specified standards of 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." In this regard, the training included opportunities for discussions and to test one's understanding of the requirements. ▪ The training did provide adequate training regarding recognizing and reporting signs and symptoms of abuse, neglect, and exploitation. Review of 23 staff records (Sample #C.2), showed that 23 (100%) of these staff had completed competency-based training on abuse and neglect during the first two weeks following hiring, which was during their orientation and prior to working directly with individuals. Review of a list of staff who were delinquent in training (DADTX Report ID: ASTR3118) provided in response to Document Request TX-AB-1102-III.10 showed that 1377 of 1399 staff (98%) had completed annual refresher training. The number of staff was obtained from the Employee Listing report dated 1/26/11.	Noncompliance

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		Based on interviews with 12 staff: ▪ Ten (83%) were able to list signs and symptoms of abuse, neglect, and/or exploitation. Two had some difficulty recalling more than one or two signs; ▪ Ten (83%) were able to describe the reporting procedures for abuse, neglect, and/or exploitation. Two were not able to say where to find the number for DFPS, which was on the back of their badges. The Facility was found to be in noncompliance with this provision of the Settlement Agreement. To promote a zero tolerance for abuse, staff must consistently be able to demonstrate competence in the identification of signs and symptoms of abuse, as well as in how to report abuse and neglect. The Monitoring Team recommends that supervisors routinely quiz staff on the reporting procedures to ensure that they are knowledgeable about the requirements, and can recall important information quickly.	
	(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 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.	ABSSLC Policy #021.II.B required that all staff sign an acknowledgement of their responsibilities to not tolerate and to report suspected abuse, neglect and exploitation during their pre-service training and annually thereafter. A sample of 23 staff (Sample #C.2) was randomly selected to determine if acknowledgements had been signed. Of the 23, 23 (100%) had signed annual acknowledgments. The Facility was asked for a list of staff who had been identified as having failed to report abuse and/or neglect. This generated a list of zero staff. However, as noted below, staff had failed to report abuse and neglect. In DFPS investigation #38182701, the investigator noted concerns that staff had been present in the hallway when an individual was being abused. They had neither intervened nor reported an allegation. The Facility responded in the related incident report that the staff would be in-serviced. There was no indication of disciplinary action for failure to report. Given that staff presumably had been trained on their obligations, and had signed acknowledgement forms, this was a serious breach of their responsibilities, and should have resulted in formal disciplinary action. In DFPS report #38480668, the investigator noted that one staff member declined to cooperate in the investigation and in discussion said that he did not think it was his job to report on staff. The Facility response recorded in the related incident report indicated that staff would be in-serviced on cooperating with DFPS investigators. One of the two staff members was terminated as reported on the Reassignment List.	Noncompliance

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		The Facility has been found out of compliance with this provision based on its failure to take adequate disciplinary action related to staff's failure to report abuse and neglect either when it occurred or during an investigation.	
	(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.	According to Facility Policy #021.I.H, the Facility maintained a resource guide on recognizing and reporting abuse, and provided it to individuals, Legally Authorized Representatives (LARs), and primary correspondents upon admission and annually thereafter. Discussions with staff revealed that this guide was to be provided at the annual Personal Support Team meeting, but that QMRPs had just received training on it in January 2011. A review was conducted of the materials to be used educate individuals, LARs, or others significantly involved in the individual's life. The guide was a brochure with lists of signs of abuse, and information about where to call. While most individuals living at ABSSLC did not have the reading skills necessary to understand the brochure, if used in combination with the posters about rights, it did an adequate job. The Facility should consider supplying the individual with a copy of the poster at the PST meeting along with the brochure to maximize the chance that individuals will understand it. Based on a review of 10 individuals' PSPs (Individual #115, Individual #429, Individual #438, Individual #505, Individual #91, Individual #46, Individual #444, Individual #245, Individual #9, and Individual #52), no evidence was found to show that the individuals, their LAR, and/or other significantly involved individual had been informed of the process of identifying and reporting unusual incidents, including abuse, neglect, and exploitation. In addition, the guide provided was not provided at the three annual PSP meetings observed for this review. At ABSSLC, a significant number of individuals cannot communicate well enough to report abuse. They likely did not understand the information on reporting that was provided, could not read the posters that were available, and did not know how to use a phone. Observation of 15 individuals indicated that they required competent staff and alert family, guardians or advocates to detect signs of abuse and report them. Some individuals were able to, and did know how to report abuse as was evident in the Sample #D.1, in which the investigation reports clearly showed that the reporter was a resident at ABSSLC. Examples included cases #37990303, #38496955, #38277195, and #37668942. In these cases it was clear that staff had facilitated access to the phone and DFPS phone number. While the Facility has a resource guide in place, QMRPs had not completed training until January 2011, and as a result, it was not clear that the guide had been shared at many PSP meetings. It also was not clear how the guide was being shared with family members	Noncompliance

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		outside of the PSP meeting, if at all. The Facility remained out of compliance with this provision.	
	(f) Posting in each living unit and day program site a brief and easily understood statement of individuals' rights, including information about how to exercise such rights and how to report violations of such rights.	According to ABSSLC Policy #021.I.F, posting of a statement on individuals' rights and information on how to report was required in each residence and day program site. A review was completed of the posting the Facility used. It included a brief and easily understood statement of: 1) individuals' rights; 2) information about how to exercise such rights; and 3) information about how to report violations of such rights. The Monitoring Team's observations of 10 living units and day programs on campus showed that 10 (100%) of those reviewed had postings of individuals' rights in an area to which individuals regularly had access. From a check-sheet provided in the Presentation Book for Section D, it was clear that the Facility was making its own checks to assure that posters were in place throughout the campus. A self-advocacy group met regularly on campus and provided an additional avenue of information to individuals about protection of their rights. According to the self-advocacy group's advisor, the group had been meeting approximately monthly, and attendance had increased. She attributed this largely to the commitment on the part of the Director of Residential Services to spread the word about meetings to individuals and staff throughout campus. Some of the topics discussed were important precursors to more in-depth discussions about rights, including being a good friend and choosing good friends, and the difference between wants and needs, dreams and wishes. The group also had begun to talk about some issues directly related to rights, such as voting. One of the next steps for this group was to hold elections for officers. The Facility is encouraged to continue its efforts to support this group, and particularly to expand their understanding of their rights and responsibilities.	Substantial Compliance
	(g) Procedures for referring, as appropriate, allegations of abuse and/or neglect to law enforcement.	According to ABSSLC Policy #021.IV.E, the Director or designee had to report all allegations that might involve criminal activity to DFPS within one hour. DFPS had the responsibility to notify the appropriate law enforcement agency. The notification to the Director of an allegation was by phone and her notification to DFPS was by phone as well. DFPS recorded the date and time of the referral in their report and the Incident Management Coordinator recorded the notification to DFPS, as well as the DFPS notification to law enforcement in the Incident Investigation Report. Based on a review of 31 allegation investigations completed by DFPS (Sample #D.1), in 25 for which a referral to law enforcement was necessary/appropriate, DFPS had made referrals in 25 (100%).	Substantial Compliance

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		Based on a review of 10 investigations completed by the Facility (Sample #D.2), referral to law enforcement was neither needed nor made. This resulted from the practice of referring all incidents in which there was a suspicion of abuse, neglect, or exploitation to DFPS, where a case was opened and DFPS reported any activity with possible criminal implications to local law enforcement and to the Office of the Inspector General.	
	(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 to retaliatory action, including but not limited to reprimands, discipline, harassment, threats or censure, except for appropriate counseling, reprimands or discipline because of an employee's failure to report an incident in an appropriate or timely manner.	ABSSLC Policy #021.IX prohibited retaliation against staff, individuals, family members or others who reported abuse. Anyone who believed they had been retaliated against was informed to call the Director, the Office of the Attorney General, the Office of the Inspector General, or DFPS, and phone numbers were provided. Based on interviews with the Facility Director, the Assistant Director of Programs, and the Incident Management Coordinator, there had been two reports of possible retaliation in the past six months. Both were investigated and there were no findings of retaliation. Based on interviews with 12 staff, all (100%) reported that they sometimes thought about retaliation, but their concern for the individuals they served meant that they would not hesitate to report abuse. Based on interviews with 10 individuals served by the Facility, none were able to communicate whether they could report if someone had injured or not taken care of them. However, some individuals could and did report allegations to DFPS including, in sample #D.1: Case #3799033, #38496955, #38277195, and #37668942. Based on a review of investigation records (Sample #D.1 and Sample #D.2), there were no concerns noted related to potential retaliation The Facility was asked for a list of staff against whom disciplinary action had been taken due to their involvement in retaliatory action against another employee who had in good faith had reported an allegation of abuse/neglect/exploitation, and two names were provided. Both allegations were investigated but there were no actions taken, since the retaliation could not be substantiated. The Facility appeared to be taking appropriate action when retaliation was alleged.	Substantial Compliance
	(i) Audits, at least semi-annually, to determine whether significant resident injuries are reported for investigation.	According to ABSSLC Policy #002.2IX.A, the Incident Management Coordinator was responsible to make use of audit reports to evaluate whether significant resident injuries were reported for investigation, at least semi-annually. The Facility Plan of Improvement indicated that audits were to begin in the January 2011 Trend Analysis Report, which was not available for this monitoring report.	Noncompliance

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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.	According to ABSSLC Policy #002.3.II.B, Facility investigators were required to complete "Comprehensive Investigator Training" (CIT100) and "People with MR" (MEN0300) within one month of employment and before completing an Unusual Incident Investigation. According to the same policy at II.C, Facility investigators, the Incident Management Coordinator, and Campus Administrators must complete "Conducting Serious Incident Investigations or Fundamentals of Investigation" training (INV0100) and a class in Root Cause Analysis, within six months of employment. There were no requirements in the policy for updates or retraining for investigators. The policy: ▪ Described in a comprehensive fashion the conduct of all such investigations in section VI of the policy; ▪ Required that investigators be qualified; ▪ Required that investigators have training in working with people with developmental disabilities, including persons with mental retardation; and ▪ Required that investigators be outside the direct line of supervision of the alleged perpetrator in Section I.H. Training curricula was reviewed for the Department of Family and Protective Services and Facility investigators. This review revealed the following: ▪ DFPS training for investigators included Instructor Led Skills Development and Instructor Led Advanced Skills Development for anyone employed from 2008 to the present. According to DFPS, prior to 2008 these courses had different names, but essentially the same content. The provided curricula included modules 1 through 4 of the ILASD training, and Modules 7, 8, and 10 of the ILSD training. It was not clear whether these were the only modules used out of a larger document, or the only ones offered as investigator training. These two courses included segments on interviewing persons with developmental disabilities, as well as overviews of the laws and policies governing the conduct of investigations, causes of abuse and neglect, evidence collection, analysis of evidence and report writing. The ILSD and ILASD training appeared to be adequate with regard to the conduct of investigations in that they provided useful information about	Noncompliance

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		interviewing skills, writing reports, detecting deception, and collecting and analyzing evidence. What was not as clear was whether the training included instruction on how to complete the DFPS report, how to review and use information from past investigations, and how to determine when recommendations would be warranted and develop appropriate recommendations. The training was not competency-based. Although it included training on topics tied to job performance, and included opportunities for discussion and practice, it was not clear that the training included any methods for evaluating performance as a result of the training. ▪ The Facility investigator training included "Comprehensive Investigator Training" (CIT0100), "People with Mental Retardation" (MEN0300), and "Root Cause Analysis" (RCA1000). The Campus Administrators and the Incident Management Coordinator were required to complete CIT0100, or "Fundamentals of Investigation and RCA1000. CIT0100 was a class conducted by Labor Relations Alternatives on preventing, identifying, investigating, and analyzing incidents. It included instruction on incident management process and policies, and practical information about how to conduct an investigation and write a report. It also provided experiential activities including observing, conducting, and completing an investigation, and presenting it to the incident management team. The training appeared to be adequate in that it provided training in job related skills such as interviewing, analyzing information, writing statements, and securing evidence. It also provided opportunities to practice the skills being learned. What was not clear was whether there was any standard of performance, and whether the student was required to demonstrate competence in accordance with that standard. Seven DFPS investigators conducted one or more of the investigations in Sample #D.1, which consisted of 31 files. The training records for these investigators were reviewed with the following results: ▪ Six out of seven DFPS investigators (86%) had completed the requirements for investigations training. An investigator whose name did not appear on the APS Training Transcript Crosswalk-Abilene, provided by the Facility, completed three investigations, #38272461, #38277195, and #38284265. Training documentation was provided for two additional investigators whose reports did not appear in the sample. ▪ Six out of seven DFPS investigators (86%) had completed the requirements for training regarding individuals with developmental disabilities. Primarily three investigators, under the direction of the Incident Management Coordinator, completed the Facility investigations. All three received training in Conducting Serious Investigations: Labor Relations Alternatives, as did the Incident	

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		Management Coordinator. The training records for these investigators were reviewed with the following results: ▪ Three out of three Facility investigators (100%) had completed the requirements for investigations training ▪ Two out of three Facility investigators (67%) had completed the requirements for training regarding individuals with developmental disabilities. The training documentation for the investigators was for the period 1/1/10 to 1/11/11, and may not have included the required course MEN0300 because it was taken prior to those dates. However, the Monitoring Team requested documentation for each investigator responsible for the conduct of investigations. ▪ One out of three Facility investigators (33%) had completed the requirements for training in Root Cause Analysis (RCA1000). It was not clear from the documents received that all investigators had received the training required and as a result, the Facility was out of compliance with this provision.	
	(b) Provide for the cooperation of Facility staff with outside entities that are conducting investigations of abuse, neglect, and exploitation.	Based on ABSSLC Policy #002.2.IV.D.2, the Director or designee was to abide by all instructions law enforcement agencies gave. ABSSLC Policy #021 specified the nature of cooperation between the Facility and DFPS. Facility staff were required to cooperate with outside entities conducting investigations of abuse and neglect. As described above with regard to Section D.2.a of the Settlement Agreement, two samples of investigation files were selected for review. These included Sample #D.1 and Sample #D.2, which consisted of DFPS investigations, and Facility investigations, respectively. ▪ Review of the investigation files in Sample #D.1 showed that in 30 out of 31 investigations (97%), Facility staff cooperated with DFPS investigators. o In one investigation, #38480668, the investigator reported that a staff member was not cooperative with the investigation. That staff member was in-serviced again on the need for cooperation.	Substantial Compliance
	(c) Ensure that investigations are coordinated with any investigations completed by law enforcement agencies so as not to interfere with such investigations.	The Memorandum of Understanding (MOU), dated 5/28/10, provided for interagency cooperation in the investigation of abuse, neglect, and exploitation. This MOU superseded all other agreements. In the MOU, "the Parties agree to share expertise and assist each other when requested." The signatories to the MOU included the Health and Human Services Commission, the Department on Aging and Disability Services, the Department of State Health Services, the Department of Family and Protective Services, the Office of the Independent Ombudsman for State Supported Living Centers, and the Office of the Inspector General. DADS Policy #002.2 stipulated that, after reporting an incident to the appropriate law enforcement agency, the "Director or designee will abide by all instructions given by the law enforcement agency."	Substantial Compliance

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		Based on a review of the investigations completed by DFPS and the Facility, the following was found: ▪ Of the 31 the investigation records from DFPS (Sample #D.1), 25 had been referred to law enforcement agencies. For 25 out of these (100%), there was adequate coordination to ensure that there was no interference with law enforcement's investigations. ▪ Of the 10 investigation records from the Facility (Sample #D.2), none had been referred to law enforcement agencies. In the POI, the Facility did not find compliance with this indicator, based on its own monitoring, but did not provide an explanation for the noncompliance. In its review, the Monitoring Team did not find any instances of noncompliance, and therefore, has made a finding of substantial compliance.	
	(d) Provide for the safeguarding of evidence.	ABSSLC Policy #002.2 explained the need for the initial reporter, as well as the Facility investigator to preserve physical evidence, and referred to Exhibit B for the Guidelines for Securing Evidence. If evidence was present and law enforcement had been called, staff were to leave all evidence in place, if possible. Otherwise, staff were to collect evidence that was most in danger of contamination first. Procedures were included for handling, documenting, and storing evidence. While on site, the Monitoring Team observed the area the Facility uses for safeguarding evidence. Physical evidence was rarely a factor in investigations as illustrated by the fact that only one abuse case in Sample #D.1 involved physical evidence. As explained by the Incident Management Coordinator, physical evidence was placed in a paper bag, documented, and secured in the home's office or medication room until it was transported to the Infirmary Medication room for storage, that being a room that was locked. Other forms of evidence, such as documentary and testimonial evidence were maintained with the case files, which were secured in the Incident Management offices. Based on a review of the investigations completed by DFPS (Sample #D.1) and the Facility (Sample #D.2): ▪ Evidence that needed to be safeguarded was in 31 out of 31 (100%) DFPS investigations; and ▪ Evidence that needed to be safeguarded was in 10 out of 10 (100%) Facility investigations. Video surveillance was in place throughout the ABSSLC campus and investigators had begun to use it as part of their investigations. DFPS investigators initially had some difficulties accessing video footage. The footage could not be accessed without downloading it onto a disk, and investigators wanted to see it to determine what they	Substantial Compliance

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		wanted copied before downloading it. The technical reasons for this were explained to the investigators, and investigators continued to use video footage.	
	(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.	Based on Facility Policy #002.2.V, investigations of serious incidents: ▪ Were to commence within 24 hours or sooner, if necessary; ▪ Were be completed within 10 calendar days of the incident; ▪ Required a written extension request from the Facility Director or Adult Protective Services Supervisor to be completed outside of the 10-day period, and only under extraordinary circumstances; and ▪ Were to result in a written report that included a summary of the investigation findings, and, as appropriate, recommendations for corrective action. To determine compliance with this requirement of the Settlement Agreement, samples of investigations conducted by DFPS (Sample #D.1) and the Facility (Sample #D.2) were reviewed. The results of these reviews are discussed in detail below, and the findings related to the DFPS investigations and the Facility investigations are discussed separately. <u>DFPS Investigations</u> The following summarizes the results of the review of DFPS investigations: ▪ Twenty-five out of 31 (81%) commenced within 24 hours or sooner, if necessary. This was determined by reviewing information included in the investigation that described the steps taken to determine the priority of investigation tasks, as well as documentation regarding the tasks that were undertaken within 24 hours of DFPS being notified of the allegation. The following were the investigations for which adequate investigatory process did not occur within the first 24 hours or sooner, if necessary: #38480668, #38212421, #38254301, #38284265, #37707240, and #37990303. In one case, #38404435, the date that appeared on the report, 11/15/10, as the date of initial DFPS notification was in conflict with the date the allegation was reported to DFPS by the Facility, 11/9/10. The investigation began within 24 hours of the 11/15/10 date, if that was the correct date. In its response to the Monitoring Team's draft report, the State clarified that Case #38404435 was reported on 11/9/10 and notification was made and documented in another Case ID#. Regional staff consulted DFPS State Office on this case given some confusion over whether the allegations should be referred to the Facility or investigated. DFPS State Office recommended investigation, and a new case ID# was generated with the 11/15/10 notification dates. Based on the Monitoring Panel's discussion with DFPS in December 2010, DFPS is in the process of developing a format to better document activities that occur within the first 24 hours of the investigation. The Monitoring Team looks forward to reviewing such additional information during upcoming reviews.	Noncompliance

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		▪ Thirty out of 31 (97%) were completed within 10 calendar days of the incident, not including sign-off by the supervisor; ▪ For Case #38272461, which was not completed within 10 days, there was no documentation of a written extension request that had been approved by the Adult Protective Services Supervisor, and there was no documentation of the extraordinary circumstances that necessitated the extension. ▪ Thirty-one (100%) resulted in a written report that included a summary of the investigation findings. The quality of the summary and the adequacy of the basis for the investigation findings are discussed below with regard to Section D.3.f of the Settlement Agreement. ▪ In nine of the DFPS investigations reviewed, recommendations for corrective action were included or concerns were expressed. In five of these nine investigations (56%), the recommendations were adequate to address the findings of the investigation. The following were the investigations for which concerns were noted with regard to the adequacy of the recommendations: o In report #38287790, the individual was known to engage in self-injurious behavior, but the fact that he sustained 19 previous injuries as a result, should have prompted a recommendation for additional review of potential strategies to prevent those injuries from continuing. o In report #38480668, DFPS reported that a staff member had confessed to not reporting incidents, but did not make a recommendation that the staff member be disciplined and/or retrained; and o In report #38284214, DFPS reported on staff's inability to place an individual in restraint, but did not recommend retraining, or a change in staffing requirements. The related incident investigation did recommend that staff be assigned to this individual who could properly restrain him. o In report #38476499, DFPS reported concerns about staff not completing bed checks in person and about possible loss of evidence of sexual abuse, due to changing underclothes before an investigation could begin. There was no indication in the related incident report of recommendations to resolve those concerns, or what, if any, follow-up was undertaken. <u>Facility Investigations</u> The following summarizes the results of the review of Facility investigations: ▪ Ten out of 10 (100%) commenced within 24 hours or sooner, if necessary. This was determined by reviewing information included in the investigation that described the steps taken to determine the priority of investigation tasks, as well as documentation regarding the tasks that were undertaken within 24 hours of the Facility being notified of the serious incident. ▪ Eight out of 10 (80%) were completed within 10 calendar days of the incident,	

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		including sign-off by the supervisor; ▪ For the two that were not completed within 10 days, 0 (0%) had documentation of a written extension request that had been approved by the Facility Director, and there was no documentation of the extraordinary circumstances that necessitated the extension. The two cases that were not completed within 10 calendar days were case #2501, where there were no signatures on the report to indicate the time of completion, and #2419, which was completed 26 days after the initial incident. ▪ Ten (100%) resulted in a written report that included a summary of the investigation findings. The quality of the summary and the adequacy of the basis for the investigation findings are discussed below with regard to Section D.3.f of the Settlement Agreement. ▪ In the 10 investigations reviewed, recommendations for corrective action were included in eight. In six of those eight investigations (75%), the recommendations were adequate to address the findings of the investigation. For the following investigations, concerns were noted with regard to the adequacy of the recommendations: i. Case #2419 involved a slip and fall in the bathroom. There was a recommendation for a shower chair in the bathroom, but he fell while walking into the bathroom. Consideration should have been given to providing slip resistant footwear or using tile treatments to prevent slipping. ii. Case #2388 involved sexual contact between two peers. These same two individuals had been involved in an incident two months earlier when they shared a bedroom. Staffing had been increased and they were assigned to separate bedrooms. However the contact recurred. The recommendations were for team meetings, and a temporary increase in staffing. While these measures might protect them temporarily, a recommendation to consider psychology staff's involvement to determine whether one of the individuals was the target of unwanted aggression, sexuality and/or relationship training for one or both of the men, or to consider having them live in different homes should have been made. Based on issues related to investigations being started timely, a lack of approval and justification for investigations that took more than 10 days to complete, and concerns about the adequacy of recommendations, a finding of noncompliance was made.	
	(f) Require that the contents of the report of the investigation of a serious incident shall be	Based on a review of ABSSLC Policy #002.2, the policy required that: ▪ The contents of the investigation report be sufficient to provide a clear basis for its conclusion;	Noncompliance

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	sufficient to provide a clear basis for its conclusion. The report shall set forth explicitly 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.	▪ The report utilize a standardized format that set forth explicitly and separately:
		o Each serious incident or allegations of wrongdoing;
		o The name(s) of all witnesses;
		o The name(s) of all alleged victims and perpetrators;
		o The names of all persons interviewed during the investigation;
		o 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;
		o All documents reviewed during the investigation;
		o All sources of evidence considered, including previous investigations of serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency;
		o The investigator's findings; and
		o The investigator's reasons for his/her conclusions.
		
		The Facility investigation files were accessible and arranged to provide easy access to key information. Beginning with its January cases, the Facility started using a new file format that DADS State Office provided. The new system was compared to the previous one, and it appeared that the new organization would have the benefit of being similar across all facilities.
		
		To determine compliance with this requirement of the Settlement Agreement, samples of investigations conducted by DFPS (Sample #D.1) and the Facility (Sample #D.2) were reviewed. The results of these reviews are discussed in detail below, and the findings related to the DFPS investigations and the Facility investigations are discussed separately.
		
		<u>DFPS Investigations</u>
		The following summarizes the results of the review of DFPS investigations:
		▪ In 31out of 31 investigations reviewed (100%), the contents of the investigation report were sufficient to provide a clear basis for its conclusion.
		▪ The reports utilized a standardized format that set forth explicitly and separately:
		o In 31 (100%), each serious incident or allegation of wrongdoing;
		o In 31 (100%), the name(s) of all witnesses;
		o In 31 (100%), the name(s) of all alleged victims and perpetrators;
		o In 31 (100%), the names of all persons interviewed during the investigation;
		o In 31 (100%), for each person interviewed, a summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material statements made;
		o In 31 (100%), all documents reviewed during the investigation;
		o In three (10%), all sources of evidence considered, including previous	

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		investigations of serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency. There was limited documentation of the review of previous investigations in the reports in the sample. The three cases where the previous investigations were documented as having been considered were: #38212421, #38345042, and 38473138. In a meeting in December 2010, DFPS indicated that investigators reviewed previous investigations electronically and only commented in the investigation report if there was relevance. However, this did not provide a mechanism for the Monitoring Teams to ascertain whether this had been done. DFPS agreed to include a statement that would describe the results of these reviews in future investigations. DFPS has indicated that it is in the process of drafting policy to instruct investigators to document the review of prior case history in each investigative report. ▪ The Facility reports that were companions to the DFPS reports did review all previous investigations, and reports of injury. In one case #38496955 there were over 20 previous allegations made by the individual involved, which should have resulted in a recommendation that psychology review the individual's programs. o In 31 (100%), the investigator's findings; and o In 31 (100%), the investigator's reasons for his/her conclusions. <u>Facility Investigations</u> The following summarizes the results of the review of Facility investigations: ▪ In 10 out of 10 investigations reviewed (100%), the contents of the investigation report were sufficient to provide a clear basis for its conclusion. ▪ The report utilized a standardized format that set forth explicitly and separately: o In 10 (100%), each serious incident or allegations of wrongdoing; o In 10 (100%), the name(s) of all witnesses; o In 10 (100%), the name(s) of all alleged victims and perpetrators; o In 10 (100%), the names of all persons interviewed during the investigation; o In 10 (100%), for each person interviewed, a summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material statements made; o In 10 (100%), all documents reviewed during the investigation; o In 10 (100%), all sources of evidence considered, including previous investigations of serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency o In 10 (100%), the investigator's findings; and	

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		o In 10(100%), the investigator's reasons for his/her conclusions. A finding of noncompliance has been made. With regard to the DFPS investigations, the issue identified was related to reports not including a description of the results of a review conducted of previous cases involving the alleged perpetrator and/or victim.	
	(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.	Based on review of ABSSLC Policy #002.2.VIII.C, it required that staff supervising the investigators review each report and other relevant documentation to ensure that: 1) the investigation was complete; and 2) the report was accurate, complete, and coherent. The policy required that any further inquiries or deficiencies be addressed promptly. To determine compliance with this requirement of the Settlement Agreement, samples of investigations conducted by DFPS (Sample #D.1) and the Facility (Sample #D.2) were reviewed. The results of these reviews are discussed in detail below, and the findings related to the DFPS investigations and the Facility investigations are discussed separately. <u>DFPS Investigations</u> The following summarizes the results of the review of DFPS investigations: ▪ In three out of 31 investigation files reviewed (10%), there was evidence that the supervisor had conducted a review of the investigation report. Those with evidence of review of previous investigations included: The files with evidence of supervisory review were: #38477185, #38496955, and #38497721. Based on discussions with APS, the Monitoring Team understands that they took an interim step of requiring their staff to append supervisory signature sheets to their reports. In response to the Monitoring Team's draft report, APS indicated that eight of the sample reports had such appended signature sheets. However, those sheets were not provided as part of the investigative report. The Monitoring Team understands that APS has made modifications to its system to provide supervisory approvals in the case reports in the future. ▪ In 0 (0%), there was evidence of any changes being recommended and/or completed. As a result, it could not be determined if deficiencies or areas of further inquiry had been addressed promptly. In discussions with the Monitoring Teams, DFPS indicated that supervisors do review all investigations. However the review was being done electronically and no documentation appeared on the investigation report. DFPS has agreed to submit a printout to be included in the Facility's investigation files to indicate they have been reviewed, until they can make a change to their electronic system to allow the supervisory note to appear on the investigation report. At the time of this monitoring review, such documentation was not available for review.	Noncompliance

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		The ABSSLC companion reports included supervisory signatures, but no documentation of any changes that were made as a result. ABSSLC had added a page to its file system to collect supervisory comments in the future. <u>Facility Investigations</u> The following summarizes the results of the review of Facility investigations: ▪ In 10 out of 10 investigation files reviewed (100%), there was evidence that the supervisor had conducted a review of the investigation report. ▪ In 0 (0%), there was evidence of any changes being recommended and/or completed. As a result, it could not be determined if deficiencies or areas of further inquiry had been addressed promptly. Although the supervisor reviewed and signed the reports, there was no documentation of any changes that might have been made as a result of that review. A new sheet has been added to the files for collection of this information in the future. A finding of noncompliance has been made based on the lack of documentation of supervisory review, and follow-up activity.	
	(h) Require that each Facility shall also prepare a written report, subject to the provisions of subparagraph g, for each unusual incident.	The findings from the Monitoring Team's review of the Facility's investigation of Unusual Incident Reports are discussed in (f) above.	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 track and document such actions and the corresponding outcomes.	According to ABSSLC Policy #002.2. IX.B, disciplinary or programmatic action necessary to correct the situation and/or prevent recurrence was to be taken promptly and thoroughly. In addition, the Facility was to have a system for tracking and documenting such actions and the corresponding outcomes, which the Incident Management Coordinator was to maintain. The system provided that when corrective action was needed, it was documented on the Unusual Incident Investigation Report in Section #13 called "Recommendations for Current/Future Actions." The instructions required that all identified concerns be addressed, discussed, negotiated, and agreed upon prior to inclusion in the report. In order to determine compliance with this provision of the Settlement Agreement, a subsample of the investigations included in Sample #D.1 and Sample #D.2 were selected for review. This subsample, Sample #D.6, included the following investigations: #2537, #2338, #2388, #38048720, #38254301, #38287790, and #38476499. The following summarizes the results of this review: ▪ For one out of three of the investigations reviewed where disciplinary action should have been considered (33%), prompt and adequate disciplinary action had	Noncompliance

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		been taken and documented. For example, the following disciplinary actions had been taken: o In report #38254301, staff members used an improper technique to remove a person from the room, resulting in terminations. ▪ The following provide examples of investigations for which it did not appear prompt and appropriate disciplinary action had been taken: o Report #38048720 involved confirmed neglect of an individual when his one-to-one coverage was not maintained as a result of failure to follow shift change procedures. The DFPS investigator also registered concerns about lack of documentation of coverage. The companion Facility report recommended staff complete in-service training on documentation requirements. There was no date for this to be completed, no mention of the need to in-service staff on proper shift change procedures, and no determination of whether disciplinary action was needed with regard to the failure to follow shift change procedures. o In report #38476499, concerns were raised about improperly conducted room checks, and about nurses reporting that an individual's briefs had been changed when sexual activity was suspected. No disciplinary action or retraining was evident in the report. ▪ For one out of three of the investigations reviewed (34%), where programmatic action should have been considered, prompt and thorough programmatic action had been taken and documented. For example, the following programmatic actions had been taken: o Facility case #2537 involved an altercation between peers that resulted in one of them falling onto a table and sustaining a laceration to the head. The injured man was treated promptly and protective actions were taken to ensure his immediate safety. The Crisis Intervention Team was summoned, and met. The Personal Support Team for each man met and decided on some actions to prevent further harm and to address the underlying cause of the incident. The results were documented in Section 10 of the UI Report, with people responsible and times completed or targeted for completion. In addition, the Director sent a memorandum to the QMRP two days after the close of the case to secure follow-up. The following provide examples of investigations for which it did not appear prompt and thorough programmatic action had been taken: o Case #2338 involved two adult males who shared a bedroom. They were discovered in the laundry room engaging in sexual activity. Action was taken and documented to move one man to another bedroom, and to increase supervision to avoid repetition of the incident. No further recommendations were made, and no evidence included showing that	

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		adequate action had been taken to prevent recurrence. o Case #2388 occurred two months later involving the same two men engaged in sexual activity in a bathroom stall. Immediate protective actions were taken by increasing the supervision for both. Follow-up was to occur with a PST meeting. There were no further recommendations. Given the proximity of the two events, a recommendation to determine the nature of the relationship between these two men and whether their behavior was consensual would have been appropriate. If their behavior was not consensual, then one man was being victimized and clearly needed more protection. Whether the two men should have been living together also should have been considered. No evidence was submitted to show that adequate action had been taken to correct the situation or prevent recurrence. o For 0 out of 6 investigations (0%), there was documentation to show that the expected outcome had been achieved as a result of the implementation of the programmatic and/or disciplinary action. The expected outcome had not been identified in these cases, nor had the mechanism for how outcomes would be effectively measured. The Facility was not in compliance with this provision.	
	(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.	Based on review of the ABSSLC policy, records of every investigation were to be maintained in a manner that permitted investigators and other appropriate personnel to easily access every investigation involving a particular staff member or individual. At the Facility, records were maintained in a record room near the investigators and the Incident Management Coordinator. Each case was maintained in a binder, using a case number as the identifier. Each binder included all documents related to the case, arranged according to a standard file format, with a copy of the file outline on top to guide access. Files were well kept, and easy to use. When personnel other than investigators needed to access the files, they had to request them in writing, explaining their need, and log them out. Files were in the electronic system and available to investigators. There was restricted access to the electronic files, as there was to the paper copies. DFPS files appeared to be maintained electronically to allow access to their authorized personnel. It appeared that their official reports were transmitted to ABSSLC in hard copy, where they were filed in the Facility record.	Substantial Compliance

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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.	Tracking of incidents was conducted through the DADS electronic system, which required logging of information on incidents into a database. That database included: ▪ 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. Separate trend reports were produced for allegations of abuse/neglect/exploitation, unusual incidents, and injuries. Trend reports arranged data by type of incident and displayed the data by month over two fiscal years. Additional graphs were added to the trend reports to show incidents by type, by home, by location, by day of the week, by hour, by shift, by cause, and by outcome. Trend reports were available to managers in the Incident Management Committee meetings where they were reviewed. It was not clear what systemic action plans and follow-up resulted from those reviews. However, steps had been taken to attempt to remedy the living situation in the residence for young men which surfaced in Facility reviews and in previous Monitoring Team reviews, including a change of building to allow for more space, and a team of consultants to try to resolve some of the long standing behavioral issues. Based on the Monitoring Team's review, it did not appear that these remedies, some of which were in their initial stages, had been completely successful at addressing the issues. As noted above, when corrective actions are put in place, it is important to track the expected outcomes to determine if the changes have been effective, or if additional changes are needed. The trend reports collected and displayed the required data except for the staff alleged to have caused the incident. In addition, the analysis of this information to determine actions that needed to be taken to resolve problematic trends, and follow-through to ensure actions were effective were in the beginning stages. As a result this indicator remains out of 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 calendar year to work directly with	By statute and by policy, all State Supported Living Centers were authorized and required to conduct the following checks on an applicant considered for employment: criminal background check through the Texas Department of Public Safety (for Texas offenses) and an FBI fingerprint check (for offenses outside of Texas); Employee Misconduct Registry check; Nurse Aide Registry Check; Client Abuse and Neglect Reporting System; and Drug Testing. Current employees who applied for a position at a different State Supported	Substantial Compliance

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	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.	Living Center, and former employees who re-applied for a position also had to undergo these background checks. In concert with the State Office, the Director had implemented a procedure to track the investigation of the backgrounds of Facility employees and volunteers. Documentation was provided to verify that each employee and volunteer was screened for any criminal history. A random sample of 23 employees confirmed that their background checks were completed. The information obtained about volunteers was discussed and confirmed with the Facility Director. Background checks were conducted on new employees prior to orientation. Portions of these background checks were completed annually for all employees. Current employees were subject to annual fingerprint checks during the month of September 2010. Once the fingerprints were entered into the system, the Facility received a "rap-back" that provided any updated information. The registry checks were conducted annually by comparison of the employee database with that of the Registry. In addition, employees were mandated to self-report any arrests. Failure to do so was cause for disciplinary action, including termination. Examination of the self-reporting information showed that two people were terminated for failure to self-report. In an interview with the Facility Director, her decisions regarding the employment of a sample of applicants with any criminal history were discussed on a case-by-case basis. In each instance, her decisions were based on the facts and were mindful of her responsibility to safeguard the individuals and staff of the Facility.	

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 or do not understand their responsibilities with regard to reporting, the Facility should evaluate reasons, and address the underlying issues.
2. The Facility should review its use of disciplinary measures, and take appropriate disciplinary action when they fail to report abuse and /or neglect, are confirmed to have perpetrated abuse or neglect, and/or fail to carry out their duties with respect to participation in investigations.
3. The Facility should routinely test staff's competence regarding the reporting of unusual incidents and abuse and neglect by having supervisors quiz them regularly on what is expected.
4. The Facility should include the Resource Guide in the PSP development process as planned, so that individual and those closest to him/her will be able to identify and report unusual incidents, including allegations of abuse, neglect, and exploitation.
5. The Facility should implement the process for documenting supervisory decisions regarding investigations, including information to show if deficiencies or areas of further inquiry have been addressed promptly.
6. DPFS should implement its plan to provide documentation of supervisory review regarding its investigations, including information to show if deficiencies or areas of further inquiry have been addressed promptly.

7. When individuals have aggressed against their peers, or there are peers who are vulnerable and cannot protect themselves, the Facility should consider and implement a wide variety of actions, including but not limited to changes in staff, individuals' programs, and living arrangements. Individuals should not be subject to abuse or aggression from peers any more than they should be from staff.
8. With regard to appropriate follow-up for investigations:
    a. The State and the Facility should focus on improving the identification of issues and appropriate recommendations in investigation reports so that recommendations address all possible aspects of the situation.
    b. The Incident Management Coordinator should review DFPS reports and ensure that all concerns raised are addressed through recommendations in the Incident Management Report that accompanies each investigation.
    c. If concerns are not identified or raised in a DFPS report, the IMC should identify them and raise them.
    d. Expected outcomes for the corrective actions identified should be set forth.
    e. In addition to reviewing documents, as appropriate, the Facility should physically confirm that changes expected as a result of the implementation of recommendations resulting from investigation reports have occurred.
9. The Facility should continue its efforts to finalize a tracking and trending system.
10. The Facility should expand its efforts to conduct critical analysis of the trend data collected to determine if any actions should be taken, or action plans developed to address any underlying causes of trends identified.

The following are offered as additional suggestions to the State and Facility:

1. The staffing and other supports currently provided to the Self-Advocacy group should continue to be provided.
2. The Facility should continue its efforts between annual training sessions to reassure staff that retaliation will not be tolerated.

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 – Review Processes: Quality Enhancement Plan, dated 9/8/09, revised 6/17/10; o ABSSLC Plan of Improvement, dated 1/31/11; o Corrective Action Plans for Section E, undated; o Corrective Action Plan for Section D by the Incident Management Coordinator, undated; o ABSSLC Trend Analysis Report: Allegations of Abuse/Neglect/Exploitation, for December 2010; o ABSSLC Trend Analysis Report: Injuries, for December 2010; o ABSSLC Unusual Incidents Trend Report, for December 2010; o ABSSLC Restraints Trend Analysis, 3/1/10 through 5/31/10; o Presentation Book for Quality Enhancement; o Leadership Council notes, dated 11/15/10 and 1/24/11; o ABSSLC Quality Assurance/Quality Improvement notes, dated 9/20/10, and 12/30/10; o Monitoring tools associated with the Quality Enhancement Plan; and o Quality Assurance Analysis (Section E), for September 2010. ▪ **Interviews with**: o Patricia Smith, Admissions/Placement Coordinator, substituting for Sam St. Clair, Director of Quality Enhancement; o Tracyl Gandee, Settlement Agreement Coordinator; and o David Daniels, Program Compliance Coordinator. ▪ **Observations of**: o Quality Assurance/Quality Improvement (QA/QI) Meeting, on 2/14/11; o Unit 3 Daily Meeting, on 2/16/11 at 8:30 am; o Ten residences including: #5961, #5962, #5971, #5972, #6330, #6350, #6370, #6460, #6480, and #6521; and o Three PSP annual meetings: Individual # 234, Individual #196 and Individual #205.
	Facility Self-Assessment: ABSSLC's Plan of Improvement had been modified to a simplified format that contained brief descriptions of the evidence used to self-determine compliance with each element of the Settlement Agreement. The POI was arranged according to the Settlement Agreement sections with an action plan for each section and corresponding reports on progress. Self-assessment of quality had begun, using revised versions of the Settlement Agreement Monitoring Team's tools. In its POI, ABSSLC provided some summary data from reviews it had completed, which is an important part of the self-assessment process. However, it was unclear specifically what had been measured. For example, for Section E.1 of the Settlement Agreement, the POI stated: "1/2011--Current monitoring results: 33% compliance from 6 reviews since 9/2010. We are currently tracking data for most of these areas; however, we do not consistently track individual staff or individuals by name." No reference

	was made to a specific indicator(s) which the data cited measured, making it difficult to interpret the data. The percentages provided appeared to be overall scores for each provision. As has been stated in previous reports, the monitoring review tools were not designed to provide overall scores. The items within the tools are not weighted. The POI for Section E contained very little narrative information explaining steps that had been taken to achieve compliance and/or plans for future compliance efforts. It would be helpful for the POI to include such summary information in the future. Based on a review of the POI with regard to Section E on Quality Assurance, the Facility found that it remained out of compliance with all five indicators. This was consistent with the Monitoring Team's findings.
	Summary of Monitor's Assessment: There had been some progress since the last monitoring visit, including: ▪ Use of quality monitoring tools to self-assess facility performance was underway and some data was available; ▪ The establishment of the Quality Assurance/Quality Improvement Committee to review quality management efforts and to strategize solutions to identified issues; and ▪ Trend analysis data included analyses by individual and staff member involved in abuse, neglect, and exploitation allegations. Quality monitoring tools had been adopted based on the tools used by the Monitoring Teams. At the time of the review, the State had issued revised tools for some of the sections of the Settlement Agreement. The Facility was beginning to use the revised tools as they arrived. Guidelines for the use of the revised tools were not yet available, but were expected. Instruction sheets or guidelines will be important 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. If the data from the monitoring tools will continue to be used to generate cumulative compliance scores for the various sections of the Settlement Agreement, weighting of the items on the tools will be needed. Trending of some basic quality indicators was being conducted in the areas of restraint, unusual incidents, including Abuse/Neglect/Exploitation and Injuries. 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 abuse, neglect, and exploitation, and Incident Management. While the ABSSLC must adhere to the requirements of State policy, it had not been required to adopt it in total. However, adopting it would be one way of assuring there was no confusion among staff with regard to what is expected. The Facility had a policy entitled Abilene SSLC – Review Processes: Quality Enhancement Plan, dated 9/8/09 revised, 6/17/10. The policy outlined the steps in its quality enhancement plan, but with little specificity as to how the steps would be implemented. For example, the steps outlined in the policy included "tracking of data with sufficient particularity to identify trends regarding program areas…" without specifying from where the data would come. The policy referenced "monitoring questions" as the basis for its activity without specifying the questions or identifying the tools to be used. The policy indicated that a Corrective Action Plan would be tracked on the Corrective Action Plan Tracking Tool, which was not made part of the policy. It was the determination of the Monitoring Team that this policy was not sufficient to meet the requirements of the Settlement Agreement. Data were available on abuse/neglect/exploitation, unusual incidents, injuries and restraints by program area, living unit, shift, and area of care (living room, bathroom, etc.). Data by individual and staff member were available for abuse/neglect/exploitation and restraint, where case numbers were used to identify individuals and employee identification numbers were used for staff. These data were 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 providing summaries of important issues or changes. These data provided a rich resource for following trends facility-wide and by individual unit. Monitoring data were emerging from the use of the Settlement Agreement monitoring tools to assess compliance with the Settlement Agreement. The available data were	Noncompliance

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		presented in bar graphs, showing the overall level of compliance with indicators on the tools. However, based on a review of the POI, the Facility appeared to be generating overall scores for each section of the Settlement Agreement. If this practice were going to continue, the indicators on the tools would need to be weighted to ensure validity. 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, as noted above, 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, 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. 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. The Facility had begun collecting compliance data resulting from the implementation of monitoring tools for each section of the Settlement Agreement, such as sampling of PSP records, restraint checklists, and incident reports. These had the potential to be used to determine areas in need of attention. In the various sections of this report, the Monitoring Team has provided comments, as appropriate, with regard to the monitoring tools and the Facility's implementation of them. Although additional work needed to be done to refine the tools and the processes being used to implement them, progress had been made in this area. As indicated in the Facility's POI, the Facility was not in substantial compliance on this subsection. However, there was some progress being made.	
E2	Analyze data regularly and, whenever appropriate, require the development and implementation of	Facility policy and procedures had not been issued to cover the analysis of data and corrective action plans. A Quality Enhancement Plan Processes policy had been revised as of 6/17/10 to establish some basic procedures for monitoring Settlement Agreement	Noncompliance

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	corrective action plans to address problems identified through the quality assurance process. Such 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.	sections, collecting data from those monitoring activities, analyzing and trending the data. Since that amendment, some of the tools for monitoring had been adopted, implemented, and revised. The Quality Enhancement Plan will need to further revision to reflect that change, and any further changes that might be forthcoming from the DADS State Office. The Quality Enhancement Plan Processes included a process for developing Corrective Action Plans (CAPS) by program areas. Assignment of responsibilities was included in the plan. Based on the current policy, the Performance Improvement Council (PIC) was charged with discussing the status of improvements and making recommendations to modify CAPS, as needed. However, as noted below, it was unclear if the PIC still existed. During the last monitoring visit, the Performance Improvement Council was meeting monthly, and was the focal point for presentation and discussion of each discipline's corrective action plans. During the most recent review, minutes for the PIC were not provided, and it appeared that the PIC had been merged into the Quality Assurance/Quality Improvement Council. The February meeting of the QA/QI included discussion of progress, as well as plans to address important issues such as aspiration pneumonia. The meeting included presentations by coordinators of sections of the Settlement Agreement. The group discussed the "Drive for 25," which was the Facility's effort to focus compliance efforts on certain provisions of the Settlement Agreement, using a corrective action plan approach. The group decided that as opposed to each discipline choosing additional action plans to work on themselves that the group would submit ideas about some particularly problematic areas, and work in an interdisciplinary fashion to address these areas In general, corrective action plans did not set forth specific actions to be taken to ensure the needed change occurred. For example, a Corrective Action Plan was provided in relation to Section F of the Settlement Agreement. It included three corrective actions. However, these were general statements, such as: "PSP facilitated by QMRP who shall ensure members of the team participate and evaluate the individual in developing, monitoring and revising treatments, services, and supports." This was worded more as an outcome, as opposed to an action plan. It was not clear for this action step or the other two what specific steps would be taken to effectuate change. The plan did not indicate if, for example, training was going to be provided, or if new tools would be developed to assist QMRPs and teams to participate adequately. During the last monitoring visit, the Settlement Agreement Monitoring Team recommended that, 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	

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		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 is expedient rollout of the change process to other homes or units. The Facility did decide to focus energy on making changes in the residence for young men, which had presented some serious concerns. The individuals were moved to a larger home, which provided the opportunity for some individuals to have their own rooms or to share with fewer others. Consultants were brought in to help address the behavior challenges present in that residence. This was a positive change effort. However, based on the Monitoring Team's review, it did not appear that these remedies, some of which were in their initial stages, had been completely successful at addressing the issues. When corrective actions are put in place, it is important to track the expected outcomes to determine if the changes have been effective, or if additional changes are needed. It was not clear how the Facility planned to evaluate the outcomes. While this element was not yet in substantial compliance due to the need for more extensive analysis of additional information, and the development of CAPs to address identified issues, some progress had been made.	
E3	Disseminate corrective action plans to all entities responsible for their implementation.	As described with regard to Section E.2 of the Settlement Agreement, the Quality Enhancement Plan Process outlined the basic CAP requirements. Two corrective actions plans were submitted in response to Document Request TX-AB-1102-IV.7, which included a request for "any corrective action plans, including information related to follow-up and modification of corrective actions plans." One, with two parts, was assigned to the Quality Assurance Director, and involved writing plans and the use of the appropriate format. The due dates for both parts were February 2011. The second, also with two parts, was assigned to the Admissions and Placement Coordinator, and had to do with ensuring correct dates were on documents. It had a due date of 2/14/11. These efforts did not represent progress in implementing the Corrective Action Plan process. However, the POI did include Corrective Action Plans generated in response to issues identified by the Settlement Agreement Monitoring Team. For example, the POI for Section C reported seven CAPs in response to recommendations, and one CAP that the Facility initiated. The POI for Section D reported on eight CAPs. It is possible that the document request was interpreted to refer only to CAPs that arose out of the Facility's internal quality assurance process. While significant work had been done to develop corrective action plans in response to the monitoring team's recommendations, there did not appear to have been as much progress in development of Corrective Action Plans resulting from Facility-generated data. ABSSLC was still at the beginning stage of the process and had not yet developed to	Noncompliance

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		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.	
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 Process. According to the Plan, the CAPS would be tracked on a CAP Tracking tool to monitor status of improvement. Departmental monitors and QA Program Compliance Monitors would monitor the program areas to provide the data to track improvement. At the time of the review, the development of the tracking tool and analysis of results were just getting underway. As noted in the POI, there had been no monitoring of corrective action plans and this indicator 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. As recommended in the previous report, 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. The data referenced in Recommendation #2 should be a core component of what the Quality Assurance/Quality Improvement Council reviews, and the analysis of this data should form the basis for the actions that the Council implements, monitors, and revises, as appropriate, to effectuate positive changes in the lives of individuals the Facility supports.
4. As recommended in previous reports, 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.
5. At the time of this most recent review, the Facility had developed a CAP in relation to starting to implement the CAP process. The Facility should monitor progress on this initiative, as well as on the CAP related to the accuracy of dates. In addition, the Facility should develop CAPs in response to data that is already available.

6. In developing CAPs, the Facility should ensure that the action steps that are identified delineate the detailed steps that will be taken to achieve the desired outcome. Care should be taken not to simply restate the desired outcome, without specifying who will do what when to effectuate change.
7. The issue of how to trend data by employee and by individual appeared to be on the way to being resolved and had started with the Trend Analysis Reports on Abuse/Neglect/Exploitation and Unusual Incidents and on Restraints. This process should continue to be developed so that it provides a practical way to determine from trend reports, which individuals and staff are in most need of attention.
8. 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 as they have done with the young men's unit. 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) with attachments, 7/30/10; o ABSSLC Plan of Improvement for Section F, dated 1/31/11; o An alphabetical list of each individual at the Facility, with the most recent PSP meeting date, and the date of the previous PSP meeting date o List of Admissions within the last six months; o Evidence from Presentation Book for Section F; o Draft Vocational Assessment, undated; o Corrective Action Plan, undated; o Supporting Visions: Personal Support Planning Workbook, dated 7/10; o Supporting Visions Tier 2 and 3: Personal Support Planning Workbook; o Settlement Agreement Cross Referenced with ICF/MR Standards Section S review tool, revised 8/10; o Settlement Agreement Cross Referenced with ICF/MR Standards Section F review tool, revised 12/10; o Integrated Team and PSP Analysis (Section F) Part 1 and Part 2, for September through December 2010; o Personal Support Plans, and related assessments for: Individual #21, Individual #74, Individual #181, Individual #69, Individual #498, Individual #395, Individual #110, Individual #346, Individual #339, Individual #246, Individual #514, Individual #349, Individual #176, Individual #115, Individual #429, Individual #438, Individual #505, Individual #91, Individual #46, Individual #444, Individual #245, Individual #9, and Individual #52; o Monthly/quarterly assessments as available for the last six months for Individual #176, Individual #110, Individual #346, Individual #514, Individual #349, Individual #181, Individual #395, Individual #498, Individual #339, and Individual #246; o Draft monitoring tool for review of PSP meeting, dated 9/1/10; and o List of individuals who PSPs had been reviewed by Qualified Mental Retardation Professionals (QMRPs) or Program Compliance Monitors during last two-month period. ▪ **Interviews with**: o Juan Herrera, QMRP Coordinator; o Jeff Branch, Active Treatment Coordinator; and o Various staff in residences and attending PST meetings. ▪ **Observations of**: o Annual Personal Support Plan meeting for Individual #283; o Annual PSP meeting for Individual #234; o Annual PSP meeting for Individual #196;

	o Annual PSP meeting for Individual #205; and o Activities in homes and day programs.
	Facility Self-Assessment: The Facility's Plan of Improvement provided a brief outline of several steps that had been taken to meet the requirements of the Settlement Agreement. The two areas where the Facility indicated it was in compliance with the Settlement Agreement were for Section F.2.a.4 and Section F.2.f, which require PSPs to include methods for implementation, time frames for completion, and the staff responsible; and the Facility to conduct annual planning for individuals and for the plans to be in effect within 30 days, respectively. This was not consistent with the Monitoring Team's findings, which are detailed further below. In addition to providing some narrative descriptions of actions the Facility had or was taking to move towards compliance, the Facility included some data from its self-assessment reviews. This was an important step. However, it was not always clear specifically to what the data referred, making it difficult to determine if the Facility had accurately identified areas in which focused attention was needed to address the concerns that were keeping it from reaching compliance. For example, Section F.2.a.1, includes a number of requirements related to PSPs, including ensuring that PSPs build on the preferences and strengths of the individual, prioritizing the individual's needs, identifying barriers to services, and encouraging community integration. The POI stated: "1/2011--Current monitoring results: 79% compliance from 126 reviews since 9/2010. The new PSP process has begun and with implementation the teams will have a better understanding of this expected outcome." Because the Facility did not provide any context to what this data meant, it could not be determined if the Facility had identified issues related to one or more of the specific elements of this provision. The score appeared to be an overall score, which did not assist in providing direction for next steps, and likely could not have been calculated accurately given the monitoring tools being used. As the Facility moves forward in its self-assessment process, it will be important to ensure that data is used in meaningful ways to assist in identifying areas in which improvements are needed. The Facility's self-assessment process related to Section F is discussed further with regard to Section F.2.g.
	Summary of Monitor's Assessment: The Facility had adopted the State PSP policy, but had not yet developed corresponding Facility policies and procedures. The DADS Personal Support Plan Process policy and associated procedures outlined the basics of PSP planning, including the focus on the individual, the role of the QMRP, the use of the Personal Focus Assessment (PFA), and required assessments and those to be determined by the PFA. The policy addressed PSP monitoring, staff training and quality assurance. Where it fell short was in describing how to design Action Plans, Skill Acquisition Plans, and Service Objectives so that they reflected the interdisciplinary coordination that is required. All QMRPs had gone through initial training on the new process. Some of the PSP meetings the Monitoring Team observed showed some improved facilitation skills, and a person centered focus. Improvement had begun to be seen in the area of identifying preferences of individuals. Incorporation of these preferences into the overall PSP continued to need work.

	Some additional areas that required attention included: ▪ As noted in many sections of this report, comprehensive, thorough, and adequate assessments were missing in many areas, including but not limited to nursing, speech and communication, 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. ▪ The State and the Facility will need to ensure that person-centered concepts are incorporated with the need to develop comprehensive, integrated plans. Many individuals require plans with multiple supports. The State, working in conjunction with the Facility, should figure out ways to have adequate, technical team discussions, while focusing on the individual and his/her preferences, strengths, etc.

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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 shall:	DADS Policy #004 Personal Support Plan Process was issued on 7/30/10. In response to the Monitoring Team's request for related policies, ABSSLC indicated that there were no Facility policies or procedures in addition to the State policy. The DADS Personal Support Plan Process policy and associated procedures outlined the basics of PSP planning, including the focus on the individual, the role of the QMRP, the use of the Personal Focus Assessment, and required assessments and those to be determined by the PFA. The policy addressed PSP monitoring, staff training and quality assurance. Where it fell short was it describing how to design Action Plans, Skill Acquisition Plans and Service Objectives so that they reflected the interdisciplinary coordination that is required. The 23 PSPs that were reviewed were either provided by the Facility in response to a document request for a sample of the most recent plans, or chosen from among the list of individuals for whom the new format/process for PSPs had been used. The sample included plans for individuals who lived in a variety of residences on campus. Therefore, a variety of QMRPs and PSTs had been responsible for the development of the plans. A more focused review was conducted of 10 of these 23 plans to allow more detailed comments to be provided, and compliance findings to be made. These plans included the most recently developed plans for: Individual #246, Individual #176, Individual #349, Individual #514, Individual #69, Individual #139, Individual #181, Individual #74, Individual #346, and Individual #395. When specific compliance findings are referenced below, they refer to these 10 plans.	Noncompliance
F1a	Be facilitated by one person from the team who shall ensure that members of the team participate in	DADS Policy #004 at II.C.1.b indicated that the QMRP would plan and facilitate the PSP meeting. The QMRP Coordinator confirmed that QMRPs facilitated the teams, including team meetings. Reviews of PSPs also suggested that the QMRP was the team leader and	Noncompliance

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	assessing each individual, and in developing, monitoring, and revising treatments, services, and supports.	responsible for ensuring team participation. Progress had been made in this area in that the new DADS policy was in place, and key Facility staff had completed initial training. Specifically, all QMRPs at ABSSLC had undergone the initial training on the new PSP process and format. This policy clearly identified QMRPs as responsible for facilitating the teams. However, based on review of PSPs as well as during observation of four meetings held the week of the on-site review, 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. This is a key requirement to achieve compliance with this component of the Settlement Agreement. Based on observations while the Monitoring Team was onsite, the following illustrated examples of good facilitation of meetings: ▪ The QMRP for Individual #283 did a nice job of soliciting the individual's preferences from various team members. This was more challenging because Individual #283 was not able to communicate her own preferences. The QMRP kept the focus of the meeting on the individual, and consistently directed the conversation towards Individual #283. ▪ The QMRP for Individual #196 led team discussions to problem-solve, and involved all team members. For example, staff reported difficulties getting the individual to her Senior Citizen program. She appeared to be afraid of the big step from the van to the ground, and often refused to get off the bus. A team member reported that she did not appear to be afraid of getting into and out of station wagons, since the step was shorter. Another team member noted that the Senior Citizen program was slated to move to a location closer to the individual's home and she would be able to walk, providing needed exercise as well. The result was a short-term solution to provide transportation via station wagon, and a long-term solution to begin having Individual #96 walk to the program. The following were examples of missed opportunities with regard to adequate facilitation to ensure integrated development of plans that addressed the full set of protections, supports, and services needed by an individual: ▪ Individual #283's PSP meeting lasted approximately a half an hour, and consisted mainly of team members providing brief updates. There was little to no integrated discussion, and little, if any, reference to data to assist the team in making decisions. Specific concerns included: o Individual #283 had a number of medical complexities, including the use of a feeding tube, and the potential for skin breakdown. She also had nursing care plans for bowel management, and to address her risk	

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		for respiratory issues. The nurse merely listed the topics of the four nursing care plans, and asked the team if that "sounds good." The team agreed to continue them with no discussion of data that would show if they remained appropriate as written, or if changes needed to be made. Likewise, there was no discussion of how any of the strategies included in the nursing care plans should be integrated with other support and services being provided, or how nursing needed to integrated strategies from other plans (e.g., the PNMP) into the nursing care plans. o The team did not discuss Individual #283's risk level, but a sign-off sheet was passed around for the team members to sign indicating that risk levels had been identified. o The Occupational Therapist mentioned that Individual #283 had a positioning plan, home exercise program, and PNMP. There was no discussion about how these plans would be integrated with specific activities, for example, the PNMP during medication administration. The team discussed no data with regard to the progress Individual #283 was making with the implementation of these plans, or any need for the plans to be modified. The plans were merely passed around the table for team members to review, and indicate if they remained acceptable. o The Physical Therapist arrived when the meeting was about to end, but mentioned that a work order had been placed for a smaller wheelchair, because Individual #283 slid down in the current one. It was anticipated that obtaining the new chair could take a while, because there was an "extensive list" for new equipment. The QMRP did not solicit any discussion from other team members about actions that could be taken in the meantime to ensure Individual #283's correct position was maintained in her current wheelchair to reduce her risk for respiratory issues. o In discussing the goals and objectives, the team engaged in no review of data. Rather, subjective information was used to determine if goals should continue, such as "she's been doing well with that." Also, the QMRP did not solicit functional measurable outcomes from team members for all of the plans mentioned in the meeting. For example, there was no discussion about outcomes or objectives for the nursing care plans, the home exercise program, positioning program, or the PNMP. ▪ In the annual PST meeting for Individual #196, her sister was contacted by phone. She could not participate in the meeting, but did agree to answer some questions. The QMRP asked if she would allow Individual #196 to participate in a group home tour as part of her education about community opportunities. The question solicited a definitive response of "no." Another way to ask the question	

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		would have been to inquire what, if any, objections she might have to her sister visiting homes in the community. This example illustrated the need for meeting facilitators to use open-ended questions, when attempting to secure participation in discussions, and to solicit information that would be helpful to the team in identifying possible obstacles. An important change was related to QMRP staffing. The number of QMRPs had increased to 23. This reduced the average caseload to 1:19. These changes should assist QMRPs in being able to complete the many requirements of their job, including the adequate facilitation of PSP meetings. Based on observations as well as review of PSPs, while some meetings were much improved, the meetings were not consistently resulting in the adequate assessment of individuals, and the development, monitoring and revision of adequate treatments, supports, and services. As a result, the Facility remained out of compliance with this provision of the Settlement Agreement.	
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 as including the individual, the Legally Authorized Representative (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. In reviewing PSP sign-in sheets, QMRPs were present at the annual meetings, and the individual almost always was present. Others participating included, at times, nurses, direct support professionals, Legally Authorized Representatives, psychologists, Occupational Therapists (OTs), Physical Therapists (PTs), Speech Language Pathologists (SLPs), and other disciplines, depending on the individual's circumstances. Physicians rarely attended. Often, neither an OT nor PT attended, even in situations in which an individual had OT/PT needs. Often, the individual presented issues requiring the attendance of specific team members, but these team members were not in attendance. In none a subsample of 10 PSPs reviewed (0%) did it appear that a duly constituted team attended. For example: ▪ Individual #245 had an interest in work and an objective about work, but no one from Vocational Services attended her PSP. ▪ Individual #176 had a Physical and Nutritional Management Plan. According to the sign-in sheet, an OT, PT, SLP, or Dietician was not in attendance at her meeting. The SLP had made a recommendation for Individual #176 to have a training objective to help her learn to operate a vibrating pillow with a jellybean switch. The team concluded, without a SLP present, that because she consistently threw a radio with a switch that: "she does not want anything to do	Noncompliance

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		with the switch." ▪ Individual #69 was considered to be at medium risk for weight issues. No dietician was at his meeting. Work was described as "very important to him." No vocational staff attended his PSP, according to the sign-in sheet.	
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 his/her 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, nursing, risk of emergency restraint, self-administration of medication, audiological screening, dental, community living options, vocational or day evaluations, the Health Risk Assessment tool, and other assessments based on specific needs. Plans included a Personal Focus Assessment that gathered information on the individual's preferences. Some of the PFAs identified the assessments that the team decided needed to be completed. 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. In none of the 10 PSP files reviewed (0%), adequate assessments were present. Often the narrative sections of individuals' PSPs identified issues of concerns for which assessments were not found. In other instances, assessments clearly did not provide the team with the information it needed to develop adequate plans for the individual. The following provide examples of PSPs in which concerns were noted: ▪ In the PSP for Individual #46, reference was made to recent episodes of agitation, during which the individual kept looking over her shoulder. The team attributed this behavior to a possible reduction in Ativan or to another individual she is not fond of coming to or trying to get into her home. In the outcomes and objectives, no further information was included about how this was to be addressed. It was not clear whether she was afraid of someone, and, if so, why that person was coming to her home. At a minimum, the team should have determined if additional assessments were needed to determine the cause	Noncompliance

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		for the agitation. ▪ Individual #349 had a stated preference for work. He was only attending a vocational program a couple of hours a week. His team cited staffing problems in the vocational program as a reason for the limited time Individual #349 worked. The team decided that additional staffing would be provided to increase his work time to include another hour or so. No vocational assessment was found, nor was one referenced in the narrative section of his PSP. Similarly, the psychiatrist had seen Individual #349, and prescribed an anti-depressant. It was suspected that he was depressed due to the loss of his father. It was not clear from either the PSP or the assessments submitted that an assessment had been completed to determine if counseling would be appropriate to assist Individual #349 in dealing with the loss of his father. ▪ Individual #69 did not have a Behavior Support Plan. During his PSP meeting, residential staff raised concerns regarding his tearing up his clothing. Agitation and "verbal hostility" also were noted when he did not want food that was offered at mealtimes, and "he will refuse to eat because of this." The team indicated that training objectives would be developed. No recommendation was made for psychology staff to assess these areas of concern to potentially provide the team additional guidance. One assessment that would prove useful for some individuals would be an annual review of incidents, and A/N/E allegations. This type of assessment was not found in any of the PSPs reviewed. However, for some individuals, it would be beneficial on an annual basis for teams to review aggregate individual data related to incidents, allegations, and restraints. This would ensure that the team considered the need to address whatever themes might be revealed, as an addition to reviewing new allegations or incidents as they arise. The intent of such a review would be to ensure that all of the protections, supports, and services necessary to reduce to the extent possible such incidents were in place and appropriately incorporated into the PSP. Overall, assessments were either not present or inadequate to guide teams properly in developing adequate PSPs. This is an area that will require the concerted efforts of all team members to resolve.	
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.	Although the new PSP process had been specifically designed to be more interactive and staff were trained not to read their assessments at the meetings, teams continued to need to incorporate thoroughly the results of assessments in the PSPs. Based on the review of the newer plans, even when assessments were present, the connection between the assessment results and the PSP were not always clear. In none of the 10 plans (0%) were all recommendations resulting from assessments addressed in the PSPs either by incorporation, or evidence that the team had considered the recommendation and	Noncompliance

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		justified not incorporating it. For example: ▪ Individual #139's package of assessments included a copy of his nutritional assessment. It indicated that he had Type I Diabetes, and specific recommendations were included related to his dietary plan, as well as fluid restrictions. Although the narrative section of his PSP identified him as having diabetes, none of his action plans incorporated the recommendations from the nutritional assessment. The only reference in the action plans related to his diabetes was that his blood sugars would be maintained. Nursing staff were responsible for this action step, and no strategies were defined, and no measurable parameters were provided. ▪ Many of the individuals plans (e.g., Individual #246, Individual #176, Individual #75, and Individual #395) included recommendations related to speech and/or communication, but none of their PSPs included related action plans or objectives. ▪ Individual #176 had a number of recommendations in the OT/PT assessment that were not incorporated into the PSP. The State and the Facility should ensure that person-centered concepts are incorporated with the need to develop comprehensive, integrated plans. Person-centered planning is not a reason for not having plans that are adequate. Many individuals require plans with multiple supports. The State, working in conjunction with the Facility, should figure out ways to have adequate, technical team discussions and incorporate such discussions into comprehensive PSPs, while focusing on the individual and his/her preferences and strengths. 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) based on observations and review of documentation in PSPs, 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.	

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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 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 the Action Plan should be based on prioritized preferences, strengths and needs. The newer PSPs reviewed generally included more information regarding the individual's preferences and strengths. Documentation showed that the teams utilized information gained about individuals' preferences at the Personal Focus Assessment meetings that were held in the month preceding the annual PSP meeting to focus the initial discussion of the team during the PSP meeting. However, many of these preferences related to the recreational interests or food preferences of the individuals. They were not necessarily comprehensive in nature, indicating individuals' specific preferences related to living environments or jobs. Moreover, some teams had clearly included preferences in the PSPs, but it often was difficult to determine how the identified preferences of the individuals were incorporated throughout their PSPs. In the subsample of 10 plans reviewed, four plans (40%) had some connection between the preferences and action plans or measurable objectives. These included Individual #349, Individual #69, Individual #74, and Individual #346. Examples of where individuals' preferences had been specifically integrated into Individual's PSPs included: ▪ The PSP for Individual #444 included some specific likes and dislikes. For example, he liked being read to, and he was interested in learning to tell time and to help with the laundry. His PSP included training objectives related to washing and drying clothes, obtaining a watch, and telling time. He also liked to	Noncompliance

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		ride his trike, and an objective was including about learning to unlock it. ▪ A number of Individual #69's preferences were integrated into action plans. Many of these were service objectives for staff to support him in going shopping, researching upcoming wrestling events, and participating in the Aktion Club. His preference for shopping had been integrated into a skill acquisition objective, which specifically required that the objective be completed at least once a month in the community. Examples of where it was less clear how individuals' preferences were incorporated into their PSPs included: ▪ Individual #246's team identified specific preferences of sitting in the yard and digging in the dirt, having visits with his family, going on outings, being able to spend "a lot" of time outside, watching television, and eating regular meals and snack. In the last Monitoring Team report, Individual #246 was discussed, and concerns were raised regarding the lack of interventions in place to address his behavior of excessive and repeated digging in the dirt outside of his residence. Although it appeared that the team met to discuss these concerns, the team had not worked effectively to identify ways of incorporating some of Individual #246's preferences into a plan that would lead toward more productive activities. Rather, the team concluded that: "being able to sit and sift through the sand/dirt is a very strong sensory input for [Individual #246] and cannot be taken away from him. In the past, the team was encouraged by outside visitors to have [Individual #246] participate in other activities. However, when the team attempted to limit his time in the yard and provide other activities, [Individual #246] became very upset and had a significant increase in self-injurious behavior and agitation. Extra visits with his parents did not lessen his agitation and his parents requested that the team let him return to his spot in the yard since it was obviously so important to him." There was no evidence that the team had methodically attempted to identify replacement behaviors that would be more functional, but might address Individual #246's very strong preference for digging in the dirt and sifting sand. For example, many people who like to dig in the dirt maintain gardens. There are jobs that would provide an opportunity to dig in the dirt, such as filling sand bags, or participating in lawn care or maintenance activities. Some of these activities also would meet his preference for being outside. However, no functional assessment was noted as having been completed to determine appropriate replacement behaviors. The team also seemed to believe that the process of replacing this behavior with other activities would occur quickly. Given that the behavior had been allowed to go on for as long as it had, a planned and incremental approach to replacing it with more appropriate activities should have been implemented. Such a plan should have identified an intense reinforcement schedule, making use of some of	

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		his other stated preferences. The team also needed to recognize that modifications likely would need to be made to any plan that was implemented. ▪ Individual #245 was said to like going to work with no further information. Her PSP included an outcome about increased independence in daily living skills with an objective of vocational services. The PSP did not indicate whether her work schedule might be expanded, how her work might have been related to other interests, or what measures might be employed to assess how she was progressing. ▪ Individual #514 had a lengthy list of preferences identified. However, none of these appeared to be integrated into any of the action plans. ▪ Individual #46's PSP indicated that she liked to work and was attending work for approximately two hours in the morning and the afternoon. She had an Action Plan with the desired outcome of increasing her independence. The Measurable steps included focusing on a task for five minutes, and not putting completed work in the tub of unfinished laundry. There did not appear to be any connection between the work (apparently laundry), and her interests, which appeared to be music, table games, table activities and walks. Clear prioritization of the individual's specific needs (e.g., one daily living skill as opposed to another, or which specific medical supports took priority over other needs or preferences, etc.), or careful delineation of barriers to addressing needs was generally not found. In reviewing objectives related to individuals' involvement in the community, they often were general community participation objectives as opposed to skill building objectives to assist individuals in accessing and utilizing community offerings. Some PSPs reviewed included no objectives related to community involvement. Of the 10 plans reviewed, two (20%) had skill acquisition objectives that specifically were to be completed in the community (i.e., Individual #69, and Individual #74). An additional four (40%) included general service objectives to assist the individual to access the community (i.e., Individual #176, Individual #349, Individual #181, and Individual #346). The remaining four (40%) made no mention of community integration in the action plan section (i.e., Individual #246, Individual #514, Individual #139, and Individual #395). Some examples of concerns noted included: ▪ Individual #176's PSP included the following objective: "She will go on outings." It did not provide any indication of what she would do on the outings, or the specific frequency with which outings should occur. It stated: "Ongoing." This was not measurable. ▪ Individual #514 had preferences listed that could easily be translated into community integration and learning opportunities. However, his action plans included no specific goals of objectives to increase his community involvement	

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		or learning opportunities in community settings. Although the team had checked "community" for one of the locations for a number of service objectives (e.g., PNMP), these did nothing to expand his community involvement on their own.	
	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 last monitoring report, PSPs generally included some individualized and measurable goals/objectives, treatment strategies and supports. However, in most of the plans reviewed, the expected outcomes were general and not measurable. In a number of cases, individualized, observable and/or measurable objectives had not been delineated in the PSP, and/or the treatments or strategies to be employed or necessary supports were not stated specifically. None of the plans (0%) included a full complement of measurable goals or objectives to address the full array of supports and services the individual required. For example: ▪ Individual # 505's PSP included outcomes such as: "gain independence and a better way of life." This was not a measurable outcome as it was written. The steps to achieve this outcome included: "Van and car rides," and "Eating out." It was difficult to understand how the car rides and trips to restaurants were supposed to assist him to gain independence. For these outcomes to work, the team would need to answer questions such as: what does "gain independence" mean to this individual? What will happen on a van ride that will improve his chances for independence? How will progress toward independence be defined? ▪ Individual #246 had a Behavior Support Plan. In his 12/7/10 PSP, the only objective related to his BSP read: "Continue BSP with target behaviors of Agitation and SIB [self-injurious behavior]." There were no measurable objectives included. Likewise, he was prescribed psychotropic medication. His only objective was: "Follow up monthly and quarterly pscyh clinics." No objectives or outcome measures were included to determine the efficacy of his psychotropic medication. ▪ None of the skill acquisition objectives in Individual #176's plan were measurable or observable. In the measurable steps column, for example, the following were listed: "Independent Travel," "Money Skills," and "Napkin." As is discussed in further detail throughout this report, improvement was needed in this area. For example, nursing plans, which should have been incorporated into the overall PSP, did not generally contain individualized measurable goals/objectives. This is further detailed in the section of this report that addresses Section M of the Settlement Agreement. Likewise, as is discussed below with regard to Sections O and P of the SA, measurable functional outcomes were not being identified for individuals in need of physical and nutritional supports. At this juncture, behavior support plans and psychiatric treatment plans did not contain all of the measurable goals and/or objectives that they should. In the section below that addresses Section T.1.b.1, there is extensive	Noncompliance

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		discussion regarding the Facility's status with regard to identifying obstacles to individuals moving to the most integrated setting, and plans to overcome such barriers. In summary, the Facility was at the very initial stages of complying with this component of the SA.	
	3. Integrates all protections, services and supports, treatment plans, clinical care plans, and other interventions provided for the individual;	PSPs appeared to integrate some, but not all protections, services and supports that individuals required. None of the 10 plans reviewed in depth (0%) integrated all of the protections, services and supports, treatment plans, clinical care plans, and other interventions provided for the individual. For example, the health services portion of the plan, similar to the BSP and PNMP, frequently still were separate plans that were not integrated in any measurable way into the PSP, through, for example, measurable objectives, and did not show an integration of various disciplines and team members. Examples of issues related to the lack of integration were found between nursing and physical and nutritional supports, incorporation of PNMPs with dental care, and dental and psychology to develop and implement desensitization plans. All of these are examples of coordination and integration that should be occurring as part of the individual planning process. For example: ▪ As noted above, Individual #246 had both a BSP and a plan for psychotropic medication. Neither was integrated into his PSP. Both were mentioned, but no measurable goals or objectives were included to measure the efficacy of either plan. The PSP document provided no narrative description of discussion about either of these plans, or their integration with other supports or services. As also noted above, Individual #246 engaged in repeated behavior of digging holes in the yard of his residence. No integrated discussion was found in the PSP to show that psychology and psychiatry staff had worked together with other members of the team to develop an integrated plan to address this behavior and identify functional alternatives. ▪ In the narrative section of Individual #176's PSP, the team discussed that: "She is a picky eater, and refuses several meals weekly. She requires staff to provide physical assistance and verbal explanation as needed at the start of the meal to help her find the placement of the plate, her drinks, and her utensils. They also need to inform her what foods are being served. She sometimes attempts to utilize her fingers versus utensils, and this should be redirected by staff. For her safety, she is to remain seated until her walker is in position for her to exit the dining room." Her PNMP was not referenced in the action plan section of her PSP at all, nor were the many specific staffing supports described in the narrative of the PSP. Moreover, there were no measurable objectives included to measure the effectiveness of the plan. Given that she was a "picky eater" and often refused meals, there was no measurable objective to track the number of missed meals. Her team had identified a number of very specific food items in	Noncompliance

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		the preference section, including meat and beans, spicy foods, such as Mexican food, ravioli, and spaghetti, salads covered in ranch dressing, chips, pizza, and junk food. There was no discussion recorded in the PSP regarding ways in which some of these preferences could be used to reduce meal refusals, while still adhering to a healthy diet. ▪ Individual #74's team had identified his behavioral concerns as the main obstacle to his ability to transition to the community. His PSP mentioned his BSP in the narrative section, but did not integrate it into the action plan section. No measurable goals were included in his PSP related to target or replacement behaviors. As discussed with regard to Section J.9 of the Settlement Agreement, the records reviewed for 37 individuals prescribed psychotropic medication did not provide documentation of an interdisciplinary, integrated process to determine if the 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, psychiatrists did not attend the individuals' annual PSP meetings, or meetings at which addenda to the PSPs were being discussed. Thus, based on the documentation reviewed, there was no forum at which a truly integrated interdisciplinary discussion was occurring between Psychiatry and all of the other relevant members of the individuals' teams.	
	4. Identifies the methods for implementation, time frames for completion, and the staff responsible;	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 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 Positive Behavior Support Plans. The following provides an example of a PSP that did not effectively address the individual's needs, and/or was not practical and functional at the Facility and/or in community settings: ▪ Individual #176's PSP included broad objectives, such as "Napkin," "Money Skills," and "Independent Travel." The PSP did not document the specific skills that would be taught, or how these were related to Individual #176's specific needs. It could not be determined if they were practical or functional. All of	Noncompliance

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		these skills were to be taught at the Facility, as opposed to be in the community. This decreased the likelihood that they would be practical in the community. For example, independent travel is very different at the Facility, which is a more protected environment, than in the community.	
	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 contained data collection methods, frequency with which data should be collected, and identified a person(s) responsible. However, again, as is discussed in other sections of this report, not all components of individuals' PSPs identified the data to be collected, the frequency, and/or the persons responsible for such data collection. For example, some of these elements were missing from the nursing care plans, as well as psychiatric services, such as the monitoring of symptoms that medications were prescribed to reduce. None of the 10 plans reviewed in detail (0%) identified the full set of data that needed to be collected, the person(s) responsible for the collection, and/or analysis of the data. Examples of this included: ▪ Although separate plans were referenced for Individual #349, such as a PNMP, and nursing care plans, these were not integrated into his PSP through the inclusion of measurable objectives. As a result, the PSP did not identify who would be responsible for data collection, or review and analysis of such data to determine the individual's progress. ▪ Individual #139's PSP indicated in the narrative that he required the implementation of a BSP, and PNMP. The only reference to the BSP in the action plans was the following word "Psychology." No reference was made to the PNMP. No measurable objectives were included for either, and, as a result, no one was identified to collect or monitor data with regard to such measurable objectives/outcomes. None of the PSPs reviewed appeared to be driven by a review of data, and the presence or lack of progress on measurable objectives and outcomes. Data from previous months, quarters, or years was seldom reviewed, according to the narrative sections of the plans.	Noncompliance
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.	Noncompliance

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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. At the time of the review, the PSP was located on the residential unit, but locked in a cabinet or office for security reasons. Given privacy and security requirements, this was appropriate. It appeared that if staff needed access to the locked records, a key was easily available. The training objectives were located on the unit and accessible to staff, usually in folders or notebooks. One of the concerns related to the ability of staff responsible for implementing PSPs to understand them was the use of professional jargon that was not defined in the plans. It is inevitable that PSPs will need to include medical and other clinical terms that all team members responsible for the implementation of the plan might not understand. However, it is important for these terms to be defined. The following provide and example of jargon that was used that was likely difficult for all team members to understand: ▪ For Individual #349, it appeared that significant portions of some assessments had been copied and pasted into the body of his PSP. This made it difficult to read, and understand. Moreover, many of the salient points included in the assessments were not translated into measurable goals and objectives in the action plan section. This made it extremely difficult for a direct support professional to know what his/her responsibilities were in supporting Individual #349. The following illustrated some of the language in the PSP that made comprehension difficult. In quoting the OT/PT evaluation, the PSP read: "On the left lateral calcaneous, mild ecchymosis with central eschar was observed… Capillary refill time responded in 4-5 seconds bilaterally, and he presented with dystrophic, jagged toenails with a yellowish coloring…" Important information related to the supports that staff needed to provide Individual #349 was mixed in with much of this clinical language. For example, bathing requirements, his assistance levels for self-care activities, and mealtime requirements were all scattered throughout approximately three pages of assessment language. None of these were translated into service objectives in the action plan section. Another issue related to comprehensibility of the PSPs reviewed was the lack of delineation of responsibility for the implementation of the plans. As a direct support professional, it would be difficult to read the PSPs as written and determine what his/her responsibilities were for the individual during the course of the 24-hour day. This in large part was due to the fact that the PSPs continued to lack integration, and many separate plans continued to exist that were not integrated into the one document.	Noncompliance

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		Although it will be necessary for the separate plans to continue to exist (e.g., BSPs, PNMPs, health care plans, etc.), the goals and objectives of these plans, and the delineation of who is responsible for what with regard to the plans should be incorporated into the overall PSP. This is necessary to provide one document that clearly identifies all of the protections, supports, and services that need to be provided to the individual, and clearly identifies the responsibilities of various team members.	
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 occurred, the interdisciplinary team shall meet to determine if the ISP needs to be modified, and shall modify the ISP, as appropriate.	DADS Policy #004 at III addressed personal support plan monitoring including the requirements of the SA. Based on interviews with Facility staff, monthly reviews were not being completed consistently. This was confirmed through document review. A sample was requested of the monthly reviews for 10 individuals. Of these, five (50%) had documentation to show that quarterly, but not monthly, reviews had been completed. For one individual, Individual #176, (10%) monthly reviews had been completed for her PSP, which was completed in December 2010. The quality of all of these reviews was inadequate. Data was not provided for any of skill acquisition programs. The comments were general, such as "progressed," "objective initiated," or "refusals, will counsel." Individual #246's monthly review included some behavioral data, but with no analysis. Moreover, due to the fact that many plans, such as PNMPs, nursing care plans, psychiatric medication plans, and BSPs, were not integrated into the PSPs, no commentary was provided on these in the corresponding monthly reviews. In particular, no data was provided to support the efficacy of these plans, or to indicate if changes needed to be considered. None of the reports reviewed identified a need for the team to meet to modify the PSP.	Noncompliance
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	DADS Policy #004.IV addressed staff training on the PSP process that comports with the SA requirements. Supporting Visions: Personal Support Planning, dated July 2010, was the new training curriculum for personal supports planning. The document designated this training as competency-based relying on two aspects of the materials, including that the learning objectives were derived by examining what employees needed to know and be able to do on the job, and that practice events in the instruction curricula related to selected learning objectives. The criteria for receiving credit for the course were attendance, participation in competency-based activity, and assessment throughout the course. This training did not meet the requirements for competency-based training. In order to meet the Settlement Agreement requirements with regard to competency-based training,	Noncompliance

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	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.	QMRPs should be required to demonstrate competency in meeting facilitation and the development of an appropriate PSP document. Such competency measures should be clearly defined and include criteria for achieving competence. Competency measures for other team members also should be identified and used to evaluate whether additional training is needed. The course contained a variety of activities including role-playing, paper and pencil self-assessments and videotaped demonstrations. A workbook was included so that learners could have a visual prompt and set of activities at hand. The training instructors had special training in presenting this course and were certified to do this training. This training course provided a good introduction to the development of PSPs, the differences between the new and the old processes, the roles of team members and the expectations for individualized and integrated plans. The training explained the "why" behind the changes, but not the "how." There will need to be additional teaching about how to the develop integrated action plans that draw together the information gathered in assessments, how to analyze that information and incorporate the individual's preferences, and how the priorities be translated into clear directions for those working with the individual. Once the "how" of designing integrated action plans has been taught, there will need to be further training on how to link those action plans with service objectives and skill acquisition objectives so that considerations of the individual's interests and priorities and vision for his/her living arrangements and work will be reconciled with medical and safety needs. Based on conversations with the QMRP Coordinator, the need for additional facilitation training for the QMRPs had been recognized. Reportedly, training was being developed, and one of the ABSSLC QMRPs and the Assistant Director of Programs were involved in the initiative. Some of the direct support professionals indicated in conversations with the Monitoring Team that they liked the "Visions" training and thought it represented a positive direction. A few expressed concern that the follow-through would not be forthcoming, and that the potential of this new learning would not be realized. Continuing efforts will be needed to assure that the new training is reinforced and supported. The QMRP Coordinator also indicated that he was considering use of a tool to evaluate QMRPs competency in coordinating the PSP meeting. He envisioned conducting these reviews in conjunction with the QMRP Educator. Based on interview and document review, a tool was available for review of the PSP document. A sample had been pulled.	

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		QMRPs were rating some plans using this tool, as were Program Compliance Monitors (PCMs) from the Quality Assurance Department. The two departments had begun to look at inter-rater reliability.	
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 written extension.	Based on the list of individuals with their most recent and previous PSP dates, 436 out of 447 plans (98%) were completed within one year. The 11 plans that had been overdue were late on average by 25 days, ranging between one and 130 days late. While it is possible that extensions were granted for some of the 11 plans, this was not evident on the provided list. What could not be determined was whether the PSPs went into effect within 30 days. At 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.	Noncompliance
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. Based on interview and document review, a tool was available for review of the PSP document. A sample had been pulled. QMRPs were rating some plans using this tool, as were Program Compliance Monitors from the Quality Assurance Department. The two departments had begun to look at inter-rater reliability. A list provided showed that 16 PSPs had been reviewed in both December 2010, and January 2011. Based on the POI and graphs the Facility provided, it appeared that such monitoring had been occurring since at least September 2010. There was some confusion, because two different review tools were provided in response to two different document requests. One was entitled the Personal Support Plan Meeting/Documentation Monitoring Checklist, and the other was the Settlement Agreement Cross Referenced with ICF-MR Standards Section F: Integrated Protections Services, Treatments and Supports. It was not completely clear how these two different review tools were being used. The latter contained guidelines, which should be helpful in ensuring that different auditors are reviewing the same information. The Monitoring Team did not review the guidelines in detail. However, an overall comment would be that the guidelines did not always provide enough information to ensure that the quality of various components of	Noncompliance

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		the PSP process was being effectively evaluated. For example, indicator F.2.3 addressed integration of services. The guideline correctly referenced that all services and supports the individual needed should be included in the PSP, and gave an example of the need for a PNMP to be "addressed in the PSP." This did not provide sufficient guidance to ensure the integration of services and supports. For example, with a PNMP, an auditor would need to look to ensure components of the PNMP were integrated into other relevant plans, such as nursing care plans and medication administration records, and that clear objectives for the measurement of the efficacy of the PNMP had been incorporated into the PSP. Similarly, in providing guidance about the indicators related to assessments, the quality of the assessments was not addressed. As the Facility gains experience with implementing the review tools, changes should be made, as necessary. A Corrective Action Plan for Section F was provided. It included three corrective actions. However, these were general statements, such as: "PSP facilitated by QMRP who shall ensure members of the team participate and evaluate the individual in developing, monitoring and revising treatments, services, and supports." This was worded more as an outcome, as opposed to an action plan, and closely mimicked the Settlement Agreement language. It was not clear for this action item or the other two what specific steps would be taken to effectuate change. The plan did not indicate if, for example, training was going to be provided, or if new tools would be developed to assist QMRPs and teams to participate adequately. As noted above with regard to the Facility's self-assessment, the Facility's monitoring results were different from those of the Monitoring Team. The Facility should continue to work to ensure that it has an adequate self-assessment process in place for Section F.	

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 continue to receive training 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. The Facility should consider encouraging the use of wall charts as an aid to facilitation of annual team meetings. The Monitoring Team encountered QMRPs who were knowledgeable about these techniques and if encouraged, might share the techniques with colleagues.
4. 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.
5. Consideration should be given to adding to the PSP process an annual review of incidents, and abuse, neglect, and exploitations 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 State and the Facility should ensure that person-centered concepts are integrated with the need to develop comprehensive, integrated plans. Many individuals require plans with multiple supports. The State, working in conjunction with the Facility, should figure out ways to have adequate, technical team discussions and incorporate such discussions into comprehensive PSPs, while focusing on the individual and his/her preferences, strengths, etc.
7. QMRPs should be required to demonstrate competence in both meeting facilitation, and the development of an appropriate PSP document. Such competency measures should be clearly defined and include criteria for achieving competence. Competency measures for other team members also should be identified and used to evaluate whether additional training is needed.
8. Ongoing training should be provided to address gaps in knowledge regarding the new PSP process, as well as to enhance the various team members' skills.
9. Consideration should be given to adding examples of PSPs that are well done, while protecting the identity of the individual, to the training manual to assist in teaching QMRPs and teams what is expected.
10. The Facility's Quality Assurance 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 International Classification of Diseases (ICD)-9 Codes for Pneumonia (in-service from Dr. Moy – State Office); o Supporting Visions PSP Workbook, dated 7/10; o SSLC PSP Meeting/Documentation Monitoring Checklist, dated 7/10; o Consultation reports and follow-up progress notes for the following individuals: Individual #199's Ophthalmology consultations on 8/6/10, 8/13/10, 8/27/10, 9/8/10, 10/6/10, 10/22/10, 10/29/10, 11/12/10, and 12/10/10, Renal consultations on 9/9/10, Gynecology consultation on 10/5/10, Surgery consultations on 11/11/10, 12/2/10, 12/16/10, Endocrinology consultation on 12/7/10; Individual #284's Dermatology consultations on 12/15/10, and 9/15/10, Psychiatry consultation on 9/21/10; Individual #176's Gastroenterology consultation on 12/13/10; Individual #101's Hematology/Oncology consultations on 8/11/10, 9/20/10, 11/15/10, and 12/15/10, Gastroenterology consultation on 1/5/11; Individual #147's Dermatology consultation on 10/13/10, Endocrinology consultation on 10/29/10; Individual #57's Orthopedic consultation on 8/25/10, 9/8/10, 10/11/10, and 11/29/10; Individual #415's Neurology consultation on 10/11/10; Individual #65's Neurology consultations on 8/9/10, and 11/8/10; Individual #306's Dermatology consultations on 8/18/10, 9/15/10, 10/13/10, and 12/15/10, Neurology consultation on 12/13/10; Individual #440's Podiatry consultation on 10/19/10, Dermatology consultation on 9/15/10, Psychiatry consultation on 10/5/10; Individual #6's Hematology/oncology consultation on 6/29/10, and 12/27/10; Individual #400's Neurology consultation on 9/13/10; Individual #203's Hematology/oncology consultation on 1/5/11, Dermatology consultation on 1/12/11; Individual #5's Dermatology consultations on 11/17/10, and 12/15/10, Neurology consultations on 8/9/10, and 10/11/10; Individual #443's Dermatology consultation on 9/15/10, Otolaryngology consultation on 10/12/10, and 11/9/10; Individual #91's Neurology consultation on 9/13/10; Individual #179's Otolaryngology consultation on 10/12/10, Endocrinology consultation on 10/7/10; Individual #355's Neurology consultation on 9/13/10, Psychiatry consultations on 8/26/10, and 11/8/10; Individual #220's Dermatology consultation on 11/17/10; Individual #547's Podiatry consultation on 9/21/10; Individual #58's Psychiatry consultation on 10/25/10, Neurology consultation on 9/27/10; Individual #494's Psychiatry consultation on 8/31/10; Individual #522's Endocrine consultation on 9/15/10, and 12/21/10, Gynecology consultation on 8/18/10, Podiatry consultation on 9/21/10, and Individual #301's Surgery consultation on 9/9/10, Psychiatry consultations on 11/2/10, 12/14/10. ▪ **Interviews with**: o Richard Chengson, MD, Medical Director; and o Mary White, RN, Quality Assurance Nurse.

	Facility Self-Assessment: ABSSLC's POI provided a list of five outcome goals, which were the focus of attention for this section of the Settlement Agreement. An important step that had occurred was the implementation of daily medical meetings with rounds in the Infirmary. These meetings were interdisciplinary in nature. The focus was to ensure all the medical staff, and representatives of nursing, psychiatry, and physical therapy, were aware of the admissions, medical treatments, and ongoing concerns of the most critically ill individuals on the campus. The POI listed several goals in the creation and development of the role of the Physical and Nutritional Management Team (PNMT). There was also a goal that there be a tracking system for consultation visits and reports that were generated from these visits, including the date of the order, the date of the consultation, the date ABSSLC received the report, and the date the primary care practitioner (PCP) reviewed the report, and documented agreement or alternative considerations. At the time of the Monitoring Team's visit, no information was submitted to show progress had been made on these goals. In order for substantial compliance to be demonstrated the Facility will need to develop a system to collect data and document of progress in these areas. In its POI, ABSSLC provided some summary data from reviews it had completed, which is an important part of the self-assessment process. However, it was unclear specifically what had been measured. For example, for Section G.1 of the Settlement Agreement, the POI stated: "1/2011--Current monitoring results: 47% compliance from 48 reviews since 9/2010. Integrated clinical services shall continue to improve with more frequent PST meetings at which multiple disciplines exchange information on each individual." No reference was made to a specific indicator(s) which the data cited measured, making it difficult to interpret the data. The percentage provided appeared to be an overall score for the provision. As has been stated in previous reports, the monitoring review tools were not designed to provide overall scores. The items within the tools are not weighted. As a result of the lack of progress in many of these areas, and/or progress without any evidence base of data, the Facility correctly determined that it was noncompliant in both the components of Section G of the Settlement Agreement.
	Summary of Monitor's Assessment: The Facility provided a campus-wide training to begin a heightened awareness and new approach for the development of the personal support planning process. The philosophy required cooperation and integrated services to assist individuals to maximize their health and safety, and growth and development. By creating a morning medical meeting each business day of the week that focused on those admitted to the Infirmary, progress had been made in developing an interdisciplinary integrated forum to discuss the health of the acutely ill individuals. Several disciplines were represented, including medical, nursing, psychiatry, and physical therapy. Further structure and expansion of the scope of these meetings is recommended to ensure the full potential of the meetings is realized. The discussion should include those individuals hospitalized, as well as acutely ill individuals in the residences about which the on-call

	physician was contacted. There was substantial discussion and information shared at the Infirmary rounds, and minutes should be recorded, with emphasis on areas of concern needing closure. Subsequent minutes should provide documentation of closure of concerns, when information becomes available. The tracking and PCP review of consultation reports continued to need improvement. The scope of the Medical Director's review should include the entire spectrum of off-site consultations used at ABSSLC. There remained a need for improvement in PCP review, and acknowledgement of agreement or not with recommendations included in consultation reports. At the time of the review, there was a complex approach for tracking consultation reports to ensure they were obtained, and consideration should be given to streamlining the process. The PNMT and the individuals it serves would benefit from a physician liaison to the team to provide support and direction from a medical perspective.

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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 receive the clinical services they need.	An overall facility plan was not in place to address this item, although a number of activities were occurring, as discussed below. A Facility policy did not exist, however, a draft DADS statewide policy was available. This state policy was not yet complete. It addressed both integrated clinical services (Section G) and minimum common elements of clinical services (Section H). The aspects of the policy that addressed section G were minimal and will not likely be helpful to the Facility because the policy merely mimicked the wording of the Settlement Agreement without providing any direction to the Facility, such as specifying certain required activities to foster integrated clinical services, and providing examples of additional actions the Facility could take to indicate that integrated clinical services were occurring. According to the Plan of Improvement, the Facility's self-assessment had showed a compliance rating of 47%. The tools that were used to determine this rating were not identified, nor was an explanation provided regarding what this figure measured. The Medical Director indicated the Quality Assurance (QA) Nurse had completed the survey, but he was not aware of the specifics of the review. The Medical Director should coordinate quality improvement reviews with the QA nurse and QA department, providing clinical guidance in all areas of health care. As part of this implementation of integrated clinical services encompassing all disciplines, all members of the Medical Department as well as other employees at ABSSLC attended an in-service entitled "Supporting Visions." This in-service provided training on the Facility's new approach to creating a personal support plan for the individual. According to page four of the handbook, this new approach was "proactive, reflects current standards of care, is person driven, with an interdisciplinary approach, in	Noncompliance

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		which assessments are not read but integrated into discussions, and assessments will reflect preferences and how they will be supported." It included a PSP process outline and serial reviews, as well as clear policy definitions. It included a SSLC PSP monitoring checklist for the meeting/documentation. This provided detailed guidance and expectations for PSP development and implementation, and defined the role of all departments at ABSSLC. As is discussed in further detail with regard to Section F of the Settlement Agreement, the Facility was in the initial stages of implementing this new process. During each business day, a daily morning meeting had been instituted. The focus was on medical rounds in the Infirmary. The meeting included all of the PCPs, as well as the psychiatrists, several nurses, such as the Chief Nurse Executive (CNE) and the Hospital Nurse Liaison, and the Habilitation Therapies Director. A couple of observations were noted. There were no written minutes, including those that attended each day, or the activity of the committee. Hence, the important discussions, the findings, and the need for closure of issued identified remained informal. There was no evidence that there was closure on any issue, because there was nothing in writing to indicate a need for closure for any individual discussed. It is recommended that each day, formal meeting minutes be taken of the rounds, with an attendance sheet, as well as documentation of discussion related to planning, and the next steps decided upon in the meeting. Subsequent meeting minutes should document the follow-up until resolution, with the closure date and outcome documented for each item. Personnel trained in health care and familiar with the hospitalized individuals or the individuals in the Infirmary would most efficiently complete these minutes. During the Monitoring Team's review, the Hospital Nurse Liaison had begun to transcribe the activity and discussion of the morning meetings into daily minutes. The quality of the information provided was excellent. Steps needed to be taken to ensure the information discussed above was included, ensuring there was a column for any updates about areas of closure. An attendance roster each day would assist in providing evidence of the interdisciplinary aspect of this meeting as required in the Settlement Agreement. It also is recommended that the morning medical meeting have additional components added to it. These were actually listed in the Facility's Presentation Book for Section L as corrections to the process, but there was no evidence in the three days of observation that they had occurred. For instance, there was no discussion about admissions to outside medical facilities during the previous 24 hours, or a review of acute problems for individuals in the residences about which the on-call physician was contacted. Emphasis was on those individuals currently in or newly admitted to the Infirmary. Additional aspects of a quality morning medical meeting are discussed with regard to Section L.1. The PNMT did not have a physician presence on the team. Given the complex health and	

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		medical issues of the individuals at ABSSLC, appointing a physician who is liaison to this team would provide the medical support needed to review recommendations and ensure PNMT recommendations are consistent with the medical and health care plan of the individual. It also would allow the other PCPs to focus on other areas of care, with the physician appointed as liaison to the team providing feedback to the PCPs as needed. It was noticeable that the Infirmary rounds did not include a member of the PNMT. Some of the critically ill individuals in the Infirmary would have benefited from assessment by the PNMT, and on-site training of staff on all shifts. Additionally, the numbers of individuals experiencing aspiration pneumonia, pneumonia, and dysphagia, as well as enterally fed individuals was substantial across the campus. There was no ability for a part-time PNMT to be successful in sharing their expertise, training staff, and following longitudinally those individuals that were had medical complexities. It is essential that a full-time dedicated team be established. A review of ABSSLC's medical emergency drills found that there was no collaboration between disciplines, specifically nursing and medical, for reviewing the Facility's medical emergency systems. A review of 239 Medical Emergency Drill Checklists indicated that no physician participated in any of the drills conducted. The Medical Department should be involved in the Facility's emergency response drill system, as well as in the analysis of data generated from the medical emergency drills. At the time of the review, there was no documentation indicating that the Medical Department was aware of the significant issues found regarding the Facility's emergency systems. Input from all the various specialty disciplines would be valuable 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.	Consultation reports and follow-up PCP integrated notes were submitted for an individual from each of the residences on campus during the time period since the last Monitoring Team visit. The consultations were reviewed to determine if the PCP initialed and dated them indicating that they had been read. In addition, to determine if the PCP had interpreted the consultation, and indicated agreement or disagreement with recommendations for alternative plans, the Integrated Progress Notes (IPNs) were reviewed for content. This review was based on the information in the packets the Facility submitted. There were a total of 48 consultations with initials and date indicating review, followed by an integrated progress note with interpretation and agreement of the consultation report. There were five consultation reports without initials and dates on the copies received. There were 18 consultations without a PCP integrated progress note providing	Noncompliance

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		evidence of interpretation of the report or agreement. Out of a total of 71 consultations reviewed, 23 did not either verify initial review, or did not document a note of agreement or alternative approach in the integrated progress notes. For one consultation neither was found (Individual #440's Psychiatry consultation on 10/15/10). This was a compliance rate of 68%. The specific findings of this review are noted below. The following consultations had initials and dates of the PCP indicating a review of the consultation document, as well as an IPN with agreement documented: Individual #147 for Dermatology consultation on10/13/10, Individual #57 for Orthopedic consultation on 10/11/10, Individual #57 for Orthopedic consultation on 11/29/10, Individual #415 for Neurology consultation on 10/11/10, Individual #65 for Neurology consultation on 8/9/10, Individual #65 for Neurology consultation on 11/8/10, Individual #306 for Dermatology consultation on 10/13/10, Individual #306 for Dermatology consultation on 8/18/10, Individual #306 for Neurology consultation on 12/30/10, Individual #440 for Dermatology consultation on 9/15/10, Individual #400 for Neurology consultation on 9/13/10, Individual #203 for Hematology/Oncology consultation on 1/5/11, Individual #203 for Dermatology consultation on 1/12/11, Individual #199 for Ophthalmology consultation on 8/13/10, Individual #199 for Ophthalmology consultation on 9/8/10, Individual #199 for Ophthalmology consultation on 10/6/10, Individual #199 for Ophthalmology consultation on 10/22/10, Individual #199 for Ophthalmology consultation on 10/29/10, Individual #199 for Surgery consultation on 12/2/10, Individual #199 for Endocrinology consultation on 12/7/10, Individual #199 for Surgery consultation on 11/11/10, Individual #199 for Surgery consultation on 12/16/10, Individual #284 for Dermatology consultation on 12/15/10, Individual #284 for Psychiatry consultation on 9/21/10, Individual #176 for Gastroenterology consultation on 12/13/10, Individual #101 for Hematology/Oncology consultation on 8/11/10, Individual #101 for Hematology/Oncology consultation on 9/20/10, and for Hematology/Oncology consultation on 11/15/10, Individual #101 for Hematology/Oncology consultation on 12/15/10, Individual #101 for Gastroenterology consultation on 1/5/11, Individual #443 Dermatology for consultation on 9/15/10, Individual #443 for Otolaryngology consultation on 10/12/10, Individual #443 for Otolaryngology consultation on 11/9/10, Individual #91 for Neurology consultation on 9/13/10, Individual #179 for Otolaryngology consultation on 10/12/10, Individual #179 for Endocrine consultation on 10/7/10, Individual #355 for Neurology consultation on 9/13/10, Individual #355 for Psychiatry consultation on 8/26/10, Individual #220 for Dermatology consultation on 11/17/10, Individual #547 for Podiatry consultation on 9/21/10, Individual #58 for Psychiatry consultation on 10/25/10, Individual #58 for Neurology consultation on 9/27/10, Individual #494 for Psychiatry consultation on 8/31/10, Individual #522 for Endocrine consultation on 12/21/10, Individual #522 for Gynecology consultation on 8/18/10, Individual #301 for Surgery consultation on	

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		9/9/10, Individual #301 for Psychiatry consultation on 11/2/10, and Individual #301 for Psychiatry consultation on 12/14/10. The following consultations were not initialed and dated to verify when the PCP originally read the consultation: Individual #57 for Orthopedic consultation on 9/8/10, Individual #440 for Psychiatry consultation on 10/5/10, Individual #6 for Hematology/Oncology consultation on 6/29/10, Individual #5 for Dermatology consultation on 11/17/10, and Individual #522 for Endocrinology consultation on 9/15/10. The following consultations had no Integrated Progress Note that interpreted the consultation report, or indicated agreement or disagreement with the recommended alternative plan: Individual #147 for Endocrinology consultation on 10/29/10, Individual #57 for Orthopedic consultation on 8/25/10, Individual #306 for Dermatology consultation on 12/15/10, Individual #306 for Dermatology consultation on 9/15/10, Individual #440 for Podiatry consultation on 10/19/10, Individual #6 for Hematology/Oncology consultation on 12/27/10, Individual #199 for Ophthalmology consultation on 8/6/10, Individual #199 for Ophthalmology consultation on 8/27/10, Individual #199 for Renal consultation on 9/9/10, Individual #199 for Gynecology consultation on 10/5/10, Individual #199 for Ophthalmology consultation on 11/12/10, Individual #199 for Ophthalmology consultation on 12/10/10, Individual #284 for Dermatology consultation on 9/15/10, Individual #5 for Neurology consultation on 10/11/10, Individual #5 for Neurology consultation on 8/9/10, Individual #5 for Dermatology consultation on 12/15/10, Individual #355 for Psychiatry consultation on 11/8/10, and Individual #522 for Podiatry consultation on 9/21/10. The Medical Director had completed a review on 42 records from neurology consultations. The neurologist had an on-site clinic at ABSSLC. Out of 42 records reviewed, 34 reportedly were compliant with the requirement for the PCP to document in the integrated progress note whether the PCP agreed with the recommendation or not, and if not, then to provide a rationale. Two physicians were noted to be responsible for most of the noncompliance, and there had been discussions to improve performance in this area. It will be important for the Medical Director to review consultation reports for which the visit occurs off campus, and to ensure the review includes a wide variety of consultations over time. This should include such specialty consultations as cardiology, nephrology, pulmonology, gastroenterology, general surgery, specialty surgery, dermatology, and others. This provides an opportunity to determine the flow and processing of information involving community providers and networks that are entirely off campus.	

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		Several different departments completed the tracking system for consultation reports. The nurse assigned to the treatment room received the order, and set up the consultation appointments. The Medical Records Department received the consultation report, and the case manager collected the date the report was reviewed by the PCP. This required many steps and several departments, which introduced potential for considerable delay and human error in coordinating information. It is suggested that a working log be placed at the front of the record listing all consultation requests, date of appointment, date the report was received, and the date reviewed. This would help to make it obvious to a nurse, physician, or case manager when an outstanding issue remained, which in turn would assist in creating a more efficient system integrating all services that had been requested. Currently, there was no streamlined tracking system for consultation reports. There did not appear to be a mechanism that would indicate if ABSSLC had not received a consultation report, including radiologic scans. Without a cohesive system with checkpoints at each level, there could be significant delays in receiving the consultation reports and processing this information.	

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

1. The Medical Director should coordinate quality improvement reviews with the QA nurse and QA department, providing clinical guidance in all areas of health care.
2. Each day, formal meeting minutes should be taken of the medical rounds, with an attendance sheet, as well as documentation of discussion related to planning, and the next steps decided upon in the meeting. Subsequent meeting minutes should document the follow-up until resolution, with the closure date and outcome documented for each item.
3. Morning medical meetings also should include a discussion of individuals currently admitted to outside facilities, as well as review of individuals experiencing acute problems in the residences for which the on-call physician was contacted since the last business day.
4. The PNMT should have a physician liaison to the Medical Department.
5. A full-time PNMT is needed to assist in addressing the needs of individuals with aspiration pneumonias, dysphagia, GERD, skin breakdown, etc. Members of the team should not have other caseload assignments.
6. As a medical quality assurance measure, the Medical Director should review PCPs responses to off-site consultation reports, and ensure the review includes a wide variety of consultations over time.
7. The tracking system for consultation reports would benefit from being streamlined. This should include a mechanism that would indicate/highlight if ABSSLC had not received a consultation report/radiologic scan in a timely manner.

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 Supporting Visions: PSP Workbook, dated 7/11; o Health Care Guidelines, 5/09; o Clostridium difficile Management Pathway; o Anticoagulation protocol; o Venous Thromboembolism (VTE): Screening and Prophylaxis Protocol with VTE Risk Assessment Screening Form; o Aspiration Pneumonia/Identifying Risk, Treatment, and Prevention of Aspiration Pneumonia/Evaluation of Suspected Aspiration Pneumonia/Adult Aspiration Pneumonia Prevention Algorithm; o Constipation Prevention and Management Protocol; o Management of Hyperlipidemia; o Screening and Treatment of Reduced Bone Density; o Clinical Guidelines for skin lesions; o Flow Chart for Seizure Management; and o DADS policies: #004 Personal Support Plan Process – Integrated Protections, Services, Treatments, and Supports; and #005 Minimum and Integrated Clinical Services. ▪ **Interviews with**: o Richard Chengson, MD, Medical Director; and o Mary White, RN, Quality Assurance Nurse.
	Facility Self-Assessment: Based on the POI, the Facility acknowledged non-compliance in all areas of Section H. The most recent progress towards compliance with any of the components of this section was the development of draft clinical pathways, which the Facility indicated it was in the process of reviewing. In the POI, the Facility specifically stated there was no self-monitoring process for provisions H.2, H.3, and H.7. The Quality Assurance Nurse reviewed the other components. However, the tools used were not well described, nor was it clear if the data collection reflected the intent and requirements of the Settlement Agreement. In addition to monitoring tools, it will be important to include clinical indicators, which can be used as measurement tools to generate data as evidence of progress towards compliance. Of significant concern, in the POI, the Facility indicated that it did not know what clinical indicators were. It stated: "Clinical Indicators is very nebulous wording, so some technical assistance from the Monitors is needed to know which specific clinical indicators they are looking at." Although the Monitoring Team is willing to discuss this during upcoming reviews, it will be important for the Medical Director to take a lead role in developing and implementing quality clinical indicators and measurement tools. If additional technical assistance is needed, the Facility should contact the State Office.

	Summary of Monitor's Assessment: The Facility was currently using guidelines derived from the HealthCare Guidelines. A number of other clinical guidelines had been developed, but remained in draft form, and were awaiting review and finalization by the State Office. As a result, ABSSLC remained out of compliance with this section of the Settlement Agreement, because it requires guidelines to be developed and implemented, followed by development of clinical indicators that measure improvement in health and safety. Each of the guidelines will require the Medical Director to provide in-service training to of all the PCPs to ensure understanding of expectations. However, there has been some campus-wide progress in development of a team approach to rating individuals' risk in various health categories. Campus-wide webinar training was completed on the At Risk Individuals policy. Additionally, a program focusing on prevention of aspiration pneumonia had begun to be implemented. In order to provide valid data for a database related to respiratory infections, the physicians were provided in-service training on correct identification of various types of pneumonia. All these areas will need a database management system to assist in identifying trends, as well as to manage evidence of compliance with the new policies. Such a database also will be essential for measuring outcomes based on clinical indicators.

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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 basis and in response to developments or changes in an individual's status to ensure the timely detection of individuals' needs.	DADS Draft Policy #005: Minimum and Integrated Clinical Services provided the administrative structure and oversight needed to obtain compliance with Section H of the Settlement Agreement. This policy provided precise guidance concerning such areas as periodicity and timeliness of clinical assessments and evaluations. It provided expectations across a wide range of disciplines, such as quarterly reviews by nurses, annual dental examinations, regular review of drugs, annual physical exams, and periodic assessment of risk status. Changes in status had assessment expectations within 24 hours for non-urgent change, within one hour for urgent change, and immediately for emergent change. There was nothing in the policy, however, regarding assessments and evaluations for psychiatry, psychology, pharmacy, physical therapy, speech and language therapy, dietary needs, occupational therapy, and respiratory therapy (in this policy, DADS added respiratory to the list of clinical services). In addition, It might be helpful to indicate how the contents of the policy related to each of the specific seven provision items of provision H. ABSSLC did not appear to have developed any Facility-specific policies based on this draft policy. To assist the Medical Department in compliance with this section of the Settlement Agreement, there were a number of clinical guidelines in draft form and undergoing review. This is discussed in further detail with regard to Section L.4. Along with the Health Care Guidelines currently in place, they will provide the framework for timely assessment/evaluation of both acute and chronic problems. The Monitoring Team's	Noncompliance

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		evaluation of the Facility's compliance with Section L.1 discusses many aspects of care, including preventive care, routine maintenance care, acute illness care, and follow up to Emergency Room (ER) and hospital visits. In certain areas, such as care of seizure disorders, and completion rates of annual evaluations, the quality and timeliness of care was excellent. In some areas, the information the Facility provided the Monitoring Team was hampered by a poor database or data collection, such as treatment of osteoporosis. To further review the adequacy and timeliness of care, the Monitoring Team conducted record reviews. These reviews resulted in several recommendations related for systems improvement for medical care, including the assessment process. There was no evidence submitted for this section of the Settlement Agreement that would suggest compliance. Since the last review, there was an At Risk Individuals Policy Training webinar provided to the medical staff as well as all clinical staff, and this was mandatory training. The focus was on the reduction of aspiration pneumonia. The new system in place for prevention of aspiration pneumonia was importantly dependent on early recognition of health status change by the direct support professionals. It also provided direction related to the roles of the other clinical disciplines. The process was at the beginning stage of implementation, and sufficient time had not passed for data collection, interpretation, and adaptation of the process to have occurred. As is illustrated throughout other sections of this report, there were issues with regard to assessments and evaluations being completed regularly, and performed in response to development or changes in an individual's status. Some examples of this included nursing assessments, particularly with regard to individuals who experienced acute illness; individuals who might benefit from communication systems; and individuals being considered for enteral nutrition. Based on a review of records of individuals who have been admitted to the Infirmary, sent to an emergency room and/or hospitalized for acute illness, nursing was not performing assessments on a regular basis and in response to developments or changes in an individuals' status. In fact, it was consistently found that nurses were not identifying many of the symptoms related to changes in status that warranted assessment and follow up. For example, while on site, an individual began coughing during her PST, and none of the team members reacted to this. She was moved into the hallway, but was not provided an assessment of her respiratory status. When asked about her coughing episodes, the team indicated that: "she always coughs," but did not recognize this as a symptom requiring assessment for someone who was at risk for aspiration.	
H2	Commencing within six months of the Effective Date hereof and with	The DADS Draft Policy #005 also set forth expectations for Facility clinical staff, specifically stating "Diagnoses must clinically fit the corresponding assessments or	Noncompliance

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	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.	evaluations and 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." In order to assist the PCPs in complying with the diagnoses that fit the ICD-9 codes, the DADS SSLC Medical Services Coordinator provided in-service training. The focus of the training was on the different codes for pneumonia, in order to provide further guidance on determining the true diagnosis and potential etiology for the many respiratory infections diagnosed as pneumonia. Approximately 30 codes were identified for the various types of pneumonia. In addition, there was a three-page handout that provided guidance in determining the correct code, as well as the list of codes for pneumonia. Given this focus, the Medical Director should take the opportunity to meet weekly with the medical staff to review each case of pneumonia and discuss the clinical history, findings, and diagnosis, based on the in-service training. This would increase the reliability and reproducibility of interpretation and findings. As is illustrated with regard to Section J of the Settlement Agreement, the assessment processes used to determine diagnoses were not always consistent with DSM criteria or generally accepted standards of practice. The psychiatric diagnoses utilized at the ABSSLC were consistent with the nomenclature in the DSM-IV-TR. The current deficiency in this area was that there was incomplete (or missing) documentation in the individual records, which set forth the specific symptoms that the individual presented with in a manner that would support the validity of the psychiatric diagnosis.	
H3	Commencing within six months of 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.	In order to determine whether or not treatments and interventions are up-to-date, appropriate to the cluster of signs and symptoms and the individual's clinical history, and provided in a timely manner, clinical guidelines are needed that address all of these areas for the common conditions that affect the Intellectual Disability/Developmental Disability (ID/DD) population. Once the guidelines are finalized and staff are trained on them, a variety of measures based on the guidelines can be used to determine compliance with the Settlement Agreement. Although progress had been made in this area, a number of guidelines remained in draft form, and had not been finalized and approved for implementation. These guidelines addressed the topics of osteoporosis, aspiration pneumonia prevention, chronic constipation, and seizure management. An additional area of urgent need was a clinical guideline on Gastroesophageal Reflux Disease (GERD). Of concern was the minimal to lack of reference in the Medical Department to recent DADS policies or drafts of policies, which provided the foundation/framework for	Noncompliance

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		implementation of all other policies and guidelines. For example: ▪ In the DADS Draft Policy #005, there was the expectation/requirement that "treatments and interventions must be timely and clinically appropriate based upon assessments and diagnoses." ▪ DADS Policy #004 Personal Support Plan Process - Integrated Protections, Services, Treatments, and Supports included the entire PST in developing timely treatment interventions. Prior to individuals' PSP meetings, a Personal Focus Assessment (PFA) was to be conducted to determine what was important to the individual. Information gained from this process would be used to determine the medical and behavioral assessments that were required. Quarterly meetings were to be held, by the PST, on each individual, which allowed for tracking of success or need to discuss further options. As discussed in detail with regard to Section F of the Settlement Agreement, assessments were missing from many of the PSPs reviewed, the PFA process did not consistently identify all of the assessments that should have been conducted based on the individuals' needs, and treatments and interventions identified in assessments were not consistently incorporated into individuals PSPs. ▪ DADS new Policy #006 - At Risk Individuals addressed change of status, risk guidelines, as well as ongoing and quarterly risk review. This provided another mechanism to ensure areas of health concern were not overlooked, but were addressed methodically. ABSSLC was at the very initial stages of implementing this policy. Before moving forward, the Medical Department should ensure there are updated Medical Department policies that are consistent with the requirements of the DADS State Office policies. The Medical Department's clinical guidelines and protocols then should be consistent with these departmental policies.	
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.	In DADS Draft Policy #005, the expectation/requirement was set forth that: "clinical indicators of the efficacy of treatments and interventions are determined in a clinically justified manner." The State Office then provided guidance for several areas of healthcare by referring the clinical departments to specific guidelines, which national organizations with expertise in specific areas of healthcare had developed and continued to update. The scope of practice covered by these guidelines was wide ranging, including preventive care, immunizations, cardiac care, diabetic care, breast cancer, cervical cancer, pneumonia, depression, and other guidelines available through the US Agency for Healthcare Quality and Research. The State Office clearly had identified a framework and level of expectation with regard to the quality of care. Based on these guidelines, the policy further stated "the facility must develop a system to identify which guidelines to follow …"	Noncompliance

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		Clinical indicators represent the quality improvement measurement tool to determine the success of treatment and intervention. A wide variety of clinical indicators can be utilized for any one disease entity or category of health. As the clinical guidelines are completed and implemented, suggested measurements should be built in that validate the treatment as successful. Additionally, clinical indicators might include areas such as therapeutic drug levels, laboratory testing to ensure therapeutic effect (i.e., improvement in a hemoglobin for anemia that is being treated), or to minimize adverse effect (low platelet counts due to a specific medication). The clinical pharmacist might be of assistance in developing some of these clinical indicators, which can be readily incorporated into the quarterly drug regimen review process. However, to be compliant with the Settlement Agreement, valid and reliable clinical indicators must be developed and tracked for a range of common illnesses or health parameters (for prevention and wellness), which can be measured across time for trend analysis and interpretation. As is illustrated in various sections of this report, clinical indicators often were not identified. For example, when psychiatric medications were prescribed, the target symptoms were generally not tracked. Tracking these symptoms would assist in determining the efficacy of the treatment. Likewise, nursing plans did not identify what clinical indicators would be tracked, by whom, or when. Many PNMPs also did not identify the functional outcomes to be measured.	
H5	Commencing within six months of the Effective Date hereof and with full implementation within two years, a system shall be established and maintained to effectively monitor the health status of individuals.	DADS Draft Policy #005 also set the standards and expectations the Medical Director needed to use in creating a health status monitoring system. The expectation appropriately, but ambitiously set the standard as monthly monitoring on a wide variety of domains of health care, including staffing, timeliness, equipment and resources, quality of care, morbidity, clinical indicators, etc. At the time of the Monitoring Team's onsite review, ABSSLC had not yet developed or begun to implement such a system. The Monitoring Team looks forward to reviewing such a system during upcoming reviews. As is discussed above with regard to Section E.1 of the SA, such indicators need to be incorporated into the QE/Risk Management systems to identify individuals, residences, and/or departments that need attention, as well as to detect and address systemic issues that impact the Facility's adequate response to clinical indicators. Additionally, DADS Policy #006, on which staff across the Facility already had been provided in-service training, provided guidance on health status changes and periodic reviews. The next phase of this process was full implementation. There are several components to ensuring successful early treatment. The direct support professionals require training and retraining to notice changes in an individual's health status. This requires the staff to be familiar with the individuals, as long-term continuity of care is essential for the individuals at ABSSLC. The direct support professionals also	Noncompliance

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		need to know how to document their observations, how to communicate changes, as well as which staff to inform of the changes. This then requires a nurse with keen clinical acumen to provide a timely and accurate assessment. This should lead to notification of the physician for acute problems (the treatment when applicable would be dependent on the requirements and expectations of the clinical guidelines). However, if the problem is not acute or if it is recurring, the PST should meet in a timely manner to provide an update to each member of the team, as well as to develop a plan in response to the illness or new risk indicator. Based on the Facility's Presentation Book, there were "short notice PST meetings" to address health status change. However, as noted with regard to Section L.1, there was no evidence in the IPNs of PST reviews for those individuals newly admitted to the Infirmary or returning from the ER. However, for one individual, Individual #100, there was a PST meeting addressing at risk issues while he was in the Infirmary. This suggested the system needed further review and support, especially in documenting the results of "short notice PST meetings." In some instances an individual should not be released from the Infirmary back to the residence unless the risk factors are addressed (e.g., training for worsening dysphagia, positioning needs, decubitus care, etc.), and equipment and trained personnel are in place to accept the individual.	
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.	DADS Draft Policy #005 also set the standard and expectations for the Medical Department with regard to this provision when it stated: "Clinicians are expected to act on reports from other staff, monitor the individual themselves, note the effects of interventions, and make changes to treatments and interventions in response to clinical indicators and as warranted." As already mentioned, the Facility had not developed and implemented clinical indicators from clinical guidelines that could be used as a measuring tool to identify medical issues and provide interventions. This section is dependent on valid clinical indicators to reflect improvement in health, and each area of health risk. Once established, this becomes the barometer by which all treatments should be measured. As noted above, clinical indicators should be part of the clinical guidelines. If the PCP followed the clinical guideline and the chosen treatment or intervention did not change the health of the individual (i.e., the clinical indicator was not met), then the PCP would again review the clinical guideline for alternative choices of treatments, or consider the need for further testing to refine treatment options. Because the clinical guidelines are not in place, and initial treatment might require days to months to result in a measurable effect, this component of the Settlement Agreement is a future goal.	Noncompliance
H7	Commencing within six months of the Effective Date hereof and with full implementation within three	As part of the integrated clinical approach to care of the individuals, there had been an ambitious training on the new Personal Support Planning process, entitled "Supporting Visions." This provided a framework on which all departments could grow and assist	Noncompliance

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	years, the Facility shall establish and implement integrated clinical services policies, procedures, and guidelines to implement the provisions of Section H.	other departments. The Facility did not submit any policies specifically related to Section H.7, but the "Supporting Visions" focus and goal should be central to any policy or protocol that is adopted.	

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

1. To ensure success of the aspiration pneumonia prevention project, for each individual diagnosed with aspiration pneumonia, the morning medical meeting minutes should reflect a discussion on the clinical history, and ways to prevent a recurrence. This should include what further work-up or tests should be considered, what treatment options are available, whether or not the clinical pathway followed, etc.
2. The Medical Director should take the opportunity to meet weekly with the medical staff to review each case of pneumonia and discuss the clinical history, findings, and diagnosis, based on the in-service training. This would increase the reliability and reproducibility of interpretation and findings.
3. The Medical Department should update its policies to be consistent with the DADS Policies #004, #005, and #006. The Medical Department's clinical guidelines and protocols then should be revised as appropriate to be consistent with these departmental policies.
4. A clinical guideline should be developed as soon as possible to address Gastroesphophageal Reflux Disease.
5. Once clinical guidelines are developed, the Medical Director should develop clinical measures (clinical indicators) that reflect success in treating the illness. It is recommended that for each clinical guideline, two or more clinical indicators be defined that can measure success of treatment (improved laboratory test results, functional improvement, reduction in medication, improvement in chest x-ray, improved findings on physical examination, etc.).
6. For the most common acute illnesses (e.g., aspiration pneumonia, sepsis, urinary tract infection (UTI), skin breakdown, acute constipation, dysphagia, GERD, etc.) in the ID/DD population residing at ABSSLC, nurses and direct support professionals should be provided competency-based training to identify early changes in health status.
7. PSTs should respond swiftly to those individuals admitted to the hospital or Infirmary for acute illness to discuss changes in condition, and identify necessary interventions to address such changes in health once the individual returns to the residence. A summary of this information should be available in the IPN at the end of the meeting. If the PST has not met, or has met, but has not identified a plan that is noted in the IPN to resolve the outstanding clinical issues (e.g., plans to address training and equipment needs, etc.), the Medical Director should decide if discharge to the residence is safe.

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 Presentation Book for Section O; o The following documents: Occupational Therapy (OT)/Physical Therapy (PT)/Speech Language Pathology (SLP) Assessments, Nutrition Assessment, Physical Nutritional Management Team (PNMT) Evaluation and Action Plan including updates, Nursing Care Plan, Occupational Therapy/Physical Therapy/Speech Language Pathology consultations for the last year, Personal Support Plan and PSP Addendums for the last year, Physical and Nutritional Management Plan (PNMP) with pictures including positioning and/or other instructions, person-specific monitoring post PNMT Evaluation, PNMP Clinic Notes for the past year, competency-based training for staff post PNMT Evaluation, PNMT Integrated Progress Notes post PNMT Evaluation, Risk Assessment, and medical records for the following: Individual #353, Individual #23, and Individual #433; o The following documents: current Medication Administration Record (MAR), PNMP, staff competency-based training for PNMPs and person-specific monitoring for PNMPs for the following: Individual #250, Individual #418, Individual #311, Individual #19, Individual #362, Individual #26, Individual #417, Individual #353, Individual #122, Individual #119, Individual #361, Individual #91, and Individual #359; o List currently available at the Facility that identify each individual who is identified to be "at risk" utilizing the State's risk categories, including, but not limited to: aspiration; aspiration pneumonia/pneumonia; chronic respiratory infections; contractures, gastroesophageal reflux, choking, dysphagia, falls, weight loss or gain, skin breakdown/decubitus ulcer, causing harm to self or others, impaction;/bowel obstruction/constipations, dehydration, Pica, metabolic syndrome, seizures, osteopenia/osteoporosis, non-ambulatory or assisted ambulation, requiring mealtime assistance, poor oral dental status, and receiving enteral feeding, by type of tube, pain (including chronic and acute), undated; o Individuals seen in emergency room, including the date seen at the emergency room and reason for visit, multiple dates; o Individuals admitted to the hospital, including date of admission, reason for admission and discharge diagnoses and date of discharge from hospital, multiple dates; o Individuals admitted to Facility's Infirmary, including date of admission/transfer, reason for admission/transfer and date transferred back to residential unit, multiple dates; o Communicable Disease Report for Aspiration Pneumonia and Pneumonia, date range from 1/1/10 to 12/31/10; o Memo regarding Infirmary documentation, dated 2/14/11; o Document entitled Risk Meetings Are a Brainstorming Process, undated; o Integrated risk rating form for: Individual #413, dated 2/14/11; Individual #393, dated 2/14/11; Individual #65, dated 2/14/11; Individual #534, dated 2/14/11; Individual #174, dated 2/14/11; Individual #544, dated 2/8/11; Individual #459, dated 2/8/11;

	Individual #27, dated 2/8/11; Individual #394, dated 2/8/11; Individual #234, dated 2/8/11; Individual #42, dated 2/8/11; Individual #494, dated 2/9/11; Individual #270, dated 2/1/11; Individual #405, dated 2/9/11; Individual #186, dated 2/15/11; Individual #468, dated 2/17/11 (TX-AB-1102-WZ.10); o Risk Action Plan: Individual #468, dated 2/17/11; Individual #186, dated 2/15/11; Individual #65, dated 2/14/11; Individual #174, dated 2/14/11; Individual #393, dated 2/14/11, and Individual #100, dated 2/16/11; o Aspiration Pneumonia/Enteral Nutrition Evaluations for the following individuals: Individual #480, dated 2/7/11; Individual #378, dated 1/31/11; Individual #373, dated 2/7/11; Individual #314, dated 2/10/11; Individual #515, dated 2/10/11; Individual #33, dated 2/7/11; and Individual #520, dated 2/10/11; and o Risk Guidelines draft for SSLCs. ▪ **Interviews with**: o Richard Chengson, MD, Medical Director; o QMRP for Residence 6521; o Bobbie Holden, Occupational Therapist; o Karen Mayfield, PT, DPT; and o Debra Sessions, MS, CCC/SLP. ▪ **Observations of**: o PNMT Evaluation for Individual #100, on 2/16/11; o PST meeting for At Risk Assessment for Individual #100, on 2/16/11; o PST Meeting for Individual #417; o Observation of Medication Administration on 2/16/11 in the Infirmary for Individual #265, and Individual #498; o Individual #186; o Infirmary bathroom.
	Facility Self-Assessment: The POI indicated the Facility's self-assessment showed noncompliance for all three provisions of Section I, which was consistent with the Monitoring Team's findings. In part, this is a new process, starting in January 2011, and the Facility had not had the opportunity to review progress, adapt and change structural needs, and begin to assimilate data. A system of data collection is needed to demonstrate that this system to identify and address the needs of at-risk individuals is being implemented according to the policy adopted.
	Summary of Monitor's Assessment: The Facility recently completed a campus-wide webinar training program to begin implementation of the DADS At Risk Individuals policy. Teams had begun to implement the process with mixed results. Although, there were several good examples or risk rating completed by the PSTs, with adherence to the risk guidelines included in the policy, there also were examples of teams who continued to complete the process in a pro forma manner, with little, if any review of relevant data. As many of these were medical in nature, the PCP was expected to guide the team to ensure the plan reflected clinical completeness and quality. At times, the PCP was involved in this leadership role, and, in other cases the PCP had not provided adequate input. At the time of the Monitoring Team's visit, approximately 20

	percent of the individuals had risk ratings completed. Measuring this entire process to determine impact remained a challenge for the Facility. Based on interview, Habilitation Therapies staff had attended initial meetings with the primary purpose of completing at-risk assessments for individuals, using the revised risk guidelines. Habilitation Therapies staff correctly identified that the initial meetings did not consistently produce the desired outcome of accurately completing risk assessments. As a result, Habilitation Therapy staff met with the Facility Director to propose providing training to PST members on the at-risk screening and assessment process. The Director supported Habilitation Therapies staff developing and implementing training for PST members. At the time of the review, a curriculum had been developed, but no plan was submitted with regard to the implementation of the training. The absence of an accurate database for Infirmary/emergency room/hospitalizations and an incomplete Communicable Disease Report for Aspiration Pneumonia and Pneumonia hindered the Facility's ability to identify individuals who met thresholds for specific categories of physical, nutritional and health risk indicators. Such a database would be an important mechanism to trigger further evaluation based on the severity or frequency incidents, such as aspiration pneumonia. Risk Management, QA/QI, and/or the PNM Team could use such data to identify trends for individuals with complex medical, physical and nutritional concerns. Only three individuals identified at high risk with multiple risk factors, Individual #353, Individual #23, and Individual #433, had been evaluated by the PNMT, since the last compliance review. The PNMT also had begun completing a detailed form for those with aspiration and dysphagia risk who used feeding tubes, but it remained unclear how this form was incorporated into the PST risk rating system. The PNMT was only a part-time team, with each member having other primary duties. The absence of a team member at the morning medical meeting, as well as in the Infirmary, indicated the need for further support for the PNMT process. Given the number of individuals with aspiration pneumonias, dysphagia, GERD, etc. at ABSSLC, a part-time team(s) is likely to have little impact on improving trends. To address the current need, a full-time team was required.

#	Provision	Assessment of Status	Compliance
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.	Based on interview, Habilitation Therapies staff had attended initial meetings with the primary purpose of completing at-risk assessments for individuals, using the revised risk guidelines. The initial meetings did not consistently produce the desired outcome of accurately completing risk assessments. As a result, Habilitation Therapy staff met with the Facility Director to propose providing training to PST members on the at-risk screening and assessment process. The Director supported Habilitation Therapies staff developing and implementing training for PST members. PNMT members were to conduct the training. No training scheduled was submitted for review.	Noncompliance

#	Provision	Assessment of Status	Compliance
		The Habilitation Therapies Department had developed some training materials. A document entitled Risk Meetings Are a Brainstorming Process, undated, stated: "The goal of the risk meeting process is for the team to 'get to the root' of problems and to develop new plans to solve problems and have better outcomes. Every team member should come with all the facts available to them and those facts should be discussed and analyzed by the team as a whole. The team should use this meeting to try to discover root causes to ongoing issues and to brainstorm new ideas. If what is being done already is not eliminating the problem, maybe another team member can offer a fresh outlook and new ides. The meetings are not about assigning risk levels, but about developing solutions and integrating services to achieve optimal health for each person." The document identified the following team members required to attend risk meetings: ▪ The individual; ▪ The individual's LAR/guardian; ▪ QMRP; ▪ Supervisor; ▪ RNs; ▪ Physicians; ▪ Dental; ▪ Pharmacy; ▪ Dieticians; ▪ Physical therapists; ▪ Occupational/Speech therapists; and ▪ Psychologists. Discipline-specific responsibilities were identified for each of the preceding members. For example, the dentist office "must come prepared with oral hygiene levels and what that level means in relation to aspiration risk and dental concerns; know the person's history of sedation needs and refusals; and have a plan of dental services if remediation is necessary." An action plan was to be developed for any risk indicator marked as high, including the following: objective, action steps, implementation date, monitoring frequency, person responsible, completion date, and follow up/outcome. In addition, the following information was presented at the conclusion of the document: ▪ Aspiration Trigger sheets were to be maintained for individuals with a history of aspiration pneumonia within the past three years and/or had a history of choking/coughing significantly at meals. ▪ Before referring to the PNMT, "ensure all team members have offered input for the unresolved issue and that NEW action plans have been developed. This may require more than one meeting with the entire PST. If the team has exhausted its resources and there are no more ides to solve a health related issues, the person should be referred to the PNMT. The team should send a consult to the	

#	Provision	Assessment of Status	Compliance
		PNMT." ▪ If the PST had exhausted its resources and there are no more ides to solve a behavioral issue, the person should be referred to the BSC [Behavior Support Committee]. Based on documentation submitted, "initial At Risk Meetings will be scheduled once the home's Personal Support Team has received proper training." These meetings were to be completed by May 31, 2011. A list of 295 individuals was submitted identifying "who is scheduled for next At Risk Meetings." A document entitled "A list of names of At Risk PSP Addendums completed as of today since the start of the process" identified an additional 152 individuals, although 42 of these individuals had an assigned meeting date past the date of the Monitoring Team's on-site review. These 42 individuals had At Risk meeting dates assigned between 2/22/11 and 6/15/11. There did not appear to be a prioritization of individuals at highest risk scheduled for completion of the screening process using the revised at-risk guidelines. For example, 27 individuals who were enterally nourished, and at risk of aspiration pneumonia were scheduled for At Risk meetings in the more distant future. Individuals with recurrent admissions to the Infirmary, emergency room, and hospital should have been prioritized to complete At Risk Meetings at the beginning of the process. PSTs had been meeting routinely to complete risk assessments for individuals. According to the Medical Director, approximately 20% of the individuals had had a health risk assessment completed, as well as an action plan developed. A sample of these was reviewed, including: ▪ A health risk assessment was completed on Individual #468. Respiratory compromise was considered a high-risk condition. There were several indicators for which Individual #468 was identified as being at medium risk, including aspiration, constipation/bowel obstruction, gastrointestinal problems, osteoporosis, seizures, poly-pharmacy and skin integrity. At the same meeting, the team completed a risk action plan to address the highest health risks. Three action steps were identified in addressing this individual's highest risk concern. It defined an implementation date, monitoring frequency, person responsible, and follow up or outcome. ▪ The PST for Individual #186 also completed a health risk assessment and an action plan. The integrated risk rating form indicated he was high risk for respiratory compromise and osteoporosis, and he was medium risk for aspiration, weight, cardiac disease, circulatory conditions, constipation/bowel obstruction, gastrointestinal problems, skin integrity, fractures, fluid imbalance, and urinary tract infections. The integrated risk rating form indicated he was treated for osteoporosis with three medications, including Boniva, Vitamin D, and calcium supplements. However, the risk action plan only indicated periodic	

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		Vitamin D levels and calcium levels were to be obtained. Obtaining these levels is not part of the routine recommendations for osteoporosis treatment, but standard daily doses of calcium and vitamin D are recommended. A normal calcium level, for instance, would not indicate the option to stop calcium supplements. There should be PCP review and guidance of the PST recommendations concerning medical diagnoses. ▪ The integrated Risk Rating Form for Individual #65, dated 2/14/11, was reviewed. There were areas of high risk for seizures and polypharmacy/side effects and several medium risk areas: aspiration, constipation, gastrointestinal problems, and skin integrity. The Risk guideline chart was followed in creating these ratings. Additionally, for the high-risk category of seizures, a Risk Action Plan was completed at the same time. Rationale for the category ratings was recorded in all cases. ▪ On 2/14/11, the PST completed an Integrated Risk Rating Form on Individual #174. The category of urinary tract infection was considered high risk, according to the risk guidelines. There were several other medium risk categories. Rationale for the rating of categories was recorded in all cases. A Risk Action Plan was developed for the high-risk category at the same time. ▪ Individual #393 had an "Integrated Risk Rating Form" completed on 2/14/11. High-risk categories included challenging behavior and falls. There were additional medium risk areas. All risk areas were provided a rationale consistent with the Risk Guidelines. A Risk Action Plan was developed on the same date for the two high-risk categories identified. While on-site, the Monitoring Team observed a number of team meetings. These showed mixed results with regard to the correct implementation of the screening process using the Risk Guidelines. Although some PSTs appeared to be following the risk guidelines, and documenting the rationale for the ratings, the PSTs would benefit from more guidance from the physicians for the Risk Action Plans. A related issue was the lack of capability/competence of the many departments to provide accurate clinical information and interpretation of this information, and to meet as a team and integrate this information. The risk guidelines and risk prevention program will only be proved valid when there is improvement in the outcomes for individuals over time. Examples of observations made during the review included: ▪ Based on a member of the Monitoring Team's observation of the At Risk screening and action plan development meeting for Individual #100, the following concerns were noted: o The PNM Team meeting to evaluate Individual #100 occurred prior to the At Risk Meeting, but when the team met, the PNMT had not finalized its evaluation. It would have been helpful to Individual #100's PST, if	

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		the PNMT had completed its evaluation prior to the At Risk meeting. This would have allowed the team to integrate the PNMT recommendations into his Action Plan. o During the At Risk meeting, members of the IDT did not consistently present clinical data to justify risk levels assigned. The team also did not refer to the Risk Guidelines delineating the indicators to be used in determining low, medium, and high levels of risk. For example, the team determined his level of risk for choking to be low "since he is G-tube," but the team did not discuss the multiple choking risk indicators. Likewise, the team assessed skin integrity as low risk, but there was no discussion of the clinical indicators. o According to the Occupational Therapist at his team meeting, Individual #100 did not meet the criteria for the Frazier water protocol. However, his physician reportedly had ordered the implementation of the Frazier Free Water Protocol. A positive decision by the IDT members was made to discontinue the Frazier water protocol. o There was discussion regarding the most appropriate degree of elevation for Individual #100. The PT stated that: "45 degrees cannot be done." The PT stated the best degree would be between 20 to 30 degrees. The decision was made to elevate his bed at 30 degrees. There was no discussion about an alternative positioning assessment to determine the most appropriate degree of elevation, as well as alternate positioning options to support his health and safety. o It was recommended that he remain upright one hour post feedings, but there was no discussion of his current PNMP, revised date 1/11/11, which did not provide staff instructions for to remain upright one hour after receiving enteral nutrition. o No team member presented a chronology of his incidents vomiting to provide the team relevant clinical data for analysis. Such information could have been used to determine if antecedents to his vomiting could be identified and resolved to potentially lower his rate of vomiting. Vomiting had the potential to place him at high risk for aspiration. o There was no discussion of assessing his lung sounds and oxygen saturation levels to establish a clinical baseline to identify his wellness state versus the onset of an illness such as aspiration pneumonia. o There was no discussion related to the appropriate elevation for Individual #100 during bathing and/or personal care such as checking/changing adult briefs. The Monitoring Team observed a flat bath slab used for individuals in the Infirmary, which would place Individual #100 at risk for aspiration pneumonia. ▪ The following concerns were noted with regard to the annual PSP meeting held	

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		for Individual #283: o Individual #283 had a number of medical complexities, including the use of a feeding tube, and the potential for skin breakdown. She also had nursing care plans for bowel management, and to address her risk for respiratory issues. The nurse merely listed the topics of the four nursing care plans, and asked the team if that "sounds good." The team agreed to continue them with no discussion of data that would show if they remained appropriate as written, or if changes needed to be made. Likewise, there was no discussion of how any of the strategies included in the nursing care plans should be integrated with other support and services being provided, or how nursing needed to integrated strategies from other plans (e.g., the PNMP) into the nursing care plans. o The team did not discuss Individual #283's risk level, but a sign-off sheet was passed around for the team members to sign indicating that risk levels had been identified. o The Occupational Therapist mentioned that Individual #283 had a positioning plan, home exercise program, and PNMP. There was no discussion about how these plans would be integrated with specific activities, for example, the PNMP during medication administration. The team discussed no data with regard to the progress Individual #283 was making with the implementation of these plans, or any need for the plans to be modified. The plans were merely passed around the table for team members to review, and indicate if they remained acceptable. o The Physical Therapist arrived when the meeting was about to end, but mentioned that a work order had been placed for a smaller wheelchair, because Individual #283 slid down in the current one. It was anticipated that obtaining the new chair could take a while, because there was an "extensive list" for new equipment. The QMRP did not solicit any discussion from other team members about actions that could be taken in the meantime to ensure Individual #283's correct position in her current wheelchair to reduce her risk for respiratory issues. Additionally, several examples of completed "Aspiration pneumonia/enteral nutrition evaluation" forms were submitted. All of the examples provided (Individual #378, Individual #515, Individual #314, Individual #520, Individual #480, Individual #373, and Individual #33 were extensive and detailed. It was not clear who completed these forms, although it appeared it was the PNMT. The concern was that this form, with extremely valuable information and well reviewed medical history, risk levels, method of eating, and completed diagnostic tests, was a separate document that, given the degree of detail provided, might be difficult to incorporate as part of the Risk Action Plan. However, to	

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		ensure good communication and consistency of information, it would be important for the "method of eating" section to be incorporated into the Risk Action Plan. The information from the "Aspiration pneumonia/enteral nutrition evaluation" should be an integral part of the Risk Action Plan for the PNMP to be successful. Despite the fact that the Facility had data showing that multiple individuals had experienced aspiration pneumonia, the "Abilene State Supported Living Center All Inclusive Risk Listing," undated, identified only two individuals at high risk for aspiration pneumonia: Individual #7, and Individual #100. Although there were discrepancies in the data, the following reports identified additional individuals who were potentially at risk: ▪ The "Communicable Disease Report for Aspiration Pneumonia," date range 1/1/10 to 12/31/10, documented 21 individuals, including Individual #7 and Individual #100, who were diagnosed with aspiration pneumonia. ▪ An analysis of the Infirmary/emergency room/hospitalization database documented multiple individuals with an admission and/or discharge diagnosis of aspiration pneumonia and/or pneumonia. ▪ Ninety-nine individuals were currently receiving enteral nutrition, which placed them at high risk for aspiration pneumonia, but these individuals were not identified at high risk. The following chart provides a summary of the data, included in these various reports:	

Individual (EN=enterally nourished)	**Communicable Disease Report Aspiration Pneumonia/ Pneumonia Diagnosis Date**	**Infirmary Admission**	**ER/Hospital Admission**
Individuals with Aspiration Pneumonia Diagnosis from Communicable Disease Report			
Individual #492 EN	6/4/10	5/17/10, 6/9/10	6/4/10
Individual #9	2/18/10	2/19/10	2/13/10
Individual #337	10/4/10	10/6/10	No admission
Individual #290	10/1/10	10/6/10	9/30/10, 10/1/10
Individual #82	9/30/10	9/30/10	No admission
Individual #228	2/28/10	2/23/10	2/28/10
Individual #285 EN	3/1/10	2/2/10	2/28/10

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		Individual #294 EN	5/4/10	5/10/10, 6/23/10	6/28/10	
		Individual #361 EN	5/21/10	5/21/10	5/21/10	
		Individual #289	2/2/10	2/2/10	2/3/10	
		Individual #208	6/19/10, 8/8/10	1/5/10, 6/18/10, 7/10/10, 8/17/10	8/8/10	
		Individual #317	10/25/10	3/22/10, 10/24/10	3/26/10, 10/24/10	
		Individual #433	12/1/10	8/11/10	No admission	
		Individual #100	7/21/10	7/21/10	7/21/10	
		Individual #409	7/29/10	7/29/10	7/29/10	
		Individual #314	8/20/10	8/20/10	No admission	
		Individual #366	8/18/10	8/18/10	No admission	
		Individual #212	10/14/10	10/15/10	No admission	
		Individual #435	10/21/10	10/15/10	No admission	
		Individual #407	11/6/10	11/12/10	6/6/10, 11/6/10	
		Individual #357	5/21/10	5/9/10	5/10/10	
		Individuals with Pneumonia Diagnosis from Communicable Disease Report				
		Individual #229	2/19/10	No admission	No admission	
		Individual #536	5/6/10	4/30/10	No admission	
		Individual #331	5/2/10	5/7/10	4/26/10	
		Individual #469	4/28/10	4/28/10, 6/12/10	No admission	
		Individual #7 EN	2/28/10, 4/24/10	3/6/10, 4/29/10	2/28/10, 4/24/10	
		Individual #475	4/19/10	2/23/10, 4/8/10	3/23/10	
		Individual #86	4/15/10	4/15/10	No admission	
		Individual #499 EN	3/27/10	3/26/10	No admission	
		Individual #431	3/24/10	3/20/10	3/18/10	
		Individual #317	3/23/10	3/22/10, 10/24/10	3/26/10, 10/24/10	
		Individual #241	3/31/10	3/27/10	No admission	
		Individual #403	3/20/10		No admission	
		Individual #531	3/19/10	1/19/10, 2/24/10, 3/20/10, 6/7/10	12/26/10	
		Individual #114	2/23/10	2/23/10	3/4/10	

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		EN				
		Individual #386	1/2/10	1/1/10	1/4/10	
		Individual #216 EN	2/24/10	2/23/10	2/23/10	
		Individual #338	1/3/10	1/3/10	No admission	
		Individual #186 EN	1/11/10	1/11/10	No admission	
		Individual #187	1/9/10	1/12/10, 10/11/10	1/8/10	
		Individual #55 EN	1/8/10	2/21/10	No admission	
		Individual #199	2/8/10	2/8/10	No admission	
		Individual #392	2/17/10	No admission	No admission	
		Individual #75 EN	3/3/10	2/26/10	No admission	
		Individual #54	9/21/10	9/19/10	No admission	
		Individual #512 EN	9/21/10	9/21/10	No admission	
		Individual #506 EN	9/28/10	10/1/10	No admission	
		Individual #466	4/9/10	No admission	No admission	
		Individual #348	2/7/10	2/6/10	2/7/10	
		Individual #393	9/17/10	No admission	No admission	
		Individual #175	5/9/10	No admission	No admission	
		Individual #88	8/13/10	No admission	No admission	
		Individual #473	8/8/10	No admission	8/8/10	
		Individual #281 EN	9/17/10, 10/13/10	10/13/10	No admission	
		Individual #103	7/6/10	7/6/10	No admission	
		Individual #359 EN	9/13/10	9/28/10	9/23/10	
		Individual #318	10/28/10	11/1/10	10/27/10	
		Individual #259 EN	10/26/10	10/22/10	10/21/10	
		Individual #362 EN	10/30/10	11/3/10	10/30/10	
		Individual #413 EN	11/11/10	11/11/10	No admission	
		Individual #10 EN	5/22/10	No admission	No admission	
		Individual #538	10/31/10	11/3/10	10/31/10	
		Individual #488	5/20/10	No admission	No admission	

#	Provision	Assessment of Status	Compliance

Individuals with a Diagnosis of Aspiration Pneumonia and/or Pneumonia from Infirmary/ER/Hospital Data Base and not identified on Communicable Disease Report for Aspiration Pneumonia and/or Pneumonia

Individual #174		6/11/10	
Individual #257		12/21/10	12/20/10
Individual #91		8/9/10	
Individual #346		12/14/10	
Individual #109		11/7/10	
Individual #270		5/10/10	
Individual #9		2/19/10	2/13/10
Individual #536		4/30/10	
Individual #463		11/23/10	11/23/10

The following concerns were noted upon completion of an analysis of the Communicable Disease Report and the database for Infirmary, emergency room, and hospitalization admission and discharge:

- Multiple individuals as documented on the chart above were diagnosed with aspiration pneumonia and/or pneumonia, but had not been identified at high risk in relation to this condition.
- Nine individuals (Individual #174, Individual #257, Individual # 91, Individual #346, Individual #109, Individual #270, Individual #9, Individual #536, and Individual #463) were diagnosed with aspiration pneumonia and/or pneumonia according to the database, but these individuals were not listed on the Communicable Disease Report for Aspiration Pneumonia and/or Pneumonia.
- According to the Communicable Disease Report, Individual #499 had a diagnosis of pneumonia on 3/27/10, but the database documented the discharge diagnosis from the Infirmary as "colonic distention, hypothyroidism, UTI, thrombocytopenia." There was no documentation of pneumonia in the database.
- Individual #431's discharge diagnosis (4/5/10) was "AGE [acute gastroenteritis], dehydration, [and] aspiration pneumonia." The Communicable Disease Report documented a diagnosis of pneumonia on 3/24/10. Individual #431 diagnosis of aspiration pneumonia in April 2010 was not documented in the Communicable Disease Report.
- According to the Communicable Disease Report, Individual #403's was diagnosed with pneumonia on 3/20/10, but the Infirmary database did not document this diagnosis.
- According to the Communicable Disease Report, Individual #531 was diagnosed with pneumonia on 3/19/10, but the Infirmary database documented diagnoses of pneumonia on 3/1/10, 3/26/10 and 6/14/10.
- Individual #538 was admitted to the hospital on 10/31/10, and discharged from

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the hospital on 11/3/10, with no diagnosis of pneumonia. The Communication Disease Report documented a diagnosis of pneumonia on 10/31/10.
Multiple individuals were admitted to the emergency room with an admission diagnosis, but the discharge diagnosis was blank. The following examples document emergency room admissions that could have been related to aspiration pneumonia and/or pneumonia, but no discharge diagnosis was documented:
<table>
<tr><th>Individual</th><th>Emergency Admission</th><th>Admission Diagnosis</th></tr>
<tr><td>Individual #473</td><td>8/8/10</td><td>Unresponsive</td></tr>
<tr><td>Individual #7</td><td>4/24/10</td><td>Respiratory distress</td></tr>
<tr><td>Individual #378</td><td>5/11/10</td><td>Respiratory distress</td></tr>
<tr><td>Individual #208</td><td>8/8/10</td><td>Respiratory distress</td></tr>
<tr><td>Individual #236</td><td>8/8/10</td><td>Respiratory distress</td></tr>
<tr><td>Individual #101</td><td>4/4/10</td><td>Respiratory distress</td></tr>
<tr><td>Individual #85</td><td>2/12/10</td><td>Lethargy</td></tr>
<tr><td>Individual #426</td><td>9/23/10</td><td>Unresponsive</td></tr>
<tr><td>Individual #290</td><td>9/30/10</td><td>Possible aspiration</td></tr>
<tr><td>Individual #492</td><td>6/4/10</td><td>Respiratory distress</td></tr>
<tr><td>Individual #292</td><td>2/18/10</td><td>Respiratory distress</td></tr>
<tr><td>Individual #447</td><td>3/17/10</td><td>Difficulty breathing</td></tr>
<tr><td>Individual #377</td><td>2/14/10</td><td>Aspiration</td></tr>
</table>
The absence of an accurate database for Infirmary/emergency room/hospitalizations and an incomplete Communicable Disease Report for Aspiration Pneumonia and Pneumonia hindered the Facility's ability to identify individuals who met thresholds for specific categories of physical, nutritional and health risk indicators. Such a database would be an important mechanism to trigger further evaluation based on the severity or frequency incidents, such as aspiration pneumonia. Risk Management, QA/QI, and/or the PNM Team could use such data to identify trends for individuals with complex medical, physical and nutritional concerns.
</td><td></td></tr>
<tr><td>I2</td><td>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</td><td>Only three individuals identified at high risk with multiple risk factors, Individual #353, Individual #23, and Individual #433, had been evaluated by the PNMT, since the last compliance review. The Monitoring Team reviewed these individual's PNMT Evaluations, PNMT Action Plans, PSP Addendums, PNMPs, and related documents. This review identified multiple concerns with the provision of physical and nutritional supports, which are addressed in detail with regard to Section O.2 below.

A review of nursing documentation for these three individuals, who were identified as</td><td>Noncompliance</td></tr>
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#	Provision	Assessment of Status	Compliance
	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.	being at risk for aspiration, identified a number of problematic issues regarding basic nursing assessment and care. From review of the records, there was no indication that nursing staff conducted any type of actual assessment to assist in determining the individuals' risk levels or developing appropriate action plans. The problematic issues found included: ▪ A lack of recognition that the respiratory symptoms the individuals experienced were signs of changes in the individuals' status and warranted nursing assessments; ▪ Nurses not documenting the type of temperatures taken; ▪ Inconsistent follow-up from symptoms noted in previous nurses' progress notes; ▪ Lack of mental status assessments documented during periods of status changes; ▪ Lack of assessments of lung sounds in response to changes in respiratory status; ▪ The lack of lung sounds routinely assessed for respiratory issues and documented; ▪ Physician/Practitioner not timely notified when changes in status began to occur; ▪ A lack of documentation that there was communication with the PNMT regarding changes in status for individuals at risk for aspiration; ▪ No indication if oxygen saturations documented were reflective of room air; ▪ A lack of adequate nursing assessments regarding the individual's status and mental status at the time of transfer to and from the Infirmary, hospital, or emergency room; ▪ Inconsistent documentation that the nurse or physician notified the receiving community facility of the individual's transfer; ▪ Inconsistent documentation in the progress notes of the exact time, date, and/or method of transfer to the receiving facility; ▪ Lack of a complete nursing assessment upon return to the Facility; ▪ The lack of ongoing follow-up assessments after transfer back to the Facility addressing the symptoms that precipitated the transfer; ▪ Lack of implementation of an adequate nursing care plan addressing risk issues; ▪ Lack of documentation of training of direct support professionals regarding risk factors and symptoms to report to nursing; and ▪ Interventions in Nursing Care Plans not consistent with PNMPs. Other systemic issues related to the nursing assessments and care plans for individuals at risk included: ▪ No competency-based training provided by the Facility to nurses regarding the assessment of lung sounds; and ▪ No Facility nursing protocols to outline the requirements for nursing documentation.	

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		These findings were consistent with the findings from the Monitoring Team's past reviews. Based on the most recent review, there was no improvement found in the nursing care and documentation for individuals with health risk issues. The lack of clinical competency in nursing regarding the identification and implementation of clinically appropriate interventions must be addressed in order for the risk system to be effective. The overall lack of identification of individuals who are at risk, the reported resistance of staff to identify an individual as being at high risk due to the documentation and meeting requirements, and the lack of competency demonstrated by nursing regarding the identification of symptoms, required assessments and intense clinical attention are critical barriers to the implementation of a successful system to ameliorate risk to the extent possible, and address risk factors when they do occur. A medical and nursing clinical review of Individual #353 documented issues that the PNMT had not addressed, which supported the need for a dedicated medical provider to join the PNMT, as well as assignment of a nurse whose only caseload would be individuals the PNMT reviewed. Facility Administration should review the current caseloads of members of PNMT I and PNMT II to determine what changes need to be made to enable the PNMT(s) to evaluate and provide ongoing supports to individuals at high risk within a swifter time frame.	
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.	Based on a review of a number of records of individuals being treated in the Infirmary in which significant issues were identified (as discussed in more detail with regard to Section M.1), the observations of Infirmary nursing staff not using the PNMPs during medication administration, observations of inadequate use and monitoring of emergency equipment in the Infirmary, and interviews with Facility staff, the nursing practices in the Infirmary placed individuals already experiencing compromises in their health status at an increased of risk for harm. Based on a review of a memorandum, dated 2/14/11, further concern related to nursing practice in the Infirmary was noted. The memorandum indicated that a Nursing Clinical Death Review, which a Facility QA Nurse conducted, found nursing documenting indicating that an individual who was admitted to the Infirmary "without a pupil in one eye and an atrophied left eye" had "repeatedly documented" that his pupils were "PERRL" (pupils equal, round, and reactive to light). This clearly reflected incompetent and unacceptable nursing practice. Such inadequate assessment of an individual's status had the potential to lead to misdiagnosis; delays in, inappropriate and/or inadequate treatment; and/or increased risk and negative outcomes for the individual. None of the PNMPs of the 13 individuals in the Infirmary at the time of the Monitoring	Noncompliance

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		Team's visit (Individual #250, Individual #418, Individual #311, Individual #19, Individual #362, Individual #26, Individual # 417, Individual #353, Individual #122, Individual #119, Individual #361, Individual #91, and Individual #359) were integrated into their Medication Administration Record, which had the potential to place the individual at risk. No competency-based training documentation for PNMPs was submitted for Infirmary staff. The following concerns were noted: ▪ Individual #250's current Medication Administration Record, for February 2011, did not identify the requirement in her PNMP, dated 8/5/10, that her position for meals, snacks, medication administration and oral care was "most upright position of wheelchair." The MAR did not list her adaptive eating equipment, which should be utilized during medication administration. The PNMP also documented: "she should remain upright for one hour after meals to reduce reflux and risk of vomiting." This precaution was not identified on her MAR. ▪ Individual #418's PNMP, dated 3/18/10, documented the optimal position for administration of medication was sitting or standing in the most upright position, which was not incorporated into his current MAR. ▪ Individual #311's PNMP, dated 8/30/10, prescribed: "the optimal position for administration of formula/medications was most upright in wheelchair," but this information was not incorporate in his current MAR. ▪ Individual #26's PNMP, dated 8/17/10, documented the optimal position for meals/snacks, administration of medications, and oral care was the most upright position of his wheelchair. His current MAR did not include this information. The Monitoring Team observed a flat bath slab in the Infirmary bathroom, which did not have the ability to be elevated for individuals at risk of aspiration pneumonia. Although Facility staff reported that this tub had been moved to the Infirmary to accommodate the needs of an individual who was no longer in the Infirmary, at the time of the Monitoring Team's review, it appeared that it was being used for others in the Infirmary. The use of this flat bath slab placed individuals at risk of aspiration pneumonia and other health related risks (GERD) at significant risk during bathing. Common diagnoses such as aspiration pneumonia, dysphagia, GERD, chronic constipation, and decubitus ulcer prevention would benefit from an interdisciplinary approach that is organized through the PNMT. However, given the number of individuals with dysphagia, feeding tubes, GERD, positioning issues, etc., timely and quality assessments will require many hours of assessment by the PNMT. Currently, the PNMT was composed of staff assigned other duties. Only a small amount of time was dedicated to the interdisciplinary assessment required by the Settlement Agreement. It is highly recommended that a full-time PNMT be created and empowered to fulfill their role at ABSSLC, because the need was great. Without a full-time committed team, other	

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		departments will struggle to sustain the new aspiration prevention policy, and likely not address all of areas causing aspiration in addition to dysphagia, such as GERD exacerbated by improper positioning. In order to have successful outcomes, a PNMT with the ability to devote its full focus to this critical area is needed to assess individuals, as well as train and monitor the staff.	

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

1. The lack of clinical competency in nursing regarding the identification of symptoms and the implementation of clinically appropriate interventions must be addressed, including but not limited to the lack of identification of individuals who are at risk, and require assessment and intense clinical attention.
2. One of the Facility's priorities should be aggressively addressing the deficits in clinical nursing competency in the ABSSLC Infirmary.
3. When risk ratings are discussed, the PCP should be present and provide direction to the PST.
4. PSTs should continue to use the risk guidelines and document the rationale in each category.
5. Quality improvement should be an integral aspect of the risk ratings the PSTs. Clinical criteria should be developed to monitor compliance with the risk guidelines, as well as to measure success over time in terms of improved outcomes for individuals (e.g., decreased sick days, decreased hospitalizations, decreased use of antibiotic, etc.).
6. The integration of the "aspiration pneumonia/enteral nutrition evaluation form" into the PST risk process should be clarified. When a PST is rating the risk of an individual who the PNMT has assessed, a member of the PNMT should be present to explain the contents of the form and to use it as a guide in making recommendations to the PST.
7. Facility Administration should review the current caseloads of members of PNMT I and PNMT II to determine what changes need to be made to enable the PNMT(s) to evaluate and provide ongoing supports to individuals at high risk within a swifter time frame.
8. The PNMT should have a physician liaison to the Medical Department.
9. The members of the PNMT should be provided cooperation from all other departments to allow them to assess individuals at-risk due to physical and nutritional management needs, as well as train and monitor staff. This should include completion of assessments of all individuals being readmitted to the Infirmary from the hospital for any acute illness that would benefit from physical and nutritional management.
10. The Facility should maintain an accurate database for Infirmary/emergency room/hospitalizations, which is consistent with the Communicable Disease Report for Aspiration Pneumonia and Pneumonia. Such information should be used to identify individuals who meet thresholds for specific categories of physical, nutritional and health risk indicators. Such a database should be used as a mechanism to trigger further evaluation based on the severity or frequency incidents, such as aspiration pneumonia. Risk Management, QA/QI, and/or the PNM Team should use such data to identify trends for individuals with complex medical, physical and nutritional concerns.
11. Individual PNMPs should be incorporated into Nursing Care Plans and Medication Administration Records to provide an integrated plan to support health and safety for individuals with complex health, physical and nutritional needs.
12. The flat bath slab in the Infirmary should be moved, and appropriate bathing equipment used that provides elevation for individuals at risk of aspiration and other related health concerns.

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**: The following Policies and Procedures and other documents were reviewed: o Policies and procedures related to the use of pre-treatment sedation medication. The source of this document was the Nursing Procedure Manual, revised March 2010; o An alphabetical list of individuals who have received pre-treatment sedation medication for medical or dental procedures (during the last six months) that included: a) date the pre-treatment sedation medication was administered; b) name and dosage of medication; c) route of the medication; and d) an indication of whether a plan was in place to minimize the need for the use of pre-treatment sedation medication; o An alphabetical spreadsheet of individuals who were prescribed psychotropic/psychiatric medication that included: a) name of individual; b) residence; c) psychiatric diagnoses inclusive of Axis I, Axis II, and Axis III; and d) psychotropic medication regimen; o List of individuals prescribed benzodiazepines; o List of individuals prescribed anticholinergic medications that included the name of the medication(s) prescribed; o List of individuals prescribed intra-class polypharmacy that included the names of medications prescribed; o Facility-wide data regarding polypharmacy, including intra-class polypharmacy; o List of individuals with tardive dyskinesia; o Spreadsheet of individuals who have been evaluated with the Monitoring of Side Effects Scale (MOSES) and the Dyskinesia Identification System: Condensed User Scale (DISCUS) scores, with dates of completion for the last six months; o List of individuals who were prescribed each of the following: a) Anti-epileptic medication being used as a psychotropic medication; b) Lithium; c) Tricyclic antidepressants; d) Trazodone; e) Beta-blockers being used as a psychotropic medication; f) Clozaril/Clozapine; g) Mellaril; and h) Reglan; o List of new admissions since January 1, 2010, and whether a Reiss screen was obtained; o Spreadsheet of all individuals who have had a Reiss screen completed, including the dates of completion; o List of individuals who have been referred for a Psychiatric Evaluation as a result of an elevated score on the Reiss screen; o List of all psychiatrists, including board status; o Curricula Vitae (CVs) of all psychiatrists; o For the past six months, minutes from the committee that addresses polypharmacy; o List of all individuals, age 18 or younger, who were receiving psychotropic medication; o The following sections of the medical records: a) Data Record; b) Social History Evaluation; c) Personal Support Plan (PSP); d) Positive Behavior Support Plan (PBSP), including addendums; e) Annual Medical Summary; f) Active Problem List; g) Inactive

Problem List; h) Psychiatric Problem List; i) Hospital Admission; j) Health Risk Assessment Rating, only most recent tool and team meeting sheet; k) Psychiatry Section inclusive of the most recent Comprehensive Psychiatric Assessment; l) MOSES/DISCUS screenings; m) Quarterly Drug Regimen Reviews; n) Neurology Consultation; o) Documentation and consultations regarding the use of pre-treatment sedation medication (i.e., Treatment Plan, Guardian Approval, HRC Approval, etc.); and p) Human Rights section, including a copy of the signed consents, were requested for the following two samples of individuals who were receiving psychotropic medication:

1. The records of the following individuals were requested in the pre-onsite review document request: Individual #390, Individual #9, Individual #355, Individual #349, Individual #37, Individual #207, Individual #393, Individual #375, and Individual #32. The records of Individual #261, Individual #450, and Individual #444 were also provided as part of the pre-onsite review document request, but were excluded from this assessment, because the files were lacking many of the sections necessary to complete a systematic review related to Section J of the SA;
2. The records of the following individuals were randomly selected from the list of individuals who were receiving psychotropic medication at the time of the review: Individual #94, Individual #160, Individual #46, Individual #39, Individual #11, Individual #447, Individual #136, Individual #325, Individual #384, Individual #363, Individual #59, Individual #33, Individual #130, Individual #376, Individual #287, Individual #517, Individual #263, Individual #178, Individual #495, Individual #293, Individual #43, Individual #532, Individual #274, Individual #337, Individual #481, Individual #438, Individual #81, Individual #351, Individual #209, Individual #478, Individual #347, Individual #518, Individual #140, and Individual #382. However, the records of the following individuals were missing specific sections of the medical record: Individual #347 (missing Psychiatric section, Behavioral Psychology section, and Human Rights section); Individual #518 (missing some of the Psychiatric Clinic Notes); Individual #33 (missing Psychiatric section and the Behavioral Psychology section); Individual #130 (missing Psychiatric section and the Behavioral Psychology section); Individual #376 (missing Psychiatric section, Behavioral Psychology section, and the Human Rights section); and Individual #287 (missing Psychiatric section and the Behavioral Psychology section). The missing sections of the individual records did not present a significant impediment to the completion of a thorough review, as a relatively large number of documents had been requested for review and, in most cases, only a few sections were missing. The individual records, that were missing specific sections, were systematically reviewed with regard to the relevant Provisions of the SA for which information was available. This resulted in slightly different total numbers for the review of some of the provisions contained within Section J. This information is reflected in the discussion of each provision, and the results are expressed as a percentage of this total number, so that the results for each

provision can be compared on a percentage basis.

- **Interviews with**:
  - Ms. Toni Wilson, RN, Psychiatric Nurse, on 2/14/11 and 2/16/11;
  - Patricia Lowermore, MD, Consulting Psychiatrist, on 2/15/11;
  - John Crowley, MD, Consulting Psychiatrist, on 2/15/11;
  - Marcos Perez, Psychiatric Assistant, on 2/15/11;
  - Amy Hodge, Psychiatric Assistant, on 2/15/11 and 2/17/11;
  - Richard Chengson, MD, Medical Director, on 2/16/11;
  - Jerry Griffen, D.D.S., Director of Dental Services; and Walter Clendenden, DDS, Staff Dentist, on 2/16/11;
  - Marla Knight, Pharm. D., Clinical Pharmacist, on 2/16/11;
  - Ron Manns, Behavioral Analyst, BCBA, on 2/16/11;
  - Mary White, RN, Quality Assurance Nurse, on 2/16/11;
  - Tracyl Gandee, Settlement Agreement Coordinator, on 2/17/11;
  - Jim Kluza, RN, Chief Nurse Executive (CNE), on 2/17/11; and
  - Trina Cormack, MD, Staff Psychiatrist, on 2/17/11.
- **Observations of**:
  - Psychiatry Clinic on the Infirmary Unit, chaired by Dr. Trina Cormack, on 2/14/11;
  - Consultation between Dr. Trina Cormack and Consulting Neurologist, Dr. Rex Anderson, on 2/14/11;
  - Psychiatric Clinic on 6450 Plum Street, chaired by Dr. Patricia Lowermore, on 2/15/11;
  - Psychiatric Clinic on Mimosa Street, chaired by Dr. Patricia Lowermore, on 2/15/11;
  - Psychiatric Clinic on 6730 Circle Drive, chaired by Dr. John Crowley, on 2/15/11;
  - Psychiatric Clinic on 6400 Plum Street, chaired by Dr. Trina Cormack, on 2/16/11;
  - Medical Rounds, Infirmary Unit, on 2/17/11; and
  - Psychiatric Consultation by Dr. Trina Cormack, Infirmary Unit, on 2/17/11;
  - Observation of the following: Individual #405, Individual #26, Individual 218, Individual #151, Individual #245, Individual #371, Individual #287, Individual #412, Individual #228, Individual #518, Individual #257, Individual #188, Individual #319, Individual #302, Individual #139, Individual #503, Individual #504, Individual #199, Individual #447, Individual #76, Individual #110, Individual #167, Individual #478, Individual #542, Individual #241, Individual #463, Individual #170, Individual #112, Individual #467, Individual #383, Individual #268, Individual #267, Individual #265, Individual #311, Individual #19, Individual #485, Individual #362, Individual #417, Individual #100, Individual #353, Individual #235, Individual #347, Individual #315, Individual #373, Individual #392, Individual #376, Individual #33, Individual #451, and Individual #402.

Facility Self-Assessment: The ABSSLC Plan of Improvement, which was updated on 1/31/11, indicated the following self-assessments with regard to the provisions of the SA, as well as a brief description of the rationale for that assessment. Although data derived from compliance reviews were cited for each provision, the specific nature of these reviews was not specified nor was a description provided of exactly what the data measured. The information provided is summarized below:

	▪ For J.1, the Facility had noted Substantial Compliance, with the comment: "74% compliance from 60 reviews since 9/20/10." ▪ For J.2, the Facility had noted Noncompliance, with the comment: "63% compliance from 60 reviews since 9/20/10." There was a notation of the addition of a full-time Psychiatrist. ▪ For J.3, the Facility had noted Noncompliance, with the comment: "84% compliance from 60 reviews since 9/20/10." ▪ For J.4, the Facility had noted Noncompliance, with the comment: "59% compliance from 60 reviews since 9/20/10." ▪ For J.5, the Facility had noted Substantial Compliance, with the comment that a new, full-time Psychiatrist had been hired, and the existing two Consulting Psychiatrists had been retained. ▪ For J.6, the Facility had noted Noncompliance, with the comment: "60% compliance from 60 reviews." There was a notation that, despite the addition of a full-time Psychiatrist, additional outside psychiatry time might be necessary. ▪ For J.7, the Facility had noted Noncompliance, with the comment: "100% compliance from 60 reviews since 9/20/10," but recognition that this provision "requires discipline expert monitoring." ▪ For J.8, the Facility had noted Noncompliance, with the comment: "100% compliance from 60 reviews since 9/20/10," but recognition that "this Provision requires discipline expert record review and meeting observation." ▪ For J.9, the Facility had noted Noncompliance, with the comment: "51% compliance from 60 reviews since 9/20/10." ▪ For J.10, the Facility had noted Noncompliance, with the comment: "No formal self-monitoring notation of addition of full-time Psychiatrist." ▪ For J.11, the Facility had noted Noncompliance, with the comment: "No formal self-monitoring done in this area." ▪ For J.12, the Facility had noted Noncompliance, with the comment: "Current monitoring = 59% compliance from 48 reviews since 9/20/10." There was a notation of the need for "discipline expert review." ▪ For J.13, the Facility had noted Substantial Compliance, with the comment: "Current monitoring = 99% compliance from 60 reviews since 9/20/10. This is reviewed periodically and the Psychologist and Psychiatrist justify ongoing use and take corrective action as necessary." ▪ For J.14, the Facility had noted Substantial Compliance, with the comment: "Current monitoring = 95% compliance from 60 reviews since 9/20/10. Consent forms are signed and filed." ▪ For J.15, the Facility had noted Noncompliance, with the comment: "No formal self-monitoring done in this area." There was a notation that the addition of a full-time Psychiatrist should be beneficial. To date, the Quality Assurance (QA) Department had completed the auditing for Section J, and members of the Psychiatry Department had not been involved. As indicated in the Facility Self-Assessment, the addition of a full-time Psychiatrist should increase the potential for internal expert discipline audits of the quality factors described in the SA.

	Interviews with the members of the QA Department, as well as inspection of the QA compliance review documents, indicated that these reviews primarily utilized a dichotomous yes/no approach regarding the presence or absence of the referenced documentation in the individual records. During onsite review discussions, members of the QA Department recognized that the determination of compliance with some of the items required not only an assessment as to whether or not the documentation was present, but also a determination as to whether or not it met quality standards. This recognition also was reflected in some of the comments in the Facility Self-Assessment, which referenced the need for "discipline expert monitoring." The primary discrepancies that existed between the Facility's findings in the POI and those of the Monitoring Team related to the quality requirements set forth in the SA. There was much closer agreement between the Facility's Self-Assessment and that of the Monitoring Team for provisions that primarily required that an evaluation, whose format was specifically described, be completed, such as the monitoring for medication side effects and the administration of the Reiss Screening instrument. It will be essential, as the Facility continues to develop its self-assessment processes that attention is paid to evaluating not only the presence of information, but also the quality of the supports provided.
	Summary of Monitor's Assessment: One significant recent positive change at ABSSLC had been the addition of a new full-time Psychiatrist, who was Board Certified in Family Practice as well as Adult Psychiatry. In addition, she had clinical experience with individuals with developmental disabilities. The Facility also continued to utilize the two Consulting Psychiatrists who were Board Certified in Adult Psychiatry, and one of whom was also Board Certified in Child and Adolescent Psychiatry. This brought the total amount of psychiatry time to approximately 1.5 full-time equivalents (FTEs), which was still not sufficient for the 222 individuals who received psychotropic medication. However, this represented a significant improvement since the last review. The Facility also was continuing its efforts to recruit additional full-time Psychiatrists. A recent change involved a revision to the format of the Quarterly Psychiatric Clinic Notes, to more fully document support for the psychiatric diagnosis, and also to include more detailed medical information. The addition of the full-time Psychiatrist also had made it possible for a Psychiatrist to attend the morning Medical Rounds in the Infirmary, which facilitated the psychiatric management of individuals admitted to the Infirmary, who also had a psychiatric illness. This also had fostered closer integration of the psychiatric and medical services in general. The format of the Comprehensive Psychiatric Assessment also had been modified to more closely comply with the outline contained in the Settlement Agreement. However, the examples of newly completed Comprehensive Psychiatric Assessments reviewed still did not contain the information required to justify the psychiatric diagnosis. In the Psychiatric Clinics observed, there was a clear attempt to review every individual's psychotropic medications, with the goal of reducing those medications when possible. A number of decisions to decrease an individual's psychotropic medications were observed in the Clinics of the three Psychiatrists. The data compiled by the Pharm. D. also documented a related, gradual reduction in the rates of

	polypharmacy, as indicated by the average number of psychotropic medications prescribed per individual. There also had been incremental progress in implementing the Desensitization Plans for dental procedures, although only a small number of Plans had been developed thus far. The dental staff also had implemented a number of environmental changes that were designed to make the Dental Office less intimidating to the individuals at the Facility. The co-identification of behaviors, that were described in the Functional Analysis as being present on a behavioral basis, and also were listed as "target" behaviors of the psychotropic medications, continued to be problematic. This was more apt to occur with individuals who had Autism Spectrum Disorders and more significant cognitive impairments, and was less likely to occur with individuals who had clear-cut major psychiatric disorders, such as Schizophrenia and Bipolar Disorders. However, the review of the individual records noted some incremental progress in addressing this issue. Systemic issues that were discussed in the prior report, and continued to be problematic, included the risk versus benefit analysis as it related to the utilization of psychotropic medication, and the corresponding Human Rights Approval/Guardian Consent process. The lack of empirical evidence to substantiate the efficacy of the psychotropic medications was an ongoing, significant deficiency. Obviously, this documentation also was related intimately to an adequate analysis of the benefits of the medication in relation to the potential and/or realized side effects of the medication.

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J1	Effective immediately, each Facility shall provide psychiatric services only by persons who are qualified professionals.	The comments that follow were based on: 1) the interviews with each of the psychiatrists, as well as other relevant professional staff; 2) the direct observation of Psychiatric Clinics, chaired by each of the Facility Psychiatrists; and 3) the review of the relevant sections of a sample of 41 medical records (18 percent) of individuals who received psychotropic medication. The description of the sample of individual medical records reviewed is detailed in the Review of Documents section above. As indicated in that discussion, some of the records were missing relevant sections. Accordingly, in the sections that follow, comments related to each of the provisions identify the total number of records reviewed, and results are expressed as percentages, so that comparisons can be made to past and future reviews. The Facility recently had hired a full-time Psychiatrist, Dr. Trina Cormack, who was Board Certified in both Family Practice and Adult Psychiatry. She also had extensive experience in the provision of medical and psychiatric services. This experience included serving as both a Primary Care Physician (PCP) and later as the Medical Director at the San Angelo State Supported Living Center. She subsequently completed a psychiatric residency at the University of Texas Medical Branch, in Galveston, Texas. Dr. Cormack also had served as a Staff Psychiatrist at both the Rusk State Hospital and the Big Springs	Substantial Compliance

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		State Hospital. This work involved the psychiatric treatment of individuals with intellectual disabilities/developmental disabilities (ID/DD) and comorbid psychiatric disorders, in addition to the general psychiatric population admitted to the hospitals. The individuals with intellectual disabilities included both those that were transferred from the State Supported Living Centers, as well as community residences. The Facility also had continued to employ the two Consulting Psychiatrists who were present at the time of the prior review. As indicated in that report, Dr. Patricia Lowermore was Board Certified in Adult Psychiatry, and Dr. John Crowley was Board Certified in Adult Psychiatry, as well as in Child and Adolescent Psychiatry.	
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.	With regard to staffing, one of the Consulting Psychiatrist's time commitment to the ABSSLC consisted of approximately 10 to 13 hours per week. Her usual schedule was to arrive on Monday at 12 noon and finish at 5:00 p.m., and then return on Tuesday and work until approximately 3:00 p.m. The other Consulting Psychiatrist's time commitment to ABSSLC was approximately eight to 10 hours per week, which was usually devoted to Psychiatric Clinics on Monday and Tuesday afternoons. As noted above, the Facility recently hired a full-time Staff Psychiatrist. All three Psychiatrists were Board Certified in Adult Psychiatry, and one of the Consulting Psychiatrists was also Board Certified in Child and Adolescent Psychiatry. One full-time Psychiatric Nurse, and two full-time Psychiatric Assistants provided support to the Psychiatrists. The Clinical Nurses and Psychologists on the residential units also worked with Psychiatry Department staff to schedule Psychiatry Clinics and the direct observations of individuals by the three Psychiatrists. The goal of the Psychiatry Department 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 Psychiatrists to achieve this goal. The review of the records of 37 individuals, who were receiving psychotropic medication, indicated that the goal of a monthly review in the Psychiatry Clinic had been achieved for all of the individuals. The corresponding goal, to have every individual observed by the Psychiatrist at least quarterly, also was attained for the individuals in the sample, or an explanation was provided as to why the interview could not occur on that day. The review of this sample of records also indicated that there was a Comprehensive Psychiatric Evaluation completed within the last two years for 11 of the 37 individuals (30%). The individuals for whom timely Comprehensive Psychiatric Assessments could not be found included: Individual #532, Individual #274, Individual #337, Individual #481, Individual #438, Individual #81, Individual #351, Individual #209, Individual	Noncompliance

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		#478, Individual #39, Individual #11, Individual # 447, Individual #136, Individual #325, Individual #384, Individual # 363, Individual #59, Individual #140, Individual #382, Individual #355, Individual #349, Individual #9, Individual #393, Individual #390, Individual #375, and Individual #32. However, those Comprehensive Psychiatric Assessments present in the records reviewed did not meet the requirements set forth in the Settlement Agreement. These assessments varied widely with regard to both the outline that was used and the content of the specific sections. However, a uniform finding was the absence of a description of the specific symptoms the individual was presenting that would support the psychiatric diagnosis identified in the record. Another deficit found in all of these documents was the lack of a well-developed "Bio-Psycho-Social-Spiritual Formulation (Case Formulation)" as described in Appendix B of the Settlement Agreement. Two of the Comprehensive Psychiatric Assessments (those of Individual #207 and Individual #94) were formatted in a manner that was consistent with the outline contained in Appendix B of the Settlement Agreement entitled, "State Supported Living Centers – Psychiatric Evaluations/Assessments." However, as is discussed below, they did not comply with the content requirements. The discussions with the new Staff Psychiatrist indicated that the format for the Comprehensive Psychiatric Assessments recently had been modified to comply with the format set forth in the Settlement Agreement. Accordingly, a sample of five recently completed Comprehensive Psychiatric Assessments, which utilized the new format, were requested. The specific individuals for whom these assessments had been completed, along with the dates of the assessments were as follows: Individual #207, on 12/10/10; Individual #74, on 12/16/10; Individual #293, on 1/5/11; Individual #534, on 1/5/11; and Individual #37, on 12/28/10. The documents followed the outline set forth in the Settlement Agreement with regard to the major category headings. However, they all deviated from the specified format with regard to the content of the subsection entitled, "XII. Diagnostic Assessment (five axes)." The wording of that subsection requires the following documentation: *i. Clinically justifiable diagnoses are provided for each individual. All diagnoses that cannot be clinically justified for an individual are discontinued no later than the next review.* *ii. The documented justification of diagnoses is in accord with the criteria contained in the most current DSM (as per DSM-IV-TR Checklist).* *iii. Differential diagnoses, "deferred," or "rule-out" diagnoses, and a diagnoses as (sic) listed as "NOS" ("Not Otherwise Specified") are timely addressed (i.e., within 60 days), through clinically appropriate assessments, and resolved in a clinically justifiable manner…*	

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		The key words in this excerpt from the Settlement Agreement are "clinically justifiable," and the related stipulation that "diagnoses that cannot be clinically justified for an individual are discontinued." This terminology suggests that the "clinical justification" should be supplied for each diagnosis referred to in this section of the assessment. A randomly selected Diagnostic section from one of the more recent Comprehensive Psychiatric Assessments (Individual #74, date of consultation 12/16/10) contained the following information in the section for the Psychiatric Diagnosis: *DIAGNOSTIC IMPRESSION – New Psychiatric Problem List below:* *Axis I: 1) Impulse Control Disorder; essentially unchanged.* *2) Stereotypic Movement Disorder; unchanged.* *3) Anxiety Disorder, NOS, with symptoms of generalized anxiety and possible Post-traumatic Stress Disorder, but it is difficult to assess this, due to his cognitive level.* *Axis II: 1) Mental Retardation; profound.* *Axis III: 1) Please see the current medical diagnoses on the Active and Inactive Problem Lists, behind the Problem List Subtab.* *2) Psychotropic Medication Trials:* *Ativan (dc'd [discontinued] 5/1999)* *Mellaril (dc'd 10/2001)* *Zyprexa (dc'd 6/2003 2º [due to] to weight gain)* *Inderal (dc'd 4/2004); rst'd [restarted](dc'd 6/28/2010)* *Tegretol, Seroquel (dc'd 4/19/2008 – only partial response)* *Celexa (dc'd 1/2007).* The Psychiatric Diagnosis section from the Comprehensive Psychiatric Assessment for Individual #393, dated 1/5/11, was similarly formatted: *DIAGNOSTIC IMPRESSION: New Psychiatric Problem List below:* *AXIS I. 1) Impulse Control Disorder.* *AXIS II. 1) Mental Retardation; severe.* *AXIS III: 1) Please see the current medical diagnoses on the Active and Inactive Problem Lists, behind the Problem List Subtab.* *2) Psychotropic Medication Trials: Mellaril (treating aggression/stuffing objects in her nose/chewing at hands/clothes); Benadryl (poss. has also been used for aggression/stuffing objects in her nose/chewing at hands/clothes); and, Vistaril (poss. has also been used for aggression/stuffing objects in her nose/chewing at hands/clothes.)*	

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		There was no information in these sections of the Comprehensive Psychiatric Assessments that described the symptoms that would "clinically justify" the identified psychiatric diagnosis. Overall, the new format for the Comprehensive Psychiatric Assessments represented a significant improvement over the documentation that was available in prior versions. However, the implementation of changes to the Diagnostic section, so that they more closely comply with the requirements of the SA, would greatly increase their alignment with the specified format. The specific information missing was the documentation that would "justify" the psychiatric diagnosis by describing the symptoms attributed to the diagnosis as outlined in Appendix B of the Settlement Agreement. The other sections of the revised Comprehensive Psychiatric Assessments were consistent with the guidelines set forth in the Settlement Agreement. 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 compatible with the timelines identified in the Settlement Agreement and Health Care Guidelines. Implementation of changes to the format of the Comprehensive Psychiatric Assessments discussed above should make it possible to move that process closer to the quality requirements set forth in the Settlement Agreement.	
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 is discussed in more detail with regard to Section J.13, psychotropic medication was utilized for individuals whose behavioral programs were inadequate. Without adequate treatment in place, it could not be confirmed that psychotropic medication was not being used as a substitute for treatment. In many cases, the psychiatric diagnosis on record was not supported by adequate documentation of the symptoms that justified the diagnosis. This is discussed in further detail with regard to Section J.2 of the Settlement Agreement. In addition, the behaviors monitored to assess the efficacy of the psychotropic medications were 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 as being related to environmental factors. This could give the impression that the psychotropic medication was being utilized to suppress behaviors that were present on a learned or environmental basis. This is discussed in further detail with regard to Section	Noncompliance

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		J.13 of the Settlement Agreement.	
J4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, if pre-treatment sedation is 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.	During an interview with the Board Certified Behavioral Analyst, he indicated that the Psychology Department was in the initial phase of implementing desensitization plans to decrease reliance on pre-treatment sedation medications prior to medical and dental appointments. The 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. There has been incremental progress regarding this provision since the review in August 2010. During the interview with the dentists at ABSSLC, they indicated that the names of 30 individuals, who might benefit from desensitization plans, had been proposed to the Psychology Department, and 10 individuals had been selected from this list. Desensitization Plans for these individuals had been developed and were in the implementation phase. A sample of seven of these protocols was requested for review. The subsequent review of these plans indicated that, although they were all formatted in a similar manner, there were specific individualized elements included in each plan. The members of the Dental Department indicated that they had been involved in implementing a number of the plans. Thus, this process had evolved from the planning phase to the implementation phase, although the actual number of individuals involved remained quite small. The Monitoring Team requested "an alphabetical list of individuals who have received pre-treatment sedation medication for medical or dental procedures that includes: date the pre-sedation was administered, and the name, dosage, and route of the medication, and an indication of whether a plan is in place to minimize the need for the use of pre-treatment sedation medication" for "the past six months." The spreadsheet submitted in response to this request listed the names of 90 unique individuals. Some individuals had multiple listings. The column that was entitled: "Plan to minimize need of pre-treatment sedation" identified the names of 40 individuals. This information was clearly different from the information supplied with regard to the number of individuals for whom Desensitization Plans had been developed, which indicated that such plans had been developed for 10 of the 90 individuals (11%). This provision of the SA also makes reference to an interdisciplinary process, including input from Psychiatry, Pharmacy, and Medical Services to determine the most appropriate medication and dosage of pre-treatment sedation for each individual. There was no indication in the documentation reviewed that this process was in place. In addition to the Desensitization Plans, the Dental Department had made a number of changes to the Dental Office in an effort to make it less intimidating to the individuals to	Noncompliance

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		whom they provided services. There did not appear to be a way to quantify the effects of this initiative at the time of the review. During the interview with the Medical Director, he also indicated that the Primary Care Practitioners (PCPs) were reassessing the need for pre-treatment sedation for all of the individuals on their caseloads who historically might have been assumed to require this medication. The Human Rights section of the record contained an indication of whether or not pre-treatment sedation was required for medical and/or dental procedures. This section of the record was available for 35 individuals within the total sample of records reviewed. Analysis of this sample indicated that pre-treatment sedation for dental procedures was required for five individuals, and pre-treatment sedation for medical procedures for four individuals. However this material did not contain a thorough discussion of the benefits of utilizing pre-treatment sedation versus the risks related to the intervention. Thus, the documentation related to the HRC approval of pre-treatment sedation contained the same deficiencies as those described in relation to Section J.10 related to the general use of psychotropic medication.	
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 222 individuals receiving psychotropic medication at the time of the February 2011 onsite review. At the time of the prior onsite review, in August 2010, there were 225 individuals receiving psychotropic medication. As indicated in the prior report, 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 at ABSSLC. This would equate to a caseload of approximately 75 individuals for each psychiatrist. In December 2010, ABSSLC hired a new full-time Psychiatrist, whose credentials are discussed with regard to Section J.1. The Facility also had continued to contract with two psychiatrists. Their consulting schedules had remained consistent since the last review, and their combined time commitment equaled approximately 20 hours per week. Thus, the total amount of psychiatric time that was available to evaluate and treat the individuals at the ABSSLC had increased to approximately 1.5 full-time equivalents. The Medical Director indicated that the Facility had additional open psychiatric positions that they had been attempting to fill. The Psychiatrists continued to be supported by a full-time Psychiatric Nurse and two full-time Psychiatric Assistants. These individuals had created an administrative infrastructure that optimized the time of the Psychiatrists. The plan the Psychiatry Department articulated during the onsite review was to divide the caseload of 222 individuals evenly between the three Psychiatrists. However, the individuals with more complex needs would be included on the caseload of the full-time	Noncompliance

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		Psychiatrist, who would also assume clinical responsibility for those individuals with psychiatric disorders who were admitted to the Infirmary.	
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 described in Appendix B.	In the materials provided for review, no policies or procedures were found related to psychiatric assessment, diagnosis, and case formulation. In response to a document request for policies related to the role of the Psychiatrist, the Facility submitted a document that read: "None." As noted above, one full-time Psychiatrist and two part-time Psychiatrists provided the psychiatric services at the ABSSLC. The primary contact the psychiatrist had with the individuals and their teams took place in the context of the monthly Psychiatric Clinics. The goal of the Psychiatry Department was to have each individual reviewed monthly and directly observed by the psychiatrist every three months. The monthly meetings, including the quarterly observations, occurred as scheduled. The Psychiatry Nurses, Psychiatry Assistants, and the residential Nursing Staff, working in conjunction with the members of the Psychology Staff, contributed to the successful execution of this schedule of Psychiatric Clinic reviews. Comprehensive Psychiatric Assessments were identified in 11 out of 37 (30%) of the records reviewed. Deficiencies related to both the documentation of the Psychiatry Clinics and the Comprehensive Psychiatric Assessments are described in more detail with regard to Sections J.2 and J.13 of the Settlement Agreement. The missing documentation included identification of symptoms that support the psychiatric diagnosis, information that would link the monitored behavior of the psychotropic medication (such as aggression, agitation, and/or self-injurious behavior) to the psychiatric diagnosis of record, and empirical data that would substantiate the efficacy of the psychotropic medication.	Noncompliance
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	At the time of the review, the total population of the ABSSLC was 447. Two hundred and twenty-two (222) individuals were receiving psychotropic medication (50%). The Reiss Screen was specifically designed to identify individuals who were not receiving psychiatric services, but 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 the screening instrument had been administered to 228 individuals. The total number of individuals administered the Reiss Screen and the number receiving psychotropic medication slightly exceeded the current number of individuals who resided at ABSSLC. This was most likely secondary to admissions and discharges that occurred during this timeframe. In order to assess the validity of the spreadsheet, a random sample of every tenth individual (10 percent) was	Noncompliance

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	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.	requested of the individuals who were identified on the spreadsheet as having been administered the Reiss Screen. They were as follows: INDIVIDUAL — DATE OF SCREENING Individual #118 — 3/15/10 Individual #488 — 9/14/09 Individual #230 — 5/17/10 Individual #480 — 1/13/10 Individual #506 — 2/2/10 Individual #289 — 7/31/09 Individual #85 — 7/13/10 Individual #145 — 2/17/10 Individual #279 — 1/19/10 Individual #411 — 6/11/09 Individual #212 — 2/3/10 Individual #368 — 1/19/10 Individual #99 — 7/28/09 Individual #41 — 12/18/09 Individual #435 — 3/8/10 Individual #157 — 9/22/10 Individual #349 — 4/19/10 Individual #34 — 1/20/10 Individual #186 — 2/11/10 Individual #498 — 12/14/09 Individual #542 — 10/2/09 Individual #297 — 3/3/10 Individual #100 — 10/9/09 Individual #14 — 3/11/10 Individual #502 — 2/27/09 Individual #97 — 4/15/10 Individual #467 — 12/15/09 Individual #86 — 10/28/09 Individual #383 — 6/23/09 Individual #170 — 9/15/09 Individual #527 — 1/28/10 This documentation indicated that all of the Reiss protocols and scoring sheets were present except for that of Individual #383, for whom there was a notation that it could not be located. Thus, the documentation for the random sample indicated that the spreadsheet was	

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		reliable, as 30 of the 31 (97%) of the relevant, individual, clinical material was produced. Within this sample, the following four individuals had a Reiss Score above the clinical cut-off score of nine, which would prompt a referral for a Psychological and Psychiatric Assessment: Individual #502, Individual #467, Individual #86, and Individual #527. The copies of these completed protocols for the random sample were received after the conclusion of the onsite review. Thus, it was not possible to request a copy of the Psychiatric Consultations that would have been triggered by an elevated score on the Reiss Screen for this sample. However, a separate on-site request had been made for a "copy of the completed Reiss Screening Instrument and report for individuals admitted in the last year and the Psychiatric Consults (if any) that have been triggered by an elevated score." The documents for this request appeared to be incomplete. A total of nine individuals had been admitted/readmitted to ABSSLC in the previous six months. In response to this request, the Facility produced the Reiss protocol for Individual #143, dated 11/18/10. A handwritten note, which accompanied the protocol, indicated that the individual was "now deceased, records have been archived, attempting to locate." The Reiss screening protocol for individual #261 was present and indicated a score of zero. Individual #450 was also admitted to ABSSLC during this time frame, and documentation of a REISS screen was not produced. This individual's name did not appear on the list of individuals who were prescribed psychotropic medication. During the review, the protocol for the administration of the REISS screening instrument was discussed with the Facility's BCBA, because the Psychology Department is responsible for this process. A specific topic discussed related to the screening process with regard to those individuals who were newly admitted to the Facility. The process described was that individuals who were receiving psychotropic medication at the time of their admission to ABSSLC would not be considered for screening with the REISS instrument, because they would automatically be referred to the Psychiatric Clinics for follow-up and would receive a psychiatric assessment as part of that process. The last sentence of this provision clearly states that all individuals who are admitted to the Facility "with a psychiatric diagnosis or prescribed psychotropic medication" must receive a Comprehensive Psychiatric Assessment that meets the quality standards described throughout the SA. The deficiencies in the current Comprehensive Psychiatric Assessment process at ABSSLC are described in detail in the discussions related to Sections J.2, J.8, and J.13. It will not be fully possible to comply with this provision of the Settlement Agreement until that process also meets the requirement related to quality.	
J8	Commencing within six months of the Effective Date hereof and with full implementation within three	During the course of the on-site reviews on 2/14/11, 2/15/11, 2/16/11, and 2/17/11, a member of the Monitoring Team directly observed approximately 11 hours of the Psychiatrists' interactions with the clinical teams during Psychiatric Clinics. These	Noncompliance

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	years, each Facility shall develop and implement a system to integrate pharmacological treatments with behavioral and other interventions through combined assessment and case formulation.	observations included samples of each of the three Psychiatrists, and provided ample evidence that the Consulting Psychiatrists worked closely with the members of the Psychology Department. The Psychologist working with 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. As is discussed with regard to Section K of the Settlement Agreement, the reliability and validity of this data was questionable. Within the sample of 37 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 30 of the 37 records reviewed (81%), the symptoms described as being "targets" of psychotropic medication also were described in the Functional Analysis as being present on an operant basis, or as a response to a demand situation, representing an escape behavior, or being related to environmental, stressful events. This is discussed in further detail with regard to Section J.13 of the Settlement Agreement. That discussion also identifies the individuals whose records provided adequate differentiation of the factors that contributed to their challenging behaviors. It is conceivable that the symptoms of a psychiatric disorder could be affected by both biological and psychological factors, but the documentation necessary to support such a connection was not present in 81% of the individual records reviewed. This suggested that the psychiatric 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 to treat the symptoms of an identified psychiatric disorder. ▪ The Treatment Plans for the use of psychotropic medications and the Behavioral Support Plans should both specify 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. In those cases where it is thought that the identified behavior is determined by both biological and psychological processes, this should be clarified. These issues were discussed with the Board Certified Behavioral Analyst and the full-time Staff Psychiatrist, who were both aware of this problem.	
J9	Commencing within six months of the Effective Date hereof and with	This provision describes a collaborative process through which "the IDT, including the psychiatrist, shall determine the least intrusive and most positive interventions to treat	Noncompliance

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	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 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.	the behavioral or psychiatric condition." There was insufficient documentation, in the records reviewed, to demonstrate that this collaborative process was occurring at ABSSLC. 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 were in attendance at the Psychiatry 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 by the nursing staff of any medication side effects. 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 might be adversely affecting the frequency of the monitored behavior. The Psychiatrist present during the review clearly took this information into account when making decisions. The records reviewed did not provide documentation of 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, psychiatrists did not attend the individuals' annual PSP meetings, or meetings at which addenda to the PSPs were being discussed. Thus, based on the documentation reviewed, there was no forum for which a truly integrated, interdisciplinary discussion was occurring between Psychiatry and all of the other relevant members of the 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	This provision of the Settlement Agreement discusses the importance of carefully assessing the benefits, 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. For all of the records reviewed (100%), this documentation consisted of only limited discussion that the benefits of the medication outweighed the risks. This was followed by a brief listing of the most commonly known side effects of the medication, but did not include any indication of the likelihood of these side effects occurring, based on the published literature. The Facility primarily utilized pre-printed sheets for each	Noncompliance

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	harmful effects of psychotropic medication and whether reasonable alternative treatment strategies are likely to be less effective or potentially more dangerous than the medications.	medication, which were then attached to the corresponding document such as the PBSP or the Consent form for HRC review. These sheets listed two categories of side effects, including "common side effects" and "less common side effects." These sheets did not specifically identify "dangerous side effects" or "potential side effects that are especially relevant to the individual's medical history." Listing these sub-classes of side effects would improve the description of the risks of the potential medication side effects. It also would be useful if the clinicians could comment on any actual side effects that the individual might have experienced to date while receiving the medication. An example, which was randomly selected from the sample of records, was contained in the excerpt below from the "HRC Review of BSP" for Individual #43, with a review date of 7/13/10. This was typical of the documentation found in the remainder of the records. *BSP INFORMATION: (TO BE COMPLETED BY PSYCHOLOGIST)* *<u>Program Summary (to include restrictive/intrusive components)</u>:* *Target Behavior: Agitation, Aggression, and Bizarre Behavior* *Medications: Lithium, Risperdal, and Depakote* *The possible side-effects of each medication may be found attached to this addendum.* *<u>Justification</u>: On 06/22/10, [the doctor] and the Personal Support Team agreed that [Individual #43] continues to experience an increase in agitation, aggression, and bizarre behavior. The doctor recommended discontinuing Ativan, Haldol, Effexor, and Cogentin and adding Lithium, Risperdal, and Depakote as a psychotropic medication in order to assist [him]. [Individual #43's] current diagnosis is Bipolar Disorder, NOS. Verbal consent was obtained from the guardians on 06/22/10.* *<u>Less intrusive approaches previously attempted</u>: Verbal redirection.* *<u>Risk vs. Risk Analysis</u>: The risk of using Lithium, Risperdal, and Depakote to treat [Individual #43's] behavioral difficulties versus not using them could result in increased episodes of aggression. Without the medication [Individual #43] could be at risk of harming staff or peers when he becomes agitated and aggressive. There is also the risk of injury to [him] should a peer retaliate when [he] becomes agitated and makes negative statements or obscene gestures. Also, the risks of side effects from the medications are attached to the plan.* *<u>Plan to remove restriction/intrusive component</u>: The PST will meet with the consulting psychiatrist to determine the effectiveness of Lithium, Risperdal, and Depakote based on the frequency to targeted behaviors.*	

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		Agitation will be exhibited 2 or fewer times per month for 12 consecutive months, by September 2010. Bizarre Behavior will not be exhibited for 6 consecutive months, by September 2010. Aggression will not be exhibited for 6 consecutive months, by September 2010. As indicated in this discussion, the changes related to the "Risk vs. Risk Analysis" involved "discontinuing Ativan, Haldol, Effexor, and Cogentin; and adding Lithium, Risperdal, and Depakote as a psychotropic medication in order to assist [Individual #43]." The only evidence to support the utility of this combination of medication was provided by the subjective opinion that "not using them could result in increased episodes of aggression." The checklist at the bottom of this one-page document indicated that this plan, which involved the removal of three psychotropic medications (Ativan, Haldol, and Effexor), plus a side effective medication in the form of Cogentin and then replacing these medications with three new ones, including Lithium, Risperdal, and Depakote, was "approved" by the HRC. The HRC "Comments" section was left blank. 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 Annual Medical Summary and Physical Examination for Individual #33, dated 10/20/10, illustrated the terminology that was nearly identical in each individual's record. *Psychiatric Diagnosis upon admission to this facility is Impulse Control Disorder: [Individual #33] currently takes Seroquel as psychotropic medication. He will be followed in Psychiatry Clinic.* *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 Seroquel; 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 03-06-04, and their purposes for the use of Seroquel.* *2. After reviewing the psychotropic medication [Individual #33] takes, it is my determination that the benefits of the psychotropic medication outweighs the potential risk and side effects; that the use of the psychotropic medication as an integral part of [his] treatment program is appropriate; and that the use of this psychotropic medication is the least restrictive, clinically appropriate intervention for him.* *3. After reviewing the psychotropic medication [Individual #33] takes, it is my*	

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		determination that if he is not treated with psychotropic medication, this 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; the age and current physical status of this person; this person's non-psychiatric medical diagnoses and non-psychotropic medications; 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 of the listed psychotropic medication, etc., and find the following:* *A. There are no known non-psychiatric medical reasons 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 their current TXDADS drug formulary, (or PDR [Physician's Desk Reference]) recommended dosage ranges.* *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.* It should be noted that the Psychiatric Problem List for this Individual indicated that his Axis II. Psychiatric Diagnosis was "Mental Retardation, Profound." Under the heading of Mental Status Examination, the Psychiatric Consultation Note dated 10/25/10 stated, "he does not respond to my attempts to interact with him, other than to make some vocalizations that sound a bit like crying." Thus, it seemed doubtful that his PCP could have carried out a detailed risk versus benefit discussion with him related to the use of the antipsychotic medication Seroquel. As discussed with regard to Section J.13, ABSSLC did not yet have a system in place that could empirically and reliably document the efficacy of the individual psychotropic medications. The determination of efficacy, as well as the consideration of both the realized and potential side effects of the psychotropic medication(s), is essential to meaningful risk-benefit determination.	
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	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 June through December 2010, although no meetings were held in August or September of 2010. The following excerpt, from the minutes of the Psychotropic Polypharmacy Review	Noncompliance

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	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.	Committee meeting, which was held on 12/20/10 in the Infirmary Conference Room, listed the following individuals who typically attend this meeting: *Richard Chengson, MD, Stephen Pritchard, MD, Theresa Whitt, MD, Trina Cormack, MD, Marla Knight, Pharm.D., Patricia Lowrimore, MD, John Crowley, MD, Marcos Perez, Psychiatry Assistant, Scottie Myers, RN, David Salas, QMRP, Stacy Dow, Home Psychologist, Cathy Hennington, Chief Psychologist, Ron Manns, Behavior Analyst, Kimberli Johnson, MD* The format for the 12/20/10 meeting included one individual Case Study, which involved a detailed presentation of the individual's psychiatric status and history with regard to the current and past utilization of psychotropic medications. The individual's treating Psychiatrist led the discussion. This was followed by four discussions referred to as "Follow-up on previous Case Studies." The minutes suggested that these were brief, individual, case-centered reviews intended to monitor progress related to recommendations made during the initial Case Study. The 12/20/10 meeting convened at 4:10 p.m. and adjourned at 5:20 p.m. The meetings were held one Monday afternoon per month, as Monday was the day that both Consulting Psychiatrists were present at the Facility. The format for the 12/20/10 meeting was representative of the other meetings. 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 Pharm. D prepared the meeting minutes, which consisted of approximately three pages. Additional documentation regarding polypharmacy resided in the Quarterly Drug Regimen Reviews (QDRRs) 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 Psychiatrist was supposed to review the QDRRs for those individuals whose regimens met the criteria for polypharmacy. The review of the sample of records described above indicated that QDRRs by the Pharm. D. were current and had been completed quarterly for all of the 41 records reviewed. The format required that the Psychiatrist review and sign off on the reviews for those individuals who met the criteria for polypharmacy, and this requirement also had been met. Consistently, these reviews were found to be of a high standard. The Pharm. D. also recently had implemented a review of the documentation of each individual's Quarterly Psychiatric Consultation Note. This should further increase the feedback to the Treating Psychiatrist regarding issues related to the individual's	

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		psychotropic medication regimen, as well as progress toward decreasing the use of polypharmacy. The prior Monitoring Report contained a table that listed the number of individuals at ABSSLC who were being treated with multiple psychotropic medications according to the number of different medications. The current pre-onsite review document request for "Facility-wide data regarding polypharmacy including intra-class polypharmacy" produced the following response. "Not available at this time. Need clarification as to what is required." During the onsite review, the availability of data similar to that quoted in the prior Monitoring Report was discussed with the Pharm. D. She indicated such data was not available in that format, because the Pharmacy did not have the necessary software. It is possible that this verbal exchange represented a miscommunication with regard to the information requested, because it was available during the prior review. This subject will be pursued again for clarification during the next monitoring visit. Information was available for the total number of psychotropic medications utilized at ABSSLC, which was reported as the total aggregate number and the average number of psychotropic medications per individual. This data, which was presented in the form of a bar graph, indicated that the average number of "psychotropics per person" for the last three quarters of 2010 was as follows: Second quarter – 3.12; third quarter - 2.94; and the fourth quarter – 2.82. This data reflected that efforts, such as those observed during the Psychiatric Clinics to actively reduce the use of psychotropic medication, were having some effect on reducing the use of polypharmacy. However, continued work in this regard was necessary.	
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 on a quarterly basis, side effect monitoring be used for individual on psychotropic medication, such as the Monitoring of Side Effects Scale (MOSES) or DISCUS. The Health Care Guidelines further clarify that the DISCUS should be completed quarterly, and the MOSES every six months. To assess for compliance, a sample of 41 individual records (18 percent) of the individuals at ABSSLC who were receiving psychotropic medication during the on-site review of the Facility was reviewed. A review of the medical records for these 41 individuals yielded documentation that a MOSES evaluation had been performed every six months over the last year, and was current for all but one individual: Individual #478 (only MOSES for 11/3/10 was in the record). This would equate to a completion rate of 98%. As noted above, the Dyskinesia Identification System: Condensed User Scale (DISCUS) was to be performed on a quarterly basis for all of the individuals who received antipsychotic medication. The sample of 41 individuals indicated that documentation of	Noncompliance

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		current and quarterly evaluations for the last year could be identified for 35 of the 41 individuals (85%). Complete documentation could not be located for the following six individuals: Individual #11 (most recent exam 9/27/10; Individual #59 (most recent exam 10/7/10, and gap between 4/16/10 and 10/7/10); Individual #532 (gap between 1/25/10 and 6/29/10); Individual #293 (gap between 3/30/10 and 9/27/10); Individual #478 (the only exam in the record was dated 11/16/10); and Individual #263 (most recent exam 6/14/10). The DISCUS and MOSES also were performed for those individuals who were receiving Reglan. The rationale for this was that although Reglan was used to treat severe Gastro Esophageal Reflux Disease (GERD), it has dopamine-blocking properties that are similar to those of some of the antipsychotic agents and, thus, can produce extrapyramidal motor side effects. A list from the Pharmacy of all individuals who were prescribed Reglan was used to select a sample. The individuals who also received psychotropic medication were deleted, and a copy of the MOSES and DISCUS evaluations for the last year was requested for every fifth individual (20 percent). This process generated a list of the following five individuals: Individual #232, Individual #261, Individual #67, Individual #294, and Individual #53. The documentation provided in response to this request indicated that the MOSES had been performed every six months and was current for one (Individual #67) of the five individuals (20%). The results with regard to the remaining four were as follows: Individual #232 (none present); Individual #261 (current and quarterly, but none prior to 10/27/10); Individual #294 (exam 1/24/11 only); and Individual #53 (only the exam for 12/7/10 was present). The missing documentation in these four records made them incompatible with the criteria identified in the Settlement Agreement, as well as the Facility's policy. The review of documentation for the DISCUS assessments indicated that the DISCUS was current and had been performed quarterly for two of the five individuals (40%); Individual #67 and Individual #232. The evaluation status for the remaining three individuals was as follows: Individual #261 (current and quarterly, but none before 10/27/10); Individual #294 (1/24/11 only); and Individual #53 (11/2/10 only). The results would suggest that the Facility's system for ensuring that the MOSES and DISCUS were performed as required for individuals who received psychotropic medication was functioning, but was not ensuring that each individual had the necessary assessments completed timely. In addition, the corresponding mechanism for assessing the side effects of Reglan (which can include tardive dyskinesia) was not operationally sound. The observation that there was some data available for all of the individuals in the random sample would imply that there was a monitoring system in place. This process should be reviewed to ascertain how it could be enhanced so that, in the future, there is improvement in the completion rates for the MOSES and DISCUS for individuals	

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		who received Reglan.	
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 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.	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. Thirty-seven of the 41 records requested included relevant information to allow analysis of these factors. The Monitoring Team's request included the following sections of the medical records: <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-treatment sedation medication (i.e., Treatment Plan, Guardian Approval, HRC Approval, etc.); and* *16. The Human Rights section.* A description of the specific symptoms, which supported and documented the diagnosis of the individuals' psychiatric disorder, could be identified in 17 (46%) of the 37 records, including the following individuals: Individual #274, Individual #495, Individual #293, Individual #481, Individual #438, Individual #81, Individual #478, Individual #263, Individual #51, Individual #94, Individual #160, Individual #363, Individual #355, Individual #37, Individual #9, Individual #207, and Individual #375. These individuals tended to have higher cognitive functioning with major Axis I Psychiatric Disorders, such	Noncompliance

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		as Schizophrenia, Schizoaffective Disorder, or Bipolar Disorder. However, it should be noted that this information was often not present in an organized fashion. The need for ABSSLC to revise its documentation with regard to the justification for the psychiatric diagnosis to meet the Settlement Agreement requirements was discussed above in relation to Section J.2. That discussion also contains two specific clinical examples derived from the Comprehensive Psychiatric Assessments prepared in the newly adopted format. The individuals, for whom documentation of symptoms that would justify the psychiatric diagnosis could not be substantiated, tended to be those who had severe to profound levels of ID/DD and/or had a primary Psychiatric Diagnosis of either Autistic Disorder or Pervasive Developmental Disorder. They also generally manifested symptoms that were identified as being present on a behavioral basis elsewhere in the record. An example of this was found in the medical record of Individual #274, whose psychiatric diagnoses were Autistic Disorder, Severe, and Impulse Control Disorder. The Psychiatric Consultation notes did not describe the specific symptoms that would support the diagnosis of an Autistic Disorder, although his general level of functioning was consistent with this diagnosis. The terminology contained in the Settlement Agreement requires that a specific description of these symptoms be identified in the Psychiatric section of the record. In addition, Individual #274 was diagnosed with an Impulse Control Disorder. Again, there was no description of the specific symptoms that would support this diagnosis. The most consistently applied description of his behavioral presentation that appeared throughout the Psychiatric Consultation notes referenced his being "hyperactive and impulsive." A full discussion of the rationale for either diagnosis could not be identified in the record of Individual # 274. A related issue was the lack of documentation to link the monitored, target behavior to the identified symptoms of the psychiatric disorder. The primary behaviors monitored to assess the efficacy of psychotropic medication were aggression, self-injurious behavior, and agitation. The documentation in the records that provided a linkage between the psychiatric diagnosis and the target behaviors was identified in nine of the 37 records reviewed (24%). The individual records that contained this information were those of: Individual #94, Individual #136, Individual #363, Individual #37, Individual #9, Individual #207, Individual #495, Individual #293, and Individual #438. A potential remedy for this issue would be to clearly state, in the diagnostic section of the Comprehensive Psychiatric Assessments, 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. For example, a clear-cut symptom of a diagnosis of Schizophrenia could be the frequency of delusional ideation and/or hallucinations. However, the link between a diagnosis of Schizophrenia and aggressive behavior is less obvious and would require explanation regarding how that	

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		behavior was derived from the diagnosis of record. This issue was discussed with the Staff Psychiatrist during the onsite review, who indicated that an attempt would be made to distinguish between the "symptoms" of a disorder, as opposed to the "behaviors" that related to the diagnosis. As noted above, with regard to Section J.8, behaviors that were identified as target behaviors of the psychotropic medication also were frequently 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, which appeared in the Behavior Support Plan for Individual #384, dated 4/26/10, was as follows: *CURRENT STATUS* *A. <u>Target Behaviors</u>: Aggression, Self-Injurious Behavior (SIB) and Biting* *B. <u>Medications</u>: Celexa, Klonopin, Depakene, Lithium, and Naltrexone Consideration will be given to medication changes in relation to progress or regression in the criteria. Possible side effects of each medication may be found as an attachment to this Behavior Support Plan (BSP).* *C. <u>Revision and Reason</u>: This plan is being revised to coincide with [Individual #384's] annual Personal Support Plan (PSP). Revisions incorporating Speech Evaluation recommendation and word changes. On February 8, 2010, he was seen by the consulting psychiatrist where he was started on Naltrexone due to increased psychiatric targets.* *BEHAVIOR ASSESSMENT* *A. <u>Functional assessment</u>: An updated Behavior Assessment was done on February 10, 2010 utilizing the Functional Assessment Interview Form to provide a current functional (sic) of his targets. [He] has a psychiatric diagnosis (Impulse Control Disorder, NOS, Stereotypic Movement Disorder with self-injury and aggression and Pervasive Developmental disorder with Autistic features).* *The function of <u>SIB, Aggression and Biting</u> appears to be a form of communicating his frustration with requested daily tasks or setting events or at times a means to gain attention and/or to obtain tangibles. [Individual #384] often becomes aggressive to escape going to the Activity Center along with unscheduled routine daily task or activities. His aggression frequently occurs as a chain response, with agitation preceding a given event. When he is asked to perform daily task or engage in active treatment he will initially display agitation and when he is*	

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		redirected he will communicate his frustration using aggression normally towards staff's redirection. At times he may become aggressive towards his peers if they are in his immediate area. *<u>Setting event for aggression and biting</u>:* * *Aggression along with biting usually occurs as a result of not getting to do something he desires or when he is redirected continuously or intervene (sic) disrupt his impulsive routine activity.* * *Aggression is more likely to occur when he unable (sic) to obtain desired staff attention or tangle (sic) item.* * *When he is strongly encouraged to participate in activity treatment.* *<u>Setting event for SIB</u>:* * *Self injurious behavior usually occurs when he is frustrated with a situation and he will begin to bang his head on hard surfaces where he has caused serious injury to himself.* The Axis 1 psychiatric diagnoses for Individual #384, as identified in the Psychiatric Consultation dated 12/13/10, were Stereotypic Movement Disorder, with aggression and self-injurious behavior, as well as Pervasive Developmental Disorder, with autistic features. The "target behaviors" of the psychotropic medications described above were listed as "1. Aggression 2. Self-injurious behavior 3. Biting." Therefore, the target behaviors that were listed for the psychotropic medication were the same as those identified as being present on a behavioral basis. Another example, which suggested that the use of psychotropic medication was being used to treat behaviors that were described as primarily being present on a behavioral basis, was contained in the Behavior Support Plan of Individual #274, dated 1/12/10, as illustrated by the following excerpt from this document: *CURRENT STATUS* *A. <u>Target Behaviors</u>: Aggression, Leaving Without Proper Escort (LWPE), Property Destruction, Self-Injurious Behavior (SIB), Tantrums and Sleep Disturbance.* *B. <u>Medication</u>: Clonidine, Seroquel, and Trileptal. Consideration will be given to medication changes in relation to progress or regression in the objectives. Possible side effects of each medication may be found as an attachment to this plan.* *C. <u>Revision and Reason</u>: This Behavior Support Plan (BSP) has been updated in conjunction with [Individual #274's] Annual Personal Support Plan meeting.*	

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		Revisions for the plan this year will be minor changes in wording, and the adjustment of the behavioral criteria for the target behaviors of Aggression, Property Destruction and SIB. The behavioral criteria set for [Individual #274] last year were not attainable for him. The Sensory diet developed by the campus Occupational Therapist (OT) will also be included in the 2009 BSP. The sensory diet assists him in regulating his targeted behaviors. [He] will also continue to have 1:1 Level of Supervision due to his lack of safety skills (he will dart out in traffic), SIB and Aggression (he will hit peers or staff). *BEHAVIOR ASSESSMENT* *A. <u>Functional Assessment</u>: [Individual #274] has no verbal language and uses physical communication (such as grabbing the hand of staff and taking them to an activity, or placing their hands on his head for a head rub) and gestural communication to navigate his environment. At this time, Aggression, SIB, Property Destruction and Tantrums function as a means of communication. The targeted behavior of Aggression functions as communication of unwanted/unpleasant tasks, sensory needs, attention getting behavior, anger, and frustration. In previously reported incidents of LWPE, [he] has used LWPE as a play interactor of cat and mouse games or to explore his surroundings. Property Destruction functions to communicate displeasure or frustration and will occur with Aggression and SIB. SIB can occasionally be reduced with sensory activities. When [he] exhibits SIB, he will use walls and doors to thrust himself into and persist in banging his head against these objects when frustrated or agitated. Tantrum behavior is occurring during request for a transition into another activity. Some target behaviors may be reduced when [he] is provided sensory activities. [Individual #274] displays these behaviors less frequently when few or no demands are placed on him. The target behaviors usually occur in a sequential order when [he] might want to continue with an activity (playing with gears or sensory toys), or postpone an event (going to bed/changing activities), when he desires attention from staff members, and when he exhibits features of his diagnoses. In other instances, [Individual #274] seems to want a high level of attention, or wishes to communicate preferences by exhibiting aggressive, SIB, or tantrum behavior. He may wait for a busy time when attention is momentarily removed from him and then take advantage of that instance to engage in the target behaviors.* The Psychiatric Consultation for Individual #274, dated 1/10/11, identified the Psychiatric Diagnoses as "Autistic Disorder; severe," and "Impulse Control Disorder, NOS." The target behaviors of the prescribed medication included those that were described above as being present on a behavioral basis.	

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		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 seven of the 37 records (19%), including: Individual #11, Individual #94, Individual #136, Individual #363, Individual #207, Individual #293, and Individual #495. The following excerpt from the Behavior Support Plan for Individual #11, dated 1/20/11, provided an example that differentiated between behaviors that were related to a psychiatric diagnosis, and those that were thought to be present on a learned basis: *CURRENT STATUS* *A. Target Behaviors: Aggression, Psychotic-Like Behavior, Sleep Disturbance (psychiatric Symptom) and Verbal Hostility* *B. Medication: Trazodone, Ativan, Invega, Ambien, and Lithium Consideration will be given to medication changes in relation to progress or regression in the objectives. Possible side effects of each medication may be found as an attachment to this plan.* *C. Revision and Reason: This plan is being revised to coincide with [Individual #11's] annual Personal Support Plan meeting. Revisions include an updated functional assessment, a revised behavior criteria, revised behavioral definitions, revised behavioral interventions, and a revised replacement behavior. Verbal Hostility will be added as a target to better track precursors leading to actual physical aggression. All of these changes are consistent with the findings of the updated functional assessment. Sleep Disturbance will be tracked as a psychiatric symptom.* *BEHAVIOR ASSESSMENT* *A. Functional Assessment: [Individual #11's] psychotic-like behavior and Sleep Disturbance is (sic) related to his mental illness, as he has been diagnosed with Psychosis due to a general medical condition. [He] appears to respond to possible auditory and visual hallucinations, these behaviors are automatically reinforced. Aggression appears to function as a means of obtaining cigarettes.* *B. Preference Assessment: A reinforce (sic) assessment indicates that [he] likes drinking sodas, taking trips to the diner, going on trips into town, and taking naps. He further likes various edibles, money, and combs for his hair. He prefers not to participate in many social activities, and he prefers not to leave his home very often. [He] also enjoys receiving attention from certain staff.* The following excerpt from the Behavior Support Plan of Individual #363 also illustrated the differentiation between target symptoms related to the psychiatric disorder, and those present on a behavioral basis:	

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		CURRENT STATUS *A. Target Behavior: Pica, Obsessive-Compulsive Behavior and Hyperactivity* *B. Medication: Tegretol, Ritalin and Celexa* *Consideration will be given to medication changes in relation to progress or regression in the objectives. Possible side effects of each 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. None of the criteria for the target behaviors were met during the reporting year. All of the behavioral criteria will be continued for the next year. The name of Excessive Activity will be changed back to Hyperactivity as this is a more accurate description of the behavior. On October 6, 2009, Celexa was started on an emergency basis by the consulting psychiatrist with verbal consent from her guardian. This medication was added to her 2009 Behavior Support Plan through an addendum and will be included in the 2010 Plan. The Replacement Behavior Functional Use of Hands will be changed to Responding to Requests. This change is being made to provide a Replacement Behavior that can be easily measured.* *BEHAVIOR ASSESSMENT* *A. Functional Assessment: Formal and informal observations were conducted at various times in various activities. [Individual #363] was formally observed on her home on multiple occasions between August 3 and August 11, 2010 during morning and afternoon hours. Observations followed an ABC format. The Questions about Behavioral Function (QABF) was completed on August 20 and September 7, 2010, by 2 staff who know [Individual #363] well. The staff, one from each daytime shift, were interviewed regarding Pica, Obsessive-Compulsive Behavior and Hyperactivity. Both interviewed staff were nominated by supervisory staff as knowing [her] best. They indicated they had known and worked with [her] from two to five years.* *Both staff ranked Non-Social as the function of Pica, Obsessive-Compulsive Behavior and Hyperactivity. Observations were consistent with these findings. Whether [Individual #363] was alone, or with staff, doing nothing or participating in a leisure activity, she was observed to display both Obsessive-Compulsive Behavior and Hyperactivity. Simply being awake serves as a setting event for [her] Target behaviors. These behaviors can be observed in any circumstance; receiving attention from others or alone, participating in a preferred or new activity. The only time these behaviors do not occur is when she is asleep.*	

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		[Individual #363's] psychiatric diagnoses of Autistic Disorder, Obsessive-Compulsive Disorder and Attention Deficit/Hyperactivity Disorder do serve as setting events for her target behaviors. She does show the impairment in social interaction and communication and the repetitive, stereotyped patterns of behavior associated with Autism. Much of [her] time is spent performing time-consuming and repetitive compulsions. This characteristic behavior of Obsessive Compulsive Disorder is targeted due to its interference with her normal routine. [Individual #363] also displays the inattention, hyperactivity and impulsivity associated with Attention-Deficit/Hyperactivity Disorder. This example also utilized the concept of the psychiatric disorder serving as "setting events" for the "target behaviors." During the onsite review, this topic also was discussed with the Facility's Board Certified Behavior Analyst (BCBA). Although this concept was legitimate, it was often not adequate enough to convey the complexity inherent in the problem of differentiating between behaviors that were present on a learned or environmental basis, from those that were derived from a psychiatric disorder. The Psychology Department was aware of this and expressed an intention not to simply rely on the use of this terminology to solve the problem in the future. Again, the individuals for whom the dual classification of behaviors was not present 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 SIB, which could not be easily linked to the identified psychiatric disorder, and appeared to be significantly influenced by environmental and interpersonal factors. It is, of course, conceivable that a behavior could be related to an underlying psychiatric disorder and also be affected by environmental and/or learned factors. In those situations, where there is evidence to support that the behaviors have both biological and psychological 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 also might 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 Personal Support Team should reconsider the appropriateness of the continued use of those medications.	

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		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 information necessary for either the PST or an external reviewer to determine if the medications currently being utilized had been effective to a degree that justified their continued use. The only exceptions to this observation were contained in the records of the following three out of 37 individuals (8%): Individual #207, Individual #481, and Individual #438. A primary deficiency, in all of the records reviewed, was the lack of baseline data that could be compared to the contemporary data to determine efficacy of treatment. 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 more complex when multiple medications are prescribed and/or multiple changes are made in close temporal proximity to each other. Maintaining this type of detailed, longitudinal data also would be a reminder to 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 increased mathematical complexity that derives from making multiple changes in close proximity, and/or prescribing multiple medications for the same constellation of monitored behaviors, should be obvious. However, the visual presentation of this material in tabular and/or graphic format could facilitate the visual perception and recognition of this complexity. 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. This issue was discussed during the onsite review with both the BCBA and the full-time Psychiatrist. Given the status of behavioral data that was routinely carried forward in the record, the documentation of efficacy will require systemic changes. As illustrated throughout this section, the Facility was not in compliance with any of the components of this provision.	

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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 medications or restrictive procedures and shall identify associated risks.	The section of the medical record that contained the Informed Consents for the use of psychotropic medications was reviewed for the sample of 39 individuals whose records contained this information. This review indicated a completion rate of 100 percent. The individuals' Legally Authorized Representative (LAR) had signed consent documentation for 21 individuals (54%). The Facility Director or her designee had signed the Informed Consent forms for the remaining individuals who did not have a Guardian of the Person. Based on this sample, signed consent documentation was being obtained for individuals residing at ABSSLC who were prescribed psychotropic medication. However, the Risk versus Benefits discussions presented in relation to Section J.10, were so minimal and formulaic in nature that it was doubtful the information presented to the LAR or the Facility Director would have been sufficient to provide a truly informed decision. Another deficiency was that the consent forms represented blanket consents for all of the psychotropic medications that the individual was receiving, rather than addressing each one individually. There was also no documentation of a specific dose range for the medications being approved by the LAR or Facility Director. Changes are needed in relation to the risk-benefit considerations for the use of psychotropic medication. Such changes should make it possible to provide the necessary information to the LARs and Facility Director to enable them to make informed decisions regarding their approval for individuals' psychotropic medication.	Noncompliance
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 onsite review with the members of the Psychiatry Department, who indicated that the primary communication with the Neurologist was accomplished through written consultations. The new Staff Psychiatrist indicated that she could reach the Neurologist by phone, if necessary. During the onsite review, the Monitoring Team directly observed a consultation between the Psychiatrist and Neurologist involving Individual #250, who had recently been admitted to the Infirmary. A Neurology Consultation within the last year was identified in the records of 17 individuals. 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 prescribed for all of the individuals, in this sample, who had been seen for consultation within the last year. The Psychiatrists' signature or initials could not be located on any of the Neurology Consultation Notes. The Psychiatric Clinic Notes contained a reference to Neurological Consultation in five of these 17 records. However, the Psychiatry section was not present in the records of two of the individuals who had received a Neurological	Noncompliance

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		Consultation within the last year. Thus, reference to the Neurology Consultation was located in 5 of the 15 (33%) records that contained sufficient information to fully assess this factor. The Psychiatry Department recently had revised the format for the quarterly Psychiatric Reviews. The newly revised format included a mechanism designed to increase the Psychiatrist's recognition of recent Neurological Consultations, so that he/she could comment on the relevance of the Neurological Consultation, when appropriate. Specifically, the plan involved the Psychiatric Assistant or the Psychiatric Nurse including a review of the most recent Neurological Consultation with the information presented to the Psychiatrist at the time of the quarterly review. This new format was in the initial phases of implementation. The effectiveness of this mechanism for increasing the communication between the Neurologist and the Psychiatrists will be assessed during future reviews.	

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 justify the psychiatric diagnosis of record.
2. Documentation should be maintained to illustrate and confirm the link between symptoms of an identified psychiatric diagnosis and target behaviors of the psychotropic medication, such as aggression, agitation, and self-injurious behavior.
3. The Psychiatric Treatment Plan and the Behavioral Support Plan should clarify which behaviors are thought to be derived from the psychiatric diagnosis, as opposed to being present on a learned and/or environmental basis.
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 for pre-treatment sedation of 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 include the probability that the potential benefits of the medications will (or have) occurred. This discussion should include similar information with regard to the potential or realized side effects of the medications.
8. The documentation of a medication's specific dosage range, for which the LAR/Facility Director's consent is being sought, should also be included on the consent form.
9. Consent should be obtained for each psychotropic medication separately.
10. ABSSLC should continue its efforts to monitor and reduce polypharmacy with psychotropic medications, and document that progress. This will require improvements in the systems for identifying and monitoring the symptoms of psychiatric diagnoses, and prescribed medications effects on such symptoms.
11. The system for monitoring the side effects of psychotropic medication with the MOSES and DISCUS instruments should be continued and improved with regard to the monitoring of side effects produced by Reglan.
12. The Facility should develop strategies that will make it possible to empirically determine if a specific psychotropic medication has been useful

in reducing the symptoms of identified psychiatric disorders and/or the maladaptive behaviors that have been directly linked to that disorder.

13. A forum should be established for team members of the Psychiatry and Psychology Departments to engage in joint discussion regarding whether psychotropic medication represents the least intrusive approach for the individual's maladaptive behavior.
14. The Quality Assurance Compliance Reviews should include a reviewer(s) from the Psychiatry Department for those provisions that require an expert opinion as to the quality of the information present in the medical record, in addition to its presence or absence.
15. In addition, the Facility should identify the specific subject matter of the QA reviews referenced in their self-assessment materials, rather than simply citing the numerical results.
16. Specific policies and procedures derived from the requirements of the SA should be developed and implemented to guide the Psychiatric Department in their efforts to develop assessment protocols that are consistent with those specifications.

The following is offered as an additional suggestion to the State and Facility:

1. A new system is being implemented to increase the psychiatrists' recognition of the Neurology Consultations for the individuals they treat. It would be useful to empirically determine if this new process achieves the stated goal.
2. 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.

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 Book: Facility Initiatives; Settlement Agreement Cross Referenced with ICR-MR Standards; Reports from External Peer Review, including Summary of Recommendations and Services (11/18/10 to 11/19/10, 12/13/10 to 12/17/10, and 1/10/11 to 1/14/11); comments on Functional Assessment and Behavior Support Plan for Individual #132; comments on Structural and Functional Assessment Report and Behavior Support Plan for Individual #371; e-mail messages from M. Nosik (9/14/10, 11/21/10, and 12/21/10) and J. Pritchard (10/5/10) to R. Manns; Nightly Routine for Individual #274; Bathroom Protocol and accompanying data sheet for Individual #274; Discrete Trial Program (gross motor imitation) for Individual #274; Mastered Items Sheet; Time Procedure for Individual #387; Token System for Individual #387; Discrete Trial Teaching (motor imitation) for Individual 387; Plans for Structural Functional Assessments for three residences; Pre-Test for Applied Behavior Analysis (ABA) Group Supervision; Case Analysis Report (2/11); Action Plan for Improving Integrated Services/Supports for People Who Live at 6460; Training Objectives for Individual #218, Individual #287, and Individual #150 to access preferred activities; e-mail from J. Goza (9/5/10) entitled The Engagement Experience; e-mail from D. Feemster and J. Branch (9/27/10) entitled Engaging; e-mail from J. Goza and J. Branch (10/1/10) entitled The Engagement Experience; e-mail from J. Branch (10/5/10) entitled Improving Integrated Services/Supports; Note from R. Manns (1/27/11) regarding 6380; Frequency and Replacement Skills Data Collection Sheet; Total Task Chain data sheet; Positive Behavior Support Monitoring Tool and Reliability Probe; Behavior Support Plan Review Checklist and two samples of completed forms (case #5386 and case #5090); cover sheets/notes on Sections K.2, K.3, K.4, K.5, K.8, K.9, K.12, K.13, K.14, K.15, and K.16; Psychology Procedure for Assessing the Implementation of Positive Behavior Support Plans and Safety Plans; Psychology Procedure for Monitoring and Observations; Psychology Procedure for Assuring Effectiveness of Positive Behavior Support Plans (Monthly Progress Review); Positive Behavior Supports – Participant's Workbook; Leader's Guide – Core Competencies for Positive Behavior Supports; Core Competencies Skills Checklist; and The TEACH System – Coaching Staff for Positive Behavior Supports; o Abilene State Support Living Center's Plan of Improvement, Section K, updated 1/31/11; o Psychology Department Staff roster, dated 2/10 with updated information; o Psychology Department Organizational Chart; o Psychology Department chart of ABA coursework completed through the University of North Texas, dated 1/10/11; o Psychology Department Meeting minutes, from 8/19/10 through 1/13/11; o Human Rights Committee Meeting minutes, from 8/3/10 through 2/15/11; o Human Rights Committee Review of Behavior Support Plans for: Individual #250,

	Individual #140, Individual #274, and Individual #132; o Individuals with Positive Behavior Support Plans, updated 1/11; o Behavior Support Plans (BSP) for: Individual #178, Individual #501, Individual #164, Individual #123, Individual #43, Individual #74, Individual #184, Individual #105, Individual #476, Individual #242, Individual #6, Individual #509, Individual #371, Individual #76, Individual #303, Individual #347, Individual #276, Individual #505, Individual #104, Individual #286, Individual #49, Individual #201, Individual #318, Individual #293, Individual #330, Individual #153, Individual #140, Individual #247, Individual #313, Individual #274, Individual #301, Individual #198, Individual #332, Individual #405, Individual #486, Individual #149, Individual #8, Individual #471, Individual #94, Individual #539, Individual #370, Individual #525, Individual #83, Individual #469, Individual #5, Individual #102, Individual #148, Individual #388, Individual #146, Individual #510, Individual #132, Individual #339, Individual #357, Individual #11, and Individual #304; o Structural and Functional Assessment Reports (SFAR) for: Individual #123, Individual #74, Individual #293, Individual #153, Individual #523, Individual #98, Individual #5, and Individual #339; o Functional Behavior Assessments (FBAs) for: Individual #390, Individual #476, Individual #6, Individual #347, Individual #247, Individual #33, Individual #58, Individual #302, Individual #94, Individual #370, Individual #388, Individual #146, Individual #132, Individual #414, and Individual #11; o Behavioral Assessments for: Individual #220, Individual #228, Individual #108, Individual #505, Individual #450, and Individual #284; o Psychiatry Consultation Reports for: Individual #228, Individual #371, Individual #108, Individual #303, Individual #293, Individual #313, Individual #33, Individual #94, Individual #414, and Individual #304; o List of individuals receiving counseling/psychotherapy; o Individual Treatment Plans (counseling) for: Individual #163, Individual #517, Individual #81, Individual #48, Individual #231, Individual #8, Individual #58, Individual #130, Individual #102, Individual #396, and Individual #132; o Behavior Observation Notes and Scatterplot Data Sheets for: Individual #387, Individual #123, Individual #390, Individual #76, Individual #313, Individual #274, Individual #522, Individual #324, Individual #146, Individual #510, and Individual #284; o Behavior Observation Notes for: Individual #486; o Scatterplot Data Sheets for: Individual #140; o Psychological Updates for: Individual #138, Individual #328, Individual #390, Individual #371, Individual #438, Individual #272, Individual #293, Individual #330, Individual #140, Individual #274, Individual #94, Individual #359, Individual #33, Individual #102, Individual #384, Individual #132, Individual #264, Individual #341, Individual #51, and Individual #414; o Psychology Monthly Progress Notes for: Individual #371, Individual #293, Individual #330, Individual #94, and Individual #304;

	○ Behavior Support Committee meeting minutes, from 7/6/10 through 12/29/10; and ○ Training materials: Chapter 12; Shaping; Stimulus Control; Chaining; Motivating Operations; Behavior Support Training – Module 5, Functional Communication Training; Prompting Fading Training Behavior Support Technician (BST) (dated 7/29/10); Basic Behavior Supports Training for BST (dated 7/29/10); Discrete Trial Training BST (dated 7/29/10); and Teaching Functional Skills for QMRPs, Participant's Handbook (dated 1/28/11). ▪ **Interviews with**: ○ Ron Manns, Behavior Analyst, on 2/16/11; and ○ Psychology Department Staff: Joseph Abeyta, Victor Aguero, Samantha Brooks, Shana Carroll, Melissa Castillo, Stacy Dow, Stacia Ellison, Jason Fry, Linda Galvin, Jenni Jamison, Kathryn Jones, Amanda Liuzza, Connie Moss, Tiffany Neely, Julia Smith, Michael Smith, Adam St. Cyr, Sarah St. Cyr, and Barbara Strelow, on 2/17/11. ▪ **Observations of**: ○ Human Rights Committee Meeting, on 2/15/11; ○ Behavior Support Committee Meeting, on 2/16/11; ○ Restraint Reduction Committee Meeting, on 2/17/11; ○ Residence 5961, Residence 5962, Residence 5971, Residence 5972, Residence 6330, Residence 6350, Residence 6360, Residence 6370, Residence 6380, Residence 6390, Residence 6400, Residence 6450, Residence 6460, Residence 6480, Residence 6500, Residence 6510, Residence 6521, Residence 6690, Residence 6710, Residence 6720, Residence 6730, Residence 6740, Residence 6750, and Residence 6760; ○ Activity Center 5921, Activity Center 5922, Activity Center 5923, and Activity Center 6340; ○ Recreation and Senior Center 659; ○ Workshop 657, Workshop 662, and Workshop 680; ○ Personal Support Planning Meeting for Individual #227, on 2/16/11; ○ Unit 4 Incident Management Meeting, on 2/15/11; and ○ Unit 1 Incident Management Meeting, on 2/17/11.
	Facility Self-Assessment: The Facility's Plan of Improvement provided a brief outline of several steps that had been taken to meet the requirements of the Settlement Agreement. The one area where the Facility indicated it was in compliance with the Settlement Agreement was related to Section K.2, which requires the Facility to have a qualified Chief Psychologist. This was consistent with the Monitoring Team's findings. Ms. Hennington held an advanced degree in psychology, was licensed in the state of Texas, and had many years experience working with individuals with developmental disabilities. Progress towards compliance was noted in several other areas. The following provide examples of information included in the Facility's self-assessment that was consistent with the Monitoring Teams' findings: ▪ Fourteen of 18 members of the psychology staff were actively pursuing certification as behavior analysts. The one BCBA staff member was providing oversight and review of all behavioral assessments and resulting behavior support plans.

	▪ Improvements had been made to the peer review process. External consultants have been hired and have made at least three visits to the Facility to provide feedback and training to staff regarding individual treatment plans. The Behavior Support Committee continued to function as an internal peer review mechanism. ▪ Data collection remained a challenge. A revised process for ensuring reliability of data and ongoing progress was scheduled to begin in 2/11. Similarly, monthly review of individual progress was ongoing. ▪ As indicated in the Facility Initiative section of the POI, particular attention had been given to the completion of functional behavior assessment for those individuals with Behavior Support Plans. Psychology staff had outlined a schedule of completion of these assessments, with priority given to those with the most challenging problems or most resistant to treatment. A staff position had been dedicated to provide ongoing support to individuals in the form of social skills training, anger management training, and other group counseling activities. ▪ Working in conjunction with residence supervisors and external consultants, the psychology staff identified five core competencies related to implementation of Behavior Support Plans. Training on the following had been incorporated into New Employee Pre-Service Training: a) building a relationship; b) using reinforcement; c) pivot; d) simple correction; and e) engaging people. New employees were to demonstrate proficiency through role-play. Implementation of Behavior Support Plans with a high degree of integrity remained a challenge however. Staff training continued to be in the form of didactic instruction. A tool had been developed to begin providing feedback and on-the-job training to staff. In addition to providing some narrative descriptions of actions the Facility had or was taking to move towards compliance, the Facility included some data from its self-assessment reviews. This was an important step. However, it was not always clear specifically to what the data referred, making it difficult to determine if the Facility had accurately identified areas in which focused attention was needed to address the concerns that were keeping it from reaching compliance. For example, for Section K.7, which requires psychological assessments to be completed for individuals within 30 days of admission and as needed thereafter, the POI stated: "1/2011--Current monitoring results: 82% compliance from review of 92 records since 9/2010." Because the Facility did not provide any context to what this data meant, it could not be determined if the Facility had identified issues related to initial psychological assessments at the time of admission, ongoing psychological assessments, the timeliness of such assessments, and/or the quality of such assessments. The score appeared to be an overall score, which did not assist in providing direction for next steps, and likely could not have been calculated accurately given the monitoring tools being used. As the Facility moves forward in its self-assessment process, it will be important to ensure that data is used in meaningful ways to assist in identifying areas in which improvements are needed.
	Summary of Monitor's Assessment: The psychology staff were clearly committed to developing an expanded understanding and skills in providing behavioral support to the individuals served. The majority of Associate Psychology staff were actively pursuing certification in Applied Behavior Analysis, with ongoing support and supervision provided by the Behavior Analyst on staff. Internal and external peer review continued. Behavior Analysts consulting to the Facility provided on-site training to professional

	and direct support professionals. A commitment to timely completion of functional behavior assessments was evident during the visit. A timeline had been developed with particular emphasis placed on those individuals who presented with more challenging behaviors or who had demonstrated a resistance to intervention. Assessment relied heavily on staff interview and response to rating scales. Improved attention to direct assessment activities was needed. Using the information gained through assessment to develop enhanced Behavior Support Plans will be critical. Plans continued to lack depth with regard to training opportunities for replacement behavior, development of enriched daily schedules, and expanded access to a variety of reinforcers. The process for obtaining consents for revisions to Behavior Support Plans remained in need of change. Due to issues with obtaining consent, plan implementation was often delayed, resulting in a lack of appropriate services and support to the individual served. Consideration should be given to developing a hierarchy of intervention restrictiveness to help streamline this process. New employee training had been expanded to focus on core competencies that were important when working with the individuals residing at the Facility. Continued efforts will be needed to ensure that true competency-based training is provided to the staff as they work to support behavior change with the individuals served. Through observation, discussion with staff, and review of documentation, it was clear that collected data did not provide an accurate measure of individual behavior. Program implementation and data collection are directly related, and should be the emphasis for staff in the upcoming months. Both will be accomplished only through ongoing work with the direct service professionals.

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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	At the time of the visit, Catherine Hennington and Ron Manns remained in their positions as Chief Psychologist and Behavior Analyst, respectively. Although the Facility had not hired any additional Board Certified Behavior Analysts, staff already employed continued to make progress towards certification. As of January 2011, Ms. Hennington and one Associate Psychologist had completed three courses in Applied Behavior Analysis through the University of North Texas. The latter was enrolled in a fourth class for the Spring 2011 semester. A second Associate Psychologist had completed two courses and enrolled in a third. Ten Associate Psychologists had completed one course, nine of whom had enrolled in a second course for the current term. Lastly, three Associate Psychologists had enrolled in the first course for the Spring 2011 semester. This resulted in 14 of 19 (74%) of the Associate Psychologists actively pursuing certification. One additional staff member was reported to be taking a break from coursework with plans to enroll in the future. All of the Associate Psychologists had Master's degrees. Further support was offered to those enrolled through the provision of fours hours of educational	Noncompliance

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	and loss of skills, and to ensure reasonable safety, security, and freedom from undue use of restraint.	leave each week, which had been announced at the Psychology Department Meeting held on 1/31/11. The State and Facility are commended for their ongoing support of staff who are pursuing certification as behavior analysts. Mr. Manns remained the only Board Certified Behavior Analyst at the time of the visit. This provision item was rated as being in noncompliance, because the professionals in the Psychology Department were not yet demonstrably competent in applied behavior analysis 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 Settlement Agreement.	
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. Hennington remained as the Chief Psychologist. Ms. Hennington held an advanced degree in psychology, was licensed in the state of Texas, and had many years experience working with individuals with developmental disabilities. She had served in this role since 1997. It is the Monitoring Team's understanding that she was planning to retire at the end of March. The Facility is encouraged to conduct a nationwide search for a doctoral-level licensed psychologist who is also board certified in behavior analysis.	Substantial Compliance
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.	The Behavior Support Committee continued to provide internal peer review. Based upon the consent data and meeting minutes provided, it appeared that this group reviewed every Behavior Support Plan. This committee was scheduled to meet weekly, during which time psychologists presented Positive Behavior Support Plans (PBSP) to colleagues and supervisors. Observation of the meeting held during the week of the on-site review reflected active participation by committee members. Review of the meeting minutes from July through December 2010 indicated that most of the discussion related to the use of restrictive procedures, specifically medication (93 of 111, or 84% of the specific reviews noted, excluding restraint discussion). These meetings should focus on the content of the PBSPs, with notes reflecting specific changes made to these plans. Using the information gained from the functional behavior assessment, staff should focus their efforts on identifying appropriate replacement behaviors, ensuring adequate training opportunities for the same, identifying a range of prevention and antecedent management strategies, strengthening reinforcement schedules, and outlining individualized consequences. As noted at the Psychology Department Meeting held on 9/30/10, two consultants had been hired to provide external peer review. Josh Pritchard and Melissa Nosik, both BCBA level practitioners, had begun providing feedback to the Facility staff as early as July 2010. Since that time they had completed the following activities: ▪ Provided feedback on a Structural and Functional Assessment Report and	Noncompliance

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		corresponding Behavior Support Plan for Individual #371; ▪ Provided feedback on a Functional Assessment and corresponding Behavior Support Plan for Individual #132; ▪ In November 2010, provided on-site support and written feedback regarding programs for four individuals; ▪ In December 2010, provided one week of on-site training with follow-up written feedback to the staff working in Residence 6700; and ▪ In January 2011, provided one week of on-site training with follow-up written feedback to the staff working in Residence 6380. Psychology staff are encouraged to follow up on all recommendations the consultants made by providing ongoing support and training to direct care professionals. Objective data should be collected on a regular basis to ensure that treatment changes are implemented with a degree of integrity, and to allow for an analysis of the efficacy of the same.	
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 revised promptly if target behaviors do not improve or have substantially changed.	As noted in the last report, steps had been taken to improve the collection of data used to measure identified target behaviors. Data sheets were being used that allowed for measures of frequency, percent occurrence (e.g., partial interval), and/or severity of the response. Staff also were plotting data separately for individual target behaviors, allowing for a clearer analysis of the efficacy of the treatment plan. There remained significant concerns regarding the accuracy of the data collected. A review of Behavior Observation Notes and corresponding Scatterplot Data Sheets was completed. Information gathered from the end of January through the third week of February was reviewed for a total of 12 individuals. While there was overall agreement between these two tracking mechanisms, there remained concerns related to the accuracy of the data. Comments regarding the data for specific individuals are provided below: ▪ Individual #123: His data sheets reflected self-injury occurring three times between the hours of 6:00 a.m. to 10:00 p.m. across 16 days. As this person spends most of his time alone in his room, the accuracy of this data is questionable. ▪ Individual #390: This individual had two targeted problem behaviors, aggression and self-injury. The instructions on the scatterplot read: "Record the frequency of the target behavior in the left hand box for the interval if the behavior occurred at any time during that interval. Use simple hash marks to indicate each episode as defined in the Behavior Support Plan." However, although it was clear from reading the Behavior Observation Notes that this individual engaged in repeated self-injury, only one mark was indicated where noted on the scatterplot. Thus, this data significantly underestimated the	Noncompliance

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		frequency of this serious behavior. Where self-injury was observed, correspondence between events (not frequency) noted in the notes and on the data sheet was 100% for eight of 10 days. The other two days reflected 75% and 86% correspondence. An additional concern was raised by the absence of data for large blocks of time or even shifts. Although not a data issue, staff should be cautioned to avoid offering a magazine or golf cart ride contingent upon self-injury (i.e., notes from 2/15/11). ▪ Individual #313: On several of the scatterplot data sheets, an "X" was drawn across five to seven half hour blocks of time. This one mark used to note the absence of the target behavior over two and one-half to three and one-half hours suggested that staff were relying on recollection to record data. Data should be recorded as the target behavior occurs. During three days, target behaviors were recorded in the notes, but not on the scatterplot. Unless the psychologist is going to check both documents, the data that is presented graphically will not be accurate. Staff should choose one method of data collection and then train staff to proficiency. ▪ Individual #324: The notes reflected occurrences of rectal digging, a behavior that was not addressed in the behavior support plan. Consideration should be given to adding this behavior to the definition of self-injury. While the scatterplot directions indicated that the frequency of aggression was to be recorded, there were several days during which the notes reflected repeated aggression, but the scatterplot reflected one occurrence. Again, this suggested that the data used to assess progress was inaccurate. Twice, it was noted that this individual "stole" the coke or coffee that a staff member was consuming. As noted elsewhere, a standard policy should be considered where staff are allowed to eat and drink only when the individuals are enjoying a snack or meal as well. A significant indication of data inaccuracy was found in the January 2011 Psychology Progress Note for Individual #387. Three target behaviors (aggression, self-injury, and tantrums) were all noted to have increased in frequency. The explanation provided was that this was "… most likely due to BCBA visiting for a week and using a counter." This clearly addressed and acknowledged the inaccuracy of the data typically collected by Facility staff. During the on-site review, there were numerous occasions when individuals were observed engaging in problem behavior. When the data sheets and observation notes were checked for several of these individuals, there was a clear discrepancy between what was observed and what was recorded. For example: ▪ On 2/14/11, Individual #387 was observed engaging in repeated aggression towards staff shortly after 5:00 p.m. However, his observation notes suggested that he was calm during the hour between 5:00 p.m. and 6:00 p.m.	

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		▪ Similarly, the notes for Individual #274 indicated that he had a good evening with only a little aggression. This same individual was observed just after 5:00 p.m. tossing his food to the floor and then resisting the staff member's efforts to have him clean up. ▪ While visiting the residence of Individual #76 on the morning of 2/15/11, she was observed displaying aggression towards the staff. A check of her scatterplot data revealed no occurrences of aggression. ▪ Lastly, Individual #390 was observed engaging in repeated self-injury around noontime on 2/14/11. His scatterplot data sheet indicated that this behavior occurred once during the 30-minute interval between 12:00 p.m. and 12:30 p.m. While data sheets were not provided for Individual #486, there were daily comments in the notes that this individual engaged in repeated eye poking behavior. This potentially dangerous behavior had been removed from his Behavior Support Plan. Staff should consider placing this back in his plan. A concern also was noted in that staff had provided the individual access to preferred activities when he refused to go to work (i.e., notes from 2/16/11). Psychology staff had initiated monthly review of progress on identified problem behavior. The monthly progress notes for five individuals were reviewed. Graphs depicting occurrences of targeted behaviors each month were provided. This was followed by a summary of behavioral events. The purpose of this summary was unclear as every occurrence of the targeted behavior was not noted (e.g., Individual #371) or no significant events were noted even though the behavior had worsened significantly (e.g., self-injury for Individual #330). Medication changes were then noted. Lastly, recommendations were provided. Concerns remained regarding this review of progress, because in no case were changes to the Behavior Support Plan recommended. For example: ▪ The five monthly progress notes for Individual #371 concluded with statements that she had "…not met established criteria for progression of her Behavior Support Plan," and "…no recommended medication changes at this time." ▪ Similar statements were provided in the six monthly progress notes for Individual #330. ▪ With the exception of a change in one target behavior, the five monthly progress reports for Individual #304 contained similar statements. Monthly reviews will be functional only if they are used to guide changes to the behavior support plan to result in improved behavior.	
K5	Commencing within six months of the Effective Date hereof and with	As is discussed with regard to Section K.6, a sample of 16 psychological assessments and updates were reviewed. Of the 16 psychological assessments sampled, all (100%)__	Noncompliance

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	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.	contained information regarding the individual's intellectual and adaptive behavior functioning levels. Currently, only one (6%) individual within this sample had information suggesting that standardized tests of IQ and Adaptive Behavior had been completed within the last five years (i.e., Individual #274). The majority of individuals (63%) participated in these tests over 10 years ago. An additional individual had his last intellectual testing completed within the previous 10 years, but his last adaptive behavior assessment was completed over 20 years before. ICAP information was not included in these psychological updates. The Psychology Staff had clearly placed a priority on the completion of functional behavior assessments for individuals with identified problem behaviors. The Facility should be commended for these efforts. Since the last Monitoring Team visit, 15 assessments had been completed as noted on the list the Facility provided of Individuals with Structural Functional Assessment. An additional 15 assessments completed within the last six months were included in the documents provided. Therefore, it appeared that the list provided by the Facility had not been updated at the time of the on-site review. The assessment reports continued to follow the standard format noted in previous Monitoring Team reports. While the information provided was comprehensive in its scope, staff should focus their efforts on determining the hypothesized function(s) of the behavior(s) and providing recommendations for the Behavior Support Plan (BSP) based upon these findings. While this information was provided, it was often found after first reading through detailed information that was not essential to the purpose of this particular report. While prenatal and early developmental history might be interesting, this information was not useful in determining the current function of identified problem behavior. Likewise, detailed histories of psychotropic medication were minimally relevant to the individual's current presentation. A simple listing of current medications would be more appropriate. Past variables were also quite lengthy in some cases, offering little information relevant to the individual's current needs. By omitting this non-essential information, these reports could be greatly streamlined, and would more effectively provide information related to behavioral function. When information was provided regarding the assessment activities, many of the plans provided detailed information regarding the feedback staff provided. Greater emphasis should be placed on descriptive assessment (i.e., direct observation), rather than on indirect assessment as provided by rating scales and interview. Fifty-two percent of the assessments reviewed included a description of what was observed. The other plans either noted that the target behaviors were not observed, provided incomplete descriptions of what was observed (i.e., the consequences provided following the target behavior were not noted), or provided a summary of a "typical" behavioral episode.	

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		While staff who work directly with the individual certainly can provide valuable insight, the information gleaned from observing in situ will give a more objective and accurate description of the setting events, antecedents, and consequences for the target behavior. In addition, a succinct summary of findings would prove helpful, followed by general recommendations addressing replacement behavior(s), antecedent strategies, reinforcement contingencies, and planned intervention when the behavior(s) is exhibited. Comments regarding specific assessments are provided below: ▪ Individual #123: The conclusions offered in this individual's report were clear and concise. One suggestion would be to avoid using labels such as tactile defensiveness. Rather, it would be helpful if the individual's observable behavior was described. Recommendations for the individual's BSP should be tied to the identified setting events, antecedents, and consequences. Accurate data collection will remain difficult as this individual spends much of his time alone in his room, without a staff member present. ▪ Individual #74: This individual's report provided an example of in-depth review of his early developmental history that had limited relevance to the purpose of the assessment. The inclusion of his daily schedule was helpful in that it reflected very little variety to the activities offered, and minimal opportunities for the development and/or expansion of functional skills. The psychologist skillfully identified intermittent reinforcement as an important variable in maintaining the individual's problem behavior. ▪ Individual #390: This individual's report included a helpful, in-depth description of what was observed during the direct assessment. ▪ Individual #476: Staff noted the dates of their observations, but indicated that no problem behaviors were observed. Staff should ensure that they are present to observe difficulties, so that they can gain a better understanding of the variables maintaining the problem behavior(s). Additional observations would have been appropriate. ▪ Individual #6: This report included a synopsis of the information gained through observation. A detailed narrative of what was observed would strengthen the report. Setting events and antecedents were clearly summarized. ▪ Individual #228: There was a clear recognition of health care matters that affected this person's behavior. Prevention strategies outlined in the recommendation section were clear and thoughtful. ▪ Individual #347: This report contained extensive historical information regarding psychotropic medication that contributed little to the understanding of the function of the target behaviors. Similar to other reports, the individual did not display target behaviors during the psychologist's observations. These observations should be rescheduled so that direct assessment is completed. ▪ Individual #505: This report included several pages of detailed history. For the	

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		purposes of this assessment, a succinct summary of critical events would have been more appropriate. While it was reported that observations were completed, there was no explanation of what was observed. This information is critical to the functional behavior assessment. ▪ Individual #293: This report reflected medical variables that impacted the individual's behavior. There was also a brief review of some of the past behavioral interventions that had been applied in an effort to improve behavior. ▪ Individual #523: An observation was conducted in the workshop area during which time the psychologist collected objective data. This data was skillfully summarized in the report. This report also included guidelines for using differential reinforcement of low rates to reduce the individual's repetitive requests to staff. ▪ Individual #94: This report provided a clear summary of observations and several thoughtful recommendations. ▪ Individual #370: The report identified medical issues that were important considerations when providing support to this individual. Missing was a description of a formal observation conducted by the psychologist. While information gleaned from informal observations over a six-month period was summarized, this information was dependent upon recall. Also included in this report were detailed summaries of evaluations that were not relevant to the purpose of this assessment. ▪ Individual #98: This report included a good narrative description of the observations completed by the psychological assistant and psychologist. ▪ Individual #5: This report included a succinct summary of setting events, antecedents, and consequences. Based on the findings of the report, staff should not reduce this individual's morning schedule. It would be more beneficial to focus on improving and enriching her afternoon schedule. ▪ Individual #388: This report provided a clear summary of the psychologist's observations and guided staff to consider this individual's medical conditions. ▪ Individual #132: This report also provided a clear summary of the psychologist's observations. ▪ Individual #284: While formal observations were completed, there was limited information provided in the report. The response to the individual's self-injury was not identified. ▪ In some cases, the individual's diagnosis of autism was cited as a setting event (e.g., Individual #74 and Individual #153). There are three core deficits/characteristics that are considered when making this diagnosis. However, each person presents with behavior patterns that are unique to him/her. Assessments should focus on the observable behaviors that the individual exhibits, and then outline recommendations to support positive behavior change.	

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In one assessment (Individual #523), the psychologist noted her title as behavior analyst. Staff should not identify themselves as such until they have obtained the necessary certification. Doing so, prior to credentialing, implies, intended or not, that one has met all the necessary qualifications.
Consideration should be given to streamlining the report to only include information that is relevant to the purpose of the assessment. One suggested format would include the following: a) identifying information (e.g., name, date of birth, date of admission, diagnosis, date of assessment, date of report, and person completing the report); b) reason for referral; c) brief profile of the individual with particular attention placed on his/her communication abilities; d) identified target behaviors, operationally defined, with corresponding data collection methodology; e) assessment procedures; f) assessment results, including a narrative description of direct observation; g) identification of setting events, antecedents, and current consequences; h) hypothesized function(s) of the behavior(s); and i) recommendations for supporting behavior change. Watson and Steege (2003) provide a format and several examples.
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<tr><td>K6</td><td>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.</td><td>
Psychological updates for 16 individuals were reviewed. The format for these reports was consistent across individuals. Background information, including reason for referral, functioning levels, diagnoses, identified problem behavior, and medications were noted first. In the body of the report, background information was provided, including early developmental history, and a review of current abilities. Past and current variables were next described, behavior outcomes were stated, and the reports ended with a summary and recommendations. The last time a full psychological evaluation had been completed for these individuals ranged from four years to 26 years. Below is a table providing specific information:
<table>
<tr><th>Individual</th><th>Date - Update</th><th>Date - Last Full Evaluation</th></tr>
<tr><td>Individual #138</td><td>1/21/99</td><td>1/15/90</td></tr>
<tr><td>Individual #371</td><td>7/31/10</td><td>2/15/90</td></tr>
<tr><td>Individual #438*</td><td>9/27/09</td><td>8/14/01</td></tr>
<tr><td>Individual #272</td><td>12/18/09</td><td>11/9/98</td></tr>
<tr><td>Individual #293</td><td>9/9/10</td><td>12/12/88</td></tr>
<tr><td>Individual #330</td><td>8/5/10</td><td>10/24/88</td></tr>
<tr><td>Individual #140**</td><td>5/27/10</td><td>10/1/96, 10/31/96</td></tr>
<tr><td>Individual #274*</td><td>8/17/10</td><td>1/9/06</td></tr>
<tr><td>Individual #359</td><td>2/20/03</td><td>5/3/01</td></tr>
<tr><td>Individual #33</td><td>1/3/10</td><td>4/5/88</td></tr>
<tr><td>Individual #94</td><td>9/29/10</td><td>1991</td></tr>
<tr><td>Individual #384**</td><td>1/15/10</td><td>2/5/01, 9/25/88</td></tr>
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</td><td>Noncompliance</td></tr>
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<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
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<tr><td>Individual #132*</td><td>8/31/10</td><td>8/25/05</td></tr>
<tr><td>Individual #264</td><td>12/15/09</td><td>1/31/83</td></tr>
<tr><td>Individual #341</td><td>8/9/07</td><td>11/25/96</td></tr>
<tr><td>Individual #414</td><td>12/1/10</td><td>1/10/86</td></tr>
</table>
* These three individuals were school-aged at the time of their psychological update. In all three cases, evaluations were overdue according to the federal Individuals with Disabilities Education Act (IDEA) mandate and Facility policy, which required that evaluations be completed once every three years for students.
** The two dates refer to a cognitive evaluation and an adaptive behavior assessment, respectively.

In all but two cases (Individual #438 and Individual #140), there was a statement indicating that there were no “clinically significant changes” in the person’s functioning levels since the time of the evaluation. To suggest that an individual had not changed over the course of time was to imply that all efforts at habilitation had been futile.

Several changes to these reports should be considered. First, developmental history should be brief, focusing on critical variables, such as significant illness or change in health, early trauma, change in diagnosis, or something similar. Second, a brief review of the individual’s history with regard to home, school, and work environments should be provided. The individual’s date of admission to the Facility should be included. Again, any significant changes in medical or health status, including hospitalizations, should be included. Included in the review of current adaptive skills, the following domains should be addressed: communication, social, self-care, domestic, leisure, academic, vocational, and community skills. The focus should be on the individual’s strengths and areas of need. When describing past variables, the focus should be placed on the behavioral and habilitative services that have been provided to the individual since his/her admission to ABSSLC. Strategies that resulted in positive behavior change (as related to both skill acquisition and problem behavior reduction) should be highlighted. When known, ineffective strategies should also be reviewed. It is suggested that an emphasis on environmental variables that support positive behavior change would be particularly useful in the recommendation section. With regard to current variables, it would be helpful to provide an overview of the individual’s regularly scheduled involvement in activities both on and off the residence, including community integration. A brief review of positive behavior supports would also be helpful and appropriate for this update. Finally, the Facility should conduct psychological evaluations at a minimum of once every five years. Measures of adaptive behavior are recommended annually.
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<tr><td>K7</td><td>Within eighteen months of the Effective Date hereof or one month</td><td>Nine individuals were admitted to ABSSLC between 8/9/10 and 1/5/11. Psychological updates were requested for the eight individuals who were still in residence at the</td><td>Noncompliance</td></tr>
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	from the individual's admittance to 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.	Facility. Information regarding seven individuals was provided, however, updates were provided for only five (71%). The psychological updates for Individual #390, Individual #495, Individual #450 (a functional behavior assessment), and Individual #444 had been completed within 30 days of admission. The update provided for Individual #51 had been completed four months prior to his apparent re-admission to the Facility. Individual #37 did not have an updated psychological report, although she had been admitted to the Facility in November. Individual #261, admitted in October, also did not have an updated psychological evaluation. Within the information the Facility provided to the Monitoring Team, a note was included indicating that the individual did not have a prescription for psychotropic medication, nor did she have a behavior support plan. Neither of these are acceptable reasons for the absence of an updated and current psychological evaluation. For those admitted without recent full psychological evaluations, staff should complete a comprehensive assessment of the individual's strengths and needs. 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.	According to the documentation provided, a total of 23 individuals were scheduled to receive counseling. Therapists not employed by the Facility provided these therapy sessions. Sixteen of these 23 individuals were provided weekly sessions on campus, with the remainder traveling off-site for biweekly therapy sessions. Individual treatment plans were provided for 10 individuals. While goals were stated for each individual, none (0%) were described in observable and measurable terms with clearly established criteria for determining progress or the lack thereof. Two goals for Individual #231 did indicate the weekly frequency with which she was to engage in pleasurable activities and social interactions, however, the duration of her engagement was not specified. For others, specific counseling goals corresponded to similar goals in their Behavior Support Plans, but were not directly linked to provide objective measurement. Examples included: ▪ Individual #8: One objective of counseling was to alleviate her depressed mood. Objective measures of this could possibly be found in a reduction of her withdrawn behavior, as targeted in her BSP. ▪ Individual #102: His BSP included a goal to reduce noncompliance. This could possibly provide objective data to support his counseling goal to comply with rules and expectations. ▪ Individual #132: One goal of counseling was to terminate all acts of violence. The data collected on aggression in his BSP could provide evidence of progress. Designing goals so that outcomes are stated in objective and measurable terms is	Noncompliance

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		necessary to allow for clearer assessment of progress, and efficacy of treatment. The responsibilities of one Associate Psychologist had been revised since the last visit. Rather than serving as a residential psychologist, she was now scheduled to provide ongoing support to identified individuals through anger management training, group therapy activities, etc.	
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. Notwithstanding the foregoing timeframes, the Facility Superintendent may grant a written extension based on extraordinary circumstances.	Behavior Support Plans for 55 individuals, representing 23% of the 242 residents of ABSSLC identified with plans, were reviewed. The format was consistent across all plans. Each section is addressed below. The heading on each plan identified the individual, his/her dates of birth and admission, and current residence. In every case, the plan number was identified by a year, such as 2010. In only 36 (65%) of the plans reviewed was there an implementation date. While this might have been left blank awaiting appropriate consents, it is strongly recommended that the date of plan development be provided. This will allow staff to discriminate current from outdated plans, and also will allow for a historical record of interventions, both successes and failures. The first section, entitled "Current Status," provided identification of the target behavior(s), a listing of current medication, and a review of revisions made to the plan. Although the target behavior was listed, absent from this section was the operational definition of the target behavior, and method of measurement or data collection system. It should be noted that this information was provided, in most cases, later in the existing plan. To streamline these plans, the information should be re-organized so that the reader has a clear understanding of the targeted problems and the manner in which they are tracked. All plans in which medication was prescribed included a statement indicating that changes would be considered in relation to the progress or regression observed. While objective measures of psychiatric symptoms would be useful when reviewing the efficacy of medication, the focus of the Behavior Support Plan should be on environmental strategies that can be identified to help promote positive behavior change. The "Revision and Review" section often indicated that the plan was being revised in conjunction with the annual PSP, a review of medication changes was provided, and/or updated assessments were referenced. A broad rationale for intervention was provided in only 22 (40%) of the plans reviewed. This section might be better utilized if a rationale for the necessity of a plan were provided. Comments regarding this section of specific plans are provided below: ▪ Individual #371: This section was brief, yet provided relevant information regarding changes to identified target behaviors, replacement behaviors, and	Noncompliance

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		diagnosis. ▪ Individual #153: This section was concise and provided a brief overview of some of the changes made to his plan. ▪ Individual #74: There was statement indicating that this individual's current reinforcement schedule had been applied inconsistently and was not effective. If the intervention had not been applied with a high degree of integrity, it was not clear how it was determined to be ineffective. ▪ Individual #313: This individual was noted to become bored with daily activities, yet her reinforcement plan was scheduled to change every 90 days, alternating between two chosen reinforcers. A change every three months was very likely not going to be sufficient in addressing boredom issues. ▪ Individual #486: It was noted that his pushing and grabbing staff served as a communicative response, and, therefore, were considered positive skills. These were removed as problem behaviors. Neither of these behaviors is socially acceptable, and a focus should be placed on teaching this individual a better way to obtain staff attention. Eye poking also was removed from this person's plan, because it was not considered dangerous, and he was observed to stop when told to do so. Again, poking one's eye is not socially acceptable, and, more importantly, it is a potentially very dangerous behavior. ▪ Individual #357: There was a note that she previously had demonstrated improved behavior when staff were providing attention at set times, prompted by a MotivAider. Her behavior had since significantly worsened, but there was no recommendation to re-introduce this reinforcement system. ▪ Individual #469: This plan provided an example of appropriate revisions, including the development of a Safety Plan and the introduction of a more dense schedule of reinforcement. The next section of the plans included a description of activities and outcomes from recent Functional Behavior Assessments, and a list of identified reinforcers. To streamline this section, staff should indicate the date(s) of completion of the FBA and then provide a clear statement regarding the hypothesized function of each targeted behavior. While all but one plan (98%) addressed functional assessment, the plans sometimes provided a lengthy review of the actions that were taken to complete the FBA. This information is better stated in the FBA itself. The goal should be to help those implementing the plan understand the relationship between the perceived purpose the target behavior has served and the proposed intervention. Examples of succinct statements regarding the findings of the FBA were included in the plans for Individual #153, Individual #8, Individual #471, Individual #539, Individual #525, and Individual #388. Although reinforcers were identified in every plan, it remained unclear whether the individual's preferences were determined through formal assessment or were identified by staff. Clarification of this matter would strengthen the plan.	

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		Baseline data were reported, as were behavioral criteria for the upcoming year. In most cases (87%, and 89% respectively), this information was stated in observable and measurable terms. Areas where problems were noted included the following: ▪ In nine plans, baseline data was either missing or was incomplete. For example, for Individual #178, Individual #476, Individual #6, Individual #149, and Individual #11, target behaviors were reported as a specific number for a specified period of time. It was unclear whether these numbers represented frequency, and if so, whether this was a total number of occurrences or a monthly average. Baseline measures had not yet been collected for Individual #405. The baseline data for Individual #486 was recorded as an average number of intervals per month, but the interval duration was not identified. ▪ With regard to treatment outcome, behavioral criteria were stated for the "reporting period," but this period was not identified (e.g., Individual #178, Individual #76, Individual #149, and Individual #8). Outcome criteria had not yet been established for Individual #318. For Individual #486, criteria for head hitting was identified as a set number of intervals or less, but interval length was not noted. Most of the plans reviewed (96%) included operational definitions of identified problem behaviors and guidelines for data collection (89%). Below are comments regarding specific BSPs as related to this section: ▪ Individual #6: The operational definitions for aggression and emotional outburst included descriptors of both the target behaviors and other behaviors that were not to be considered in the definition (i.e., non examples). This resulted in a clearer definition of the target behavior. ▪ Individual #104: The definition for disruptive behavior included touching others, as well as going to the bathroom or water fountain more than three times per shift. These behaviors might not be members of the same response class. ▪ Individual #11: Topographically, verbal hostility and psychotic-like behaviors were defined as raising his fist in the air and gesturing to the air, respectively. The discrimination between the two might very likely be unclear. ▪ Individual #247: His self-injurious behavior was defined employing descriptors of hitting or biting himself. Further review of the plan also suggested that he used items as weapons to harm himself. This information should be included in the definition. ▪ Individual #94: This person's plan offered a good example of how to record a partial interval time sample for several target behaviors. ▪ Individual #123: Staff were directed to record the frequency of self-injurious behavior. However, this individual spent most of his time alone in his room. Without direct observation of the behavior, measurement of the behavior will not be accurate.	

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		▪ Individual #184: Staff were advised not to record data in the individual's presence. This suggested that staff would need to recall the occurrence of problem behavior at a later time, leading to measurement inaccuracy. ▪ Individual #509 and Individual #198: Staff were directed to record a maximum of one mark per time interval on scatterplots, yet baseline and outcome data was reported as average frequency of occurrence. ▪ Individual #505: Similarly, staff were instructed not to record more than two occurrences of any problem behavior within the time interval on the scatterplots, yet baseline and outcome data were reported on the number of occurrences. ▪ Individual #104: It was noted in the documentation section that much of this individual's target behaviors occurred in the workshop. Workshop staff were advised to contact the residential staff when behaviors occurred so that the scatterplot data could be completed. This is one more step in a process that will likely contribute to missing and inaccurate data. An alternative would be for the workshop staff to have their own data sheets. ▪ Individual #357: Staff were directed to record data "…according to directions on the chart." This did not allow the reader of the plan to understand the measurement system employed to track behavioral occurrences. The identification of replacement behaviors remained a challenge. Although all plans included an identified behavior(s) or activity in this section, rudimentary operational definitions were provided in 50% of the plans. Plans that included clearer descriptions of the replacement behavior included the following: ▪ To escape demands, Individual #74 was learning to say "No" in response to a task request. ▪ To learn to relax, Individual #184 was encouraged to walk around the circle (outside his residence), close his eyes and take deep breaths, or count, among other responses. To be measurable, specific criteria regarding the duration of each of these responses should be included. ▪ To gain attention, Individual #6 was learning to call a staff member's name, to request attention from a staff member, or to approach a staff member. ▪ To request a break, Individual #293 was learning to respond: "I don't want to," or "I don't like that." Other plans included broad descriptions of identified replacement behaviors that were neither observable nor measurable. Examples included the following. ▪ Individual #501: His plan included sing sign language, communication board, gestures, pointing, and leading staff to his wants and needs. ▪ Individual #49: The plan included showing discomfort and allowing staff to correct the situation causing the discomfort.	

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		▪ Individual #201: The plan included responding to relaxation training steps by relaxing and cooperating with requested task. While training packets indicated that staff received instruction on identifying replacement behaviors that were efficient, effective, and less effortful in obtaining the same outcome as the target behavior, there were several examples where it was difficult to understand the relationship between the replacement behavior and the hypothesized function of the target behavior. Examples included the following: ▪ Individual #123: The function of aggression was identified as escape from touch. One replacement behavior was learning to wear a brief. While this was an important skill for him to learn, it did not offer him an alternative to escape interaction with others. Wearing a brief might have been more appropriately addressed in the prevention section. ▪ Individual #303: His target behaviors were hypothesized to serve the function of obtaining tangible reinforcers, yet his replacement behavior was identified as following his activity schedule. It would be important to ensure that this individual had an appropriate method for telling others when he wants something. ▪ Individual #247: One of his target behaviors was stealing. As this was a behavior that resulted in his obtaining tangibles, it would appear that an appropriate replacement would be teaching him to request items. However, the identified replacement behavior actually described a differential reinforcement contingency (i.e., obtaining an item for the absence of stealing). While this was a good component to his plan, it would be better placed in the prevention section. ▪ Individual #486: His replacement behavior was identified as accepting alternate sensory stimulation. However, the function of his problem behavior was identified as primarily a means to escape or avoid unwanted situations. It would be better to teach him an appropriate escape response. ▪ Individual #525: His replacement behavior was defined as responding to questions from staff. It would be more beneficial if this individual could learn to spontaneously request staff attention. ▪ Individual #102: This person displayed noncompliance when asked to complete a non-preferred task. However, his replacement behavior did not include support or training in requesting a break or negotiating a sequence of activities. While plans for teaching replacement behaviors advised staff to ask him whether he needed a break, requests for breaks should be under his control. Consideration should be given to teaching him that he can request, at his discretion, a specified number of breaks across a specified period of time. Teaching of identified replacement behaviors was often insufficient. For several individuals, they were provided one opportunity per shift to learn and/or practice their	

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		replacement behaviors. This limited training will severely impact timely acquisition of important skills. Examples included the following: ▪ Individual #184 was going to be given an opportunity to practice relaxation techniques once per shift. ▪ Individual #104 was to sit down once per shift with staff to use a communication book or board to convey his wants, needs, or feelings. Once per shift did not offer sufficient training opportunities. ▪ Individual #318 was scheduled to have one opportunity per each daytime shift to work on his anger management skills. ▪ Individual #330 was to engage in appropriate activities once per shift. ▪ Individual #313 was to participate in an activity and practice "calming" once per shift. Further, when she refused to go to work, she was to choose something to do. Several of the examples provided might have been potentially reinforcing activities, thereby, reinforcing her work refusal. ▪ One skill Individual #405 was to learn was to ask for attention appropriately. Staff were directed to provide a training opportunity once per shift. ▪ Once per shift, Individual #539 was to be given the opportunity to learn problem-solving skills, and appropriate attention-seeking skills. Other specific areas of concern are addressed below: ▪ Individual #178: Staff report indicated that this individual's self-injurious behavior was likely maintained by automatic reinforcement. Staff were directed to keep this individual engaged in activities that involved the use of his hands. Teaching guidelines noted that once every hour the individual should be offered an activity. If he chose to stop participating, that was acceptable and he would be prompted again in the next hour. Edible reinforcement was to be offered "occasionally." These guidelines did not provide a clear and systematic plan for increasing engagement. ▪ Individual #123: One of two replacement behaviors was to use a button to request food or drink. In the teaching section, staff were told to use hand-over-hand assistance to teach him to use the button during meals and snacks. Bites of food or sips of liquid were to be provided contingent upon his using the button. It is inappropriate to make his meal contingent upon requesting food or drink, particularly as touch from others was also identified as an aversive stimulus. ▪ In some cases, replacement behaviors were appropriate to the function of the target behavior(s), but the teaching of the replacement response did not promote independence. For example, Individual #105 engaged in problem behavior to obtain tangible reinforcers. He was to learn to ask for items he wanted. However, rather than teaching spontaneous requesting, staff were advised to ask him three times per shift what it was he wanted. ▪ Individual #286 was encouraged to use his verbal communication skills.	

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		However, staff were directed to ask him to repeat himself if he could not be understood. If he then became frustrated, they were advised to prompt him to "Stop, take a deep breath, and try again." It might be more beneficial and effective to teach this person to use an augmentative system (such as a communication book), to help clarify his speech. ▪ For Individual #274, included in this section was a statement that he should use his Picture Exchange Communication System (PECS) card. This should be reworded to indicate he will use a picture/icon card. PECS refers to a formal communication training system (Bondy & Frost, 2001). Also in this section were guidelines for teaching him to request something to do following an incident of vomiting or a toilet accident. As written, there was a significant risk of strengthening a chain of behaviors in which the target behavior occurred, personal hygiene was addressed, and then the person accessed a highly preferred activity. ▪ Individual #301 was learning to walk away when others might be agitated. She was to be given a dollar for displaying the behavior, but only if staff observed it. If she reported that she had walked away, she was praised, while reminded that staff needed to observe the behavior. This severely limited the likelihood that this person will learn to walk away spontaneously and independently. ▪ The guidelines for teaching Individual #510 to ask for a break directed staff to provide the individual a break after two attempts, even if she had not displayed the sign. As written, there was no need for the person to learn a new form of communication, because breaks were provided regardless of her behavior. The breadth of direction offered in the prevention section varied from plan to plan. Some plans reflected consideration of setting events that had been identified in the functional behavior assessment, while others clearly recognized the impact of medical conditions. Feedback regarding specific plans is provided below: ▪ In the case of Individual #6, there were several good recommendations that reflected careful planning to avoid problem behavior. These included providing newspapers at different times of the day, and responding to behavior that had been identified as precursors to problem behavior. ▪ The prevention section in the plan for Individual #371 offered some clear and simple guidelines for staff. These included to not repeatedly state the individual's name as this annoyed her, offering multiple opportunities to listen to Spanish music or watch Spanish television stations, offering alternative activities when work was not available, and observing for behavior patterns that were indicative of her experiencing pain. ▪ In some cases, there might have been a medical or health issue that contributed to the target behavior. For Individual #471 and Individual #388, there was consideration given to dry, itchy, or healing skin that possibly contributed to the	

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		occurrence of self-injurious behavior, particularly in the form of scratching. For both these individuals, lotion was provided at prescribed times. In other cases, this was not addressed in the prevention section. For example, Individual #178 was noted to use towels or other material to remove scabs. Consideration needed to be given to the discomfort that can be caused by healing skin. ▪ In some cases, the purpose of strategies outlined in the prevention section was unclear. For example, in the case of Individual #164, staff were advised to: "Identify any body movement and give it a variety of consequences." When this individual turned his head to the left, staff were told to brush his hair, put a radio next to him, or push him in front of a window. It was unclear how this would help develop a functional response for this person. ▪ As a preventative action for Individual #276, staff were advised, on the first signs of agitation including slapping his head, to move him from a loud environment to the quiet of his room where he could watch television or listen to the radio. This was potentially reinforcing his self-injurious responding. ▪ Staff were told to have Individual #104 stand when he was in the workshop to prevent the occurrence of problem behavior. If his job was one that typically was completed while seated, this would clearly be a violation of his rights. ▪ Staff were directed to try to engage Individual #318 in activities immediately following a family visit. While staff are commended for recognizing this situation to be difficult for the individual, the recommendation would have been strengthened had specific activities been listed. A reduction in demands and increased interaction with staff might also prove helpful. Also included in this individual's prevention section was advice to staff not to eat in front of the individual. This expectation should be standard across the Facility. ▪ Individual #486 was noted to have allergies. If symptoms were observed, staff were advised to contact the nurse. This represented an appropriate consideration of health care needs. One suggestion would be to consider regular medication should these allergies be seasonal. Staff should consider teaching this individual an alternative means of gaining attention, rather than responding to grabbing and pushing as an acceptable means of communication. ▪ The plan for Individual #132 had guidelines for the use of a weighted vest with the rationale that this "… will help regulate his sensory system and keep him focused…" Unless there is objective data to support this statement, it should not be included in the BSP. The efficacy of sensory integration strategies has yet to be documented in the research literature (see National Autism Center, 2009). ▪ Individual #339 was noted to display emotional outbursts when he could not go to work, or when he observed peers eating ice cream. While staff were told to provide a warning regarding workshop closings and offer a choice of desserts, the plan would be strengthened if alternatives to work were outlined, and if desserts that were similar to ice cream (e.g., sherbet) could be provided, if	

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		possible. The vast minority of plans (13%) included schedules of reinforcement that were sufficient to promote positive behavior change. While point systems were employed with several individuals, the exchange took place only once per week. For individuals who displayed serious problem behavior, more frequent access to tangible reinforcement for appropriate behavior is recommended. Depending upon the total number of points earned, individuals could enjoy a trip on- or off-campus. Those who took part in this point system included Individual #43, Individual #184, Individual #303, Individual #247, Individual #313, Individual #405, Individual #149, Individual #94, Individual #539, Individual #102, Individual #339, and Individual #357. Two others who were earning points had different schedules of exchange. Individual #301 could exchange his points twice weekly, while Individual #469 could exchange his on a daily basis. While these plans reflected improvements in the point system, unless a significant positive change in behavior is observed, an enriched schedule of reinforcement should be considered. The overall availability of reinforcement was very limited. Comments on specific plans follow: ▪ Individual #501 was to receive five minutes of attention for the absence of aggression. ▪ Individual #276 had individual supervision, yet his plan advised that he should be praised once hourly for the absence of target behaviors. A more enriched schedule of reinforcement, involving a variety of tangible reinforcers should be implemented. ▪ Individual #318 was scheduled for reinforcement with an edible reinforcer once per shift, as long as he had not exhibited any problem behaviors. ▪ Individual #247 was to be rewarded with a preferred item once per shift, as long as he did not have others' belongings, or had not hidden any items in his pants. ▪ Individual #313 was noted to be easily bored. Yet, her plan called for a change in the reinforcement plan every 90 days, alternating between two chosen reinforcers. Further, she was able to earn "visitation" coupons during the day. It remained unclear how this functioned as a reinforcer, because this person was observed moving about the campus, frequently visiting with others without the exchange of a coupon. ▪ The plan for Individual #149 indicated that she could trade tokens for toiletry items. This should be clarified to ensure that her access to personal hygiene items was not dependent upon appropriate behavior. ▪ If the weekly reinforcement trip for Individual #94 was cancelled due to his being off campus or ill, inclement weather, or the unavailability of behavior support services, it was not to be rescheduled. If this individual had acquired the points necessary for a trip, the trip should have been provided. ▪ Individual #539 was scheduled to earn one dollar per day as long as he engaged	

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		in four out of five appropriate behaviors. While money might be motivating, this remained a very lean schedule of reinforcement. ▪ Individual #469 was to receive positive attention for at least five minutes every half hour. He was also to receive an edible reinforcer for exhibiting no more than one target behavior over a two hour time period. He was also able to earn a trip off campus every day contingent upon a predetermined number of stickers. This plan reflected a much richer schedule, and more varied use of identified reinforcers. Treatment procedures were consistently described clearly and fully. However, these often appeared to be generic interventions, which were not tailored to the specific needs of the individual. Many of the plans reflected standard procedures to follow when the individual displayed a problem behavior. For example, in 26, or 47%, of the plans, the individual was told to stop the behavior, and then if he/she did not comply, staff would make an effort to separate the individual from his/her peers. There was the potential for these consequences to strengthen the identified problem behavior(s) as attention and escape from loud or crowded environments were often noted as reinforcers. Other plans included consequences that clearly could produce a strengthening of the identified problem behavior. Examples included the following. ▪ Individual #501: Contingent upon aggression, staff were to explain to this individual that his behavior was not appropriate, and then ask him if something was wrong. As attention was identified as a reinforcer, this attention might in fact strengthen his aggressive responding. ▪ Loud environments were identified as unpleasant for many individuals. Yet, their plans indicated that contingent upon identified target behaviors, they were to be directed to a quieter environment (e.g., Individual #74 and Individual #476). ▪ Individual #74: The plan suggested that use of papers for coloring was a highly preferred activity. One identified problem behavior was sleep disturbance. While the guidelines were written very clearly, staff were told to give this individual paper, when he was awake during the overnight shift. It would appear that this contingency would result in a strengthening of his sleep disturbance. ▪ Individual #347: Contingent upon self-injury, staff were directed to ask this person to stop the behavior, and then direct her to her preferred chair or a change to a quieter environment where she could watch television. These activities were noted to be reinforcers. ▪ Individual #505: Staff were advised to ask questions, or offer a range of activities/items before his self-injury became "injurious." The criterion for such non-injurious behavior was not identified, resulting in staff potentially reinforcing this problem behavior.	

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		▪ Individual #330: Included in the consequence for self-injury was an opportunity for this person to sit in front of a fan, hold a vibrating pillow, or listen to the radio, which all were identified as preferences. ▪ Individual #198: One identified preference was a quieter environment with sufficient personal space. Yet, contingent upon aggression and biting, he was to be offered a quieter area. ▪ Individual #539: Inappropriate sexual comments were identified as an attention seeking behavior. The consequence for this behavior was to tell him the comment was inappropriate, thereby providing him attention for the behavior. ▪ Individual #525: Contingent upon aggression, he was to be told why his behavior was inappropriate, and then be moved to a different environment, where he could listen to music. Both attention and time in his room listening to music were identified preferences. ▪ Individual #148: Contingent upon self-injury, the individual was told to stop. If he did not cease the behavior, several options were available to him, including placement in a rope swing or access to Maracas to manipulate, which both were identified as preferences. Comments on two other plans are provided below: ▪ Individual #303: Staff were told that if this person had made a mess, he would be asked to pick things up. It was unclear whether this was optional. In order to avoid inconsistency across staff, guidelines should clearly indicate what steps are to be followed. ▪ Individual #313: The BSP provided to the Monitoring Team included personal restraint. This should be removed from the plan. The list of individuals with restraint in their BSPs indicated that a Safety Plan had not yet been developed for this individual. This should be completed as soon as possible. Psychology staff should not to use misleading terms in BSPs. For example, direct support professionals were advised not to use "bribes" to encourage Individual #476 to return to the residence. This term implied that the use of reinforcers to improve behavior is ethically questionable. Staff also should not use the individual's diagnosis as an explanation for observable behavior. For example, Individual #242 was described as hyperactive and impulsive with a short attention span due to his autism. None of these characteristics are included in the diagnostic criteria of this disorder (American Psychiatric Association, 2000). Rocking was identified as a characteristic of autism for Individual #509. A need for consistent routine and limited interest in activities were noted to be possible features of the person's autism diagnosis for Individual #303 and Individual #505. While these characteristics might be observed in these individuals, this does not preclude their learning to tolerate change or to develop an interest in a greater range of activities. Individual #276 was noted to have a diagnosis of pervasive development disorder. Staff were told that characteristics of this disorder include short	

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		attention span, impulsivity, self-injurious, and aggressive behavior. Professional staff should not misrepresent the characteristics of a disorder, or suggest that behavior cannot change as a result of a disorder. The author of the plan was identified in 20 of the 55 plans (36%). None of the plans were signed. It is strongly recommended that all plans be signed, indicating the author and any supervisory staff who provided review. The Human Rights Committee maintained a regular schedule of weekly meetings. Minutes of 23 meetings held between 8/3/10 and 2/15/11 were reviewed. In the majority of the meetings (17, or 74%), members present included the human rights officer, a parent or non-affiliated member, a psychologist, and a nurse. During three meetings, a psychological assistant was required to review BSPs, behavior therapy addenda, and plans for sedation. Due to the nature of these issues, at a minimum, a master's level psychologist should have been present. When a psychologist was present, he/she was responsible for reviewing plans that another psychologist had authored. As observed during the meeting attended by a member of the Monitoring team, this resulted in limited ability to address questions raised by other committee members. It is highly recommended that the psychologist who works directly with the individual be the person presenting the plan(s). During this same time period, there were two meetings held without a nurse or medical personnel in attendance. As noted previously, a member of the medical staff should be present when the discussion focused on medication matters. Finally, one meeting held during this time period lacked the presence of a family or non-affiliated member. As one purpose of the HRC is to ensure that practices are in accordance with community standards, a review should be completed with regard to membership and quorum criteria. There are two minor points with regard to the form the HRC used to review behavior support plans. First, there was a question regarding the use of aversive therapy. As this was not an approved intervention, consideration should be given to deleting this from the form. Second, there was a question regarding the completion of a functional analysis. As most assessments completed to determine the possible function served by identified problem behaviors did not include systematic manipulation of different contingencies, it would be more appropriate to question whether a functional behavior assessment had been completed. This review of the HRC practices raised further concerns with regard to timely consent. During the meeting conducted the week of the Monitoring Team's visit, there were several PBSPs presented that had been drafted several months' earlier (determined by the baseline data). The individual and the date of their PBSPs are provided below: • Individual #250 – August 2010;	

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		• Individual #140 – July 2010; • Individual #274 – August 2010; and • Individual #132 – October 2010. Additionally, a review of the document "Individuals with Positive Behavior Support Plan," dated 1/11, revealed that consent was not obtained from the HRC within 30 days for 54 (22%) of the 242 individuals with plans. In some cases the delay was less than a week past 30 days (e.g., Individual #366, Individual #120, and Individual #545), but in other cases the delay was several months (e.g., Individual #276, Individual #49, and Individual #439). A hierarchy of treatment restrictiveness should be developed and used as a guide in identifying necessary consents. A hierarchy of restrictiveness could help expedite the review process ensuring that PBSPs are implemented and amended as necessary in a timely manner. Lastly, consents for the introduction or change in medication should be the responsibility of the prescribing psychiatrist and his/her staff. It should be noted that the summary psychology staff provided identified the date consent was obtained from the Behavior Support Committee and the Human Rights Committee. It would be beneficial to include the date that consent was obtained from the individual, and/or his/her guardian.	
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.	Data collection and treatment implementation were two areas that require ongoing attention. Although the Psychology Department had introduced monthly review of progress, graphs continued to display monthly averages. As noted during the baseline on-site review, 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. At the time of the Monitoring Team's review, inter-observer agreement (IOA) for PBSP data was not being collected. This was consistent with previous findings during the previous visits. As a result, the accuracy of the data could not be assured. As discussed above with regard to Section K.4 of the Settlement Agreement, there were concerns related to the collection of accurate and reliable data. As presented in previous Monitoring reports, the availability of data that PSTs can have confidence in is essential in ensuring that teams are making effective data-based decisions. 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 residences, activity centers, and vocational settings.	Noncompliance

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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.	All of the plans reviewed contained interventions that were clearly written. Behavioral terms (e.g., DRO, time out, response cost) were avoided and consequences were clearly described. There were several examples where the plan could have been enhanced with objective descriptions of staff behavior. For example, several plans advised staff to redirect the individual (e.g., Individual #405, Individual #486, Individual #539, Individual #388, and Individual #510). These plans would have been enhanced had this "redirection" been operationally defined. Other plans included instructions using a "deep, firm, and calm tone of voice (e.g., Individual #76 and Individual #303). Again, operational definitions and examples of these staff responses would have improved the plans. One plan (Individual #539) advised staff to be "…mindful of their posture, body language, and tone of voice," while another suggested that staff use a "… matter-of-fact tone of voice." A description of specific, observable responses by the staff would have greatly improved the clarity of interventions. One plan (Individual #74) advised staff to encourage the individual to pick up any messes he made. It remained unclear how the individual was to be encouraged or whether he was required to clean up. To help staff clearly understand the steps they should take to support positive behavior change, it will be important to write plans that clearly describe all aspects of the plan. Two or more people should be able to read the plan and then know exactly how they should respond. Observations that occurred during the last on-site review indicated that staff asked the individual to stop engaging in the problem behavior, tried to determine what the person wanted (often offering various items or changes in environments), or expressed concern regarding the behavior. Steps were also taken to reduce harm to the individual or others. These steps were standard patterns of behavior displayed by staff regardless of the individual's specific Behavior Support Plan.	Noncompliance
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.	While new employee training had been expanded to include a review of five core competencies, psychology staff reported that training of staff on Behavior Support Plans remained a challenge. It was difficult to schedule time for staff to be free of other responsibilities. As noted below, the introduction of a monitoring tool will help the psychology staff give structured feedback to the direct support professionals who are providing support and training to the individuals served. Specific changes to this tool are suggested below. Additionally, the Psychology Department is encouraged to recruit the participation of direct support professionals in the weekly Behavior Support Committee meeting. This will afford an opportunity for them to not only give input on the plan, but also to identify potential difficulties with the plan's implementation. Additionally, as noted in the last report, psychology staff should continue to provide more in-depth training on Positive Behavior Support to new employees. Training should include the following: a) possible functions of problem behavior; b) identification and teaching of replacement behavior; c) identification and application of reinforcement; d)	Noncompliance

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		antecedent strategies; and e) interventions that can be applied contingent upon the target behavior. Psychology staff provided a copy of the "Positive Behavior Support (PBS) Monitoring Tool & Reliability Probe." The tool was divided into four sections: a) observation; b) integrity; c) reliability; and d) scoring. The observation section allowed psychology staff to provide feedback to direct support professionals regarding their interactions with individuals, including their provision of support for and training of replacement behaviors, and their appropriate response, as outlined in the individual's Behavior Support Plan (BSP), to target behaviors. As this tool is used, it might be appropriate to expand the descriptions of staff behavior to include appropriate implementation of preventative strategies and reinforcement contingencies. The integrity section required staff to accurately describe components of the BSP. Caution is advised, because treatment integrity is best measured through observation rather than interview. Similarly, the reliability section indicated that staff could accurately describe methods of data collection. Again, inter-observer agreement can only be determined through simultaneous and independent observation, and recording by two or more observers. The check to ensure that collected data is current will be helpful in providing feedback to staff. While this tool was a useful first step in developing a competency-based training system, the Facility will need to take additional action to ensure that staff are able to demonstrate skilled implementation of BSPs, as they provide support and training to the individuals served.	
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 Psychology Department at ABSSLC consisted of a master's level Chief Psychologist, one master's level Board Certified Behavior Analyst, 18 master's level Associate Psychologists, nine Psychology Assistants (one of whom had a bachelor's degree), 19 Behavior Services Team staff, and one Clerk. There were no vacancies. The Facility was providing services to 447 individuals. Based on the 18 Masters-level Associate Psychologists who carried caseloads, this resulted in an average ratio of approximately one to 25. Although the number of Associate Psychologists exceeded the ratio identified in the Settlement Agreement, as noted with regard to Section K.1 of the SA, this provision was rated as in noncompliance because the professionals in the Psychology Department were not yet demonstrably competent in applied behavior analysis as evidenced by the absence of professional certification, as well as by the quality of the programming observed at the Facility. As noted in Section K.1, the majority (74%) were actively pursuing certification. The ratio of Psychology Assistants to Associate Psychologists adhered to the established standard.	Noncompliance

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

1. The State and Facility should continue to support Psychology staff who are pursuing their Board Certification. As vacancies arise, individuals who are Board Certified Behavior Analysts should be recruited for these positions. As noted previously, consideration should 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. With regard to the Behavior Support Committee, greater focus should be placed on behavioral interventions included in Behavior Support Plans. This committee should function as a staff training mechanism, particularly through ongoing discussion and consideration of data collection systems, appropriate and adequate training of replacement behaviors, expanded preventative strategies (including the provision of enriched environments), stronger and more varied schedules of reinforcement, and individualized consequent strategies. Direct support professionals should be recruited to participate in the weekly meetings of this committee.
3. To support the important activities the external peer review consultants completed, Psychology staff should ensure that continued support and training is provided to staff as they implement the recommended changes.
4. As recommended previously, revisions to the structural functional assessment process and report format should be made. Greater emphasis should be placed on information gathered through direct observation, and when conducted, functional analysis. Consideration should be given to streamlining the report to only include information that is relevant to the purpose of the assessment. One suggested format would include the following: a) identifying information (e.g., name, date of birth, date of admission, diagnosis, date of assessment, date of report, and person completing the report); b) reason for referral; c) brief profile of the individual with particular attention placed on his/her communication abilities; d) identified target behaviors, operationally defined, with corresponding data collection methodology; e) assessment procedures; f) assessment results, including a narrative description of direct observation; g) identification of setting events, antecedents, and current consequences; h) hypothesized function(s) of the behavior(s); and i) recommendations for supporting behavior change. Watson and Steege (2003) provide a format and several examples.
5. 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.
6. Data collection systems should be revised to ensure that accurate data is collected on identified target behaviors. With the introduction of new data systems, discussion should be ongoing with the direct support professionals to obtain information about the usefulness of these systems and staff confidence in collecting the required information. Inter-observer agreement measures should be collected on a regular basis.
7. 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.
8. With regard to the content of the plans:
    a. PBSPs should include the date of plan development, as well as date of implementation;
    b. The "Current Status" sections should include the operational definition of the target behavior, and method of measurement or data collection system;
    c. The "Revision and Review" section should include a rationale for the necessity of a plan;
    d. To streamline the assessment section of the plans, staff should indicate the date(s) of completion of the FBA and then provide a clear statement regarding the hypothesized function of each targeted behavior;
    e. Lengthy reviews of the actions that were taken to complete the FBA should be removed from the BSPs, and a succinct statement included, the goal of which to help those implementing the plan understand the relationship between the perceived purpose the target behavior has served and the proposed intervention;
    f. Professional staff should not misrepresent the characteristics of a disorder, or suggest that behavior cannot change as a result of a

disorder; and

g. All plans should be signed, indicating the author and any supervisory staff who provided review.

9. Behavior Support Plans should be developed with greater emphasis placed on:
    a. Teaching of replacement behaviors with adequate opportunities for learning, particularly functional communication skills;
    b. Expanded antecedent and preventative strategies;
    c. 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
    d. 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.
10. With regard to the Human Rights Committee:
    a. When PBSPs are presented, the master's level psychologist who works directly with the individual should present the plan;
    b. A member of the medical staff should be present when the discussion focused on medication matters; and
    c. Given that one of the purposes of the HRC is to ensure that practices are in accordance with community standards, a review should be completed with regard to membership and quorum criteria.
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. 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. A system should be developed for assessing and monitoring inter-observer agreement for PBSP data. Psychology staff could begin to complete this assessment during daily visits to residences, activity centers, and vocational settings.
13. Efforts should be made to reduce the redundancy of information provided in reports. Graphs were presented in functional behavior assessment and safety plans. While graphic presentation of current levels of behavior is important, this information is not necessary in either of these documents. Likewise, historical information was provided in the functional assessment and the psychological update. Templates for reports should be developed so that the purpose of each report is clearly addressed with limited overlap across reports.
14. Psychology staff should continue their efforts to work closely with all personnel who have direct involvement with the individuals (i.e., direct support, active treatment, QMRP, therapists, vocational). Without an improvement in the environments in which the individuals live, work, and recreate, there will be little change in behavior.

The following are offered as additional suggestions to the State and Facility:

1. In filling the Chief Psychologist role, the Facility is encouraged to conduct a nationwide search for a doctoral-level licensed psychologist who is also board certified in behavior analysis.
2. The Facility should consider making changes to the format of its psychological updates as described with regard to Section K.6.
3. With regard to the form used by the Human Rights Committee:
    a. As aversive therapy was not an approved intervention, consideration should be given to deleting this from the form.
    b. As most assessments completed to determine the possible function served by identified problem behaviors did not include systematic manipulation of different contingencies, consideration should be given to modifying the question regarding completion of a functional analysis to a question of whether or not a functional behavior assessment had been completed.

References

American Psychiatric Association (2000). *Quick reference to the Diagnostic Criteria from DSM-IV-TR*. Washington, DC: American Psychiatric Association.

Bondy, A., & Frost, L. (2001). *A picture's worth: PECS and other visual communication strategies in autism.* Bethesda, MD: Woodbine House.

National Autism Center (2009). *National standards project: Findings and conclusions.* Randolph, MA: National Autism Center.

Watson, T.S., & Steege, M.W. (2003). *Conducting school-based functional behavioral assessments: A practitioner's guide*. New York, NY: The Guilford Press.

SECTION L: Medical Care	
	Steps Taken to Assess Compliance: The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o At Risk Individuals Policy: SSLC Risk Guidelines, draft; o Aspiration Pneumonia Initiative: Frequently Asked Questions, Quick Start for Risk Process, Risk Process Flowchart, Aspiration Triggers Data Sheet, Aspiration Pneumonia/Enteral Nutrition Evaluation, Aspiration Pneumonia draft, Identifying Risk, Treatment, and Prevention of Aspiration Pneumonia draft, Adult Aspiration Pneumonia Prevention Algorithm draft; o Clostridium Difficile Management Pathway, updated 9/12/07; o SSLC Policy: Anticoagulation Protocol draft, updated 9/21/10; o Venous Thromboembolism (VTE) Screening and Prophylaxis Protocol draft, updated 9/10; o VTE Risk Assessment Screening Form, updated 9/10; o SSLC Policy: Constipation Prevention and Management Protocol draft, updated 10/10; o Management of Hyperlipidemia, dated12/10; o SSLC Policy: Screening and Treatment of Reduced Bone Density draft, updated 11/10; o Clinical guidelines for skin lesions, dated 10/7/09; o Flow Chart to Seizure Management, updated 11/10/10; o Admissions since last on-site visit, from 8/9/10 to 1/5/11; o Deaths since last on –site visit, from 8/9/10 to 1/5/11; o Shift Report for Tuesday 2/15/10; o Shift Report for Wednesday 2/16/10; o Shift Report for Thursday 2/17/10; o Medical records for the following: Individual #429, Individual #311, Individual #378, Individual #236, Individual #120, Individual #306, Individual #426, Individual #290, Individual #335, Individual #67, Individual #124, Individual #259, Individual #23, Individual #67, Individual #473, Individual #491, Individual #208, Individual #116, Individual #114, Individual #317, Individual #433, and Individual #143; o Annual medical summaries and physical examination evaluations for 2009 and 2010 for the following: Individual #138, Individual #19, Individual #126, Individual #129, Individual #480, Individual #55, Individual #452, Individual #108, Individual #257, Individual #272, Individual #53, Individual #467, Individual #24, Individual #215, Individual #275, Individual #225, Individual #117, Individual #536, Individual #527, and Individual #512; o Hospital Nurse Liaison Documentation November/December 2010 for the following individuals (TX-AB-1101-IX.34): Individual #311, Individual #390, Individual #378, Individual #318, Individual #346, Individual #114, Individual #407, Individual #344, Individual #37, and Individual #312; o List of those with Down Syndrome, date of last thyroid test (TX-AB-1102-IX.30); o List of women age 50 or over with date of most recent mammogram or reason not up-to-

	date (TX-AB-1102-WZ.2.2); o List of those individuals age 50 and over with date of last colonoscopy or reason if not up-to-date (TX-AB-1102-WZ.2.1) o List of individuals by residence, admission date/date of birth/legal status as of 1/10/11 (TX-AB-1102-I.6); o Anticonvulsant medication by individual, from 12/22/10 to 1/6/11 (TX-AB-1102-IX.48); o Anticonvulsant medications by individual, from 12/22/10 to 1/6/11 (TX-AB-1102-IX.4.a.b.c.d) o Total number of individuals on anticonvulsants, dated 1/6/11 (TX-AB-1102-IX.53); o Vagal nerve stimulators, updated 1/18/11 (TX-AB-1102-IX.24b) o List of individuals seen by neurologist with dates seen and reason, since last monitoring visit (TX-AB-1102-IX.46); o Neurology consultation reports for the following: Individual #311, Individual #417, Individual #366, Individual #124, and Individual #100 (TX-AB-1102-IX.45); o List with status epilepticus, since last monitoring visit (TX-AB-1102-IX.47); o Policy: seizure management (TX-AB-1102-IX.43); o Policies and procedures for medical screening and routine evaluations (TX-AB-1102-IX.25); o Bone densitometry reports for the following: Individual #178 on 8/4/10, Individual #424 on 6/19/08, Individual #540 on 7/28/10, Individual #184 on 7/19/10, Individual #84 on 8/3/10, Individual #279 on 10/21/09, Individual #201 on 8/9/10, Individual #546 on 8/5/10, Individual #194 on 8/4/10, Individual #398 on 8/3/10, Individual #532 on 8/2/10, Individual #497 on 8/13/10, Individual #167 on 7/15/10, Individual #5 on 11/15/10, Individual #165 on 8/9/10, and Individual #143 on 9/24/10 (TX-AB-1102-IX.29); o Drug Order Report, from 1/6/10 to 1/6/11 osteoporosis medications (TX-AB-1102-IX.28); o Individuals' names, dates of diagnosis, and specific diagnoses for past year who have been newly diagnosed with: new onset preventable cardiovascular disease, and new onset diabetes mellitus (TX-AB-1102-IX.42.a.b.c.); o Incidence rate (prior year, by month) for decubitus ulcers, January 2011 (TX-AB-1102-IX.41.b); o For individuals with pica or ingesting inedibles, copy of most recent BSP and subsequent addendums: Individual #440, Individual #25, Individual #199, Individual #151, Individual #242, Individual #218, Individual #229, Individual #120, Individual #272, Individual #276, Individual #320, Individual #67, Individual #141, Individual #383, Individual #205, Individual #312; o List of individuals with pica or ingesting inedible object, date of ingestion, object ingested, whether taken to ER or hospitalized, since the last on site review (TX –AB-1102-IX.24e); o Admitted/transferred to the Facility's Infirmary, including date of admission/transfer, reason for admission/transfer, and date transferred back to residence (TX-AB-1102-VI.5.c.);

	o Incidence rate (prior year, by month) for pneumonia, January 2011 (TX-AB-1102-TX.41.a); o Summary report or trend analysis of infectious disease/communicable disease last two quarters, date range 7/1/10 to 12/31/10 (TX-AB-1102-IX.37); o Avatar pneumonia tracking forms for past six months (TX-AB-1102-IX.38) o List of individuals with diagnosis of pneumonia in last six months and taking food/liquid by mouth, type of liquid (amount of thickening), and type of texture of solid food ordered, with last swallow study (TX –AB-1102-IX.39); o Specialty Clinics from June 2010 through December 2010 (TX-AB-1102-IX.22) o Percentage of individuals on two, three, four, and five antiepileptic drugs (AEDs) (TX-AB-1102-IX.52); o For Vagus Nerve Stimulator (VNS) placement, list of people with refractory seizure disorder who are being evaluated, the stage of evaluation (TX-AB-1102-IX.51); o List of those going to ER for uncontrolled/prolonged/new onset seizures, since last monitoring visit, dated 1/10/11 (TX-AB-1102-IX.49); o Employees in Medical Department Completing Cardiopulmonary Resuscitation (CPR) Training Certification with Date of Completion, dated 1/11 (TX-AB-1102-IX.5); o Number of individuals on each physician's caseload, dated 1/11 (TX-AB-1102-IX.4); o Continuing Medical Education (CME) for each primary care provider over last six months, dated 1/11 (TX-AB-1102-IX.7); o Drug Utilization Report – Antibiotics, from 8/1/10 to 1/6/11 (TX-AB-1102-IX.40a); o Medication History for individuals with Jejunostomy feeding tube (J-tubes) and Gastrostomy feeding tube (G-tubes), in past six months (TX-AB-1102-XI.26); o Rate of Autopsy Completion in last year per quarter: January 1, 2010 to December 31, 2010 (TX-AB-1102-IX.19); o List of Death Reports That Remain Incomplete/Outstanding, dated 1/11 (TX-AB-1102-IX.20); o Abilene SSLC Do Not Resuscitate (DNR) Information (TX-AB-1102-IX.18); o Individuals Whose DNR has been rescinded as of February 17, 2011; o DNRs Rescinded /DNR list updated, dated 12/12/10; o Notes and orders for any DNRs and rescinding of DNRs (TX-AB-1102-IX.17); o Out of Hospital Do Not Resuscitate order for Individual #513, dated 12/19/05, with progress notes documenting details of decision; o ABSSLC Infection Control Meeting Minutes, dated 7/8/10, and 10/21/10; o Preprinted "Annual physician orders;" o ABSSLC Nursing Services Policy: Management of Transabdominal Feedings (TX-AB-1102-WZ.8.9); o Dietician notes on Individual #19 (TX-AB-1102-WZ.5); o Semi-Annual Case Conference physician orders, dated 12/11/09 (TX-AB-1102-WZ.7); o Infirmary Rounds Minutes, dated 2/15/11, 2/16/11, 2/17/11, and 2/18/11 (TX-AB-1102-WZ-11); o Medical Emergency Response policy, dated 7/21/10; o ABSSLC's Medical Emergency Drill Checklists from August through December 2010 (239

	checklists); o ABSSLC's Program Compliance Monitor (PCM) data from September 2010 through January 2011; o ABSSLC's Nursing Education competency-based training rosters for emergency equipment; o Adverse Drug Reaction (ADR) for Individual #202; and o ABSSLC Code Drill data for August 2010 through January 2011. ▪ **Interviews with**: o Richard Chengson, MD, Medical Director; o Edward Craig, MD, Staff Physician; o Kimberly Johnson, MD, Locum Tenens Physician; o Stephen Pritchard, MD, Staff Physician; o Jung Lien, MD, Staff Physician; o Dr. Lowrimore, Consulting Psychiatrist; o Trina Cormack, MD, Staff Psychiatrist; o Mary Pat Heath, RN, FNP, Nurse Practitioner; o RN Case Manager and Staff Nurse for deceased individual; o Jim Kluza, RN, BA, Chief Nurse Executive; o Terri Massengill, RN, Nurse Manager; o Irene Akin, RN, Campus RN; o Lisa Roberson, RN, Campus RN; and o Mary White, RN, MSN, Quality Assurance Nurse. ▪ **Observations of**: o Individual #178, Individual #250, Individual #418, Individual #311, Individual #19, Individual #362, Individual #26, Individual #417, Individual #485, Individual #364, Individual #265, Individual #405, Individual #353, Individual #498, Individual #100, Individual #103, and Individual #36.
	Facility Self-Assessment: The Facility's POI listed indicated that Facility was in compliance with provision L.1 of the Settlement Agreement. This reportedly was based on a review not completed by members of the Medical Department. In the comments/status section, the Facility noted: "1/2011--Current monitoring results: 100% compliance from 24 reviews since 9/2010. All individuals are provided with ongoing routine care and preventive care is reviewed and implemented at the annual medical summary. Emergency care is available 24/7 and home staff and nursing personnel are trained to respond quickly and notify the provider on call of problems." It was unclear what the 24 reviews entailed. In addition, it was unclear how one overall compliance score had been determined for Section L.1, because it includes multiple requirements. As noted in the discussion related to Section L.1, the Monitoring Team found several areas of noncompliance. Although it remained unclear why the Facility's reviews showed compliance when the Monitoring Team found significant issues, one factor might have been that the Monitoring Team reviewed the presence or absence of treatment and care, as well as the quality. For the three other provisions within this section, the Facility determined that it was noncompliant. The

	Medical Department had not created a database system to capture information that would be helpful in providing evidence of compliance. This will be an essential step in the future. Additionally, in the POI, there were several outcome measures with corresponding action steps listed. These were reviewed with the Medical Director. Although there had been some progress, most had not been completed. For instance, the Clinical Pharmacist had created a system to ensure medications were reviewed prior to administration through a J-tube to determine appropriateness of providing the medication through this route. However, there was no progress for most of the action plans, such as lack of a monitoring system for positioning, nor a simplified consultation tracking system. Another area of progress has been the implementation of morning medical rounds in the Infirmary.
	Summary of Monitor's Assessment: There was now a full complement of primary care practitioners, with caseloads that were adequate to address the clinical challenges and promote quality care. The Medical Director had a small caseload, allowing a majority of time to be focused on medical administration. As mentioned in relation to Section G, the morning medical meetings showed the beginnings of a process with great potential. They should be expanded to include clinical review of individuals with acute care problems, but also include in-service training on new guidelines and discussion of complex clinical issues. There continued to be a need an urgent need for a clinical guideline for GERD. In addition, further training was needed on such topics as the administration of fluids and medication through J-tubes, work-ups for GERD, identification of dementia, and critical thinking to prevent recurrent ER visits and hospitalizations. Routine care appeared adequate, but preventive care needed attention. There were eight deaths in the past six months at ABSSLC. None of these had undergone a clinical mortality or administrative mortality review. The last clinical mortality review was completed in 5/10. As of the end of December 2010, there remained 16 death reports that were incomplete or outstanding. The clinical death review committee had not met on these cases, because the reports had not been finalized. Based on the Monitoring Team's reviews of the deaths that occurred over the last six months, a number of issues or questions were identified that required follow-up. The Facility's failure to conduct such reviews itself was limiting its ability to potentially proactively prevent other deaths in the future, and generally improve the healthcare treatment provided at ABSSLC. It is strongly recommended that ABSSLC conduct mortality reviews in a timely and thorough manner. Since the last review, the Facility had implemented very few interventions to address the emergency response systems. The most promising change was having the Program Compliance Monitors present to record data at some of the Medical Emergency Drills. However, most of the problematic issues the Monitoring Team identified during the past reviews continued to be problems during the current review. Some of these included: a lack of a consistent tracking system for Medical Emergency Drills to ensure that they were being conducted according to policy; a lack of a system to ensure that nurses were familiar with the operation of all emergency equipment through demonstration at least quarterly of the use of this equipment, as well as during Medical Emergency Drills; a failure to activate all emergency systems during

	Medical Emergency Drills to ensure they were functional and adequate; no review or analysis of emergency procedures, and data generated from the emergency medical drills; no consistent documentation or form to record actual medical emergency codes; and a failure to consistently check emergency equipment. The Facility should promptly develop and implement systems addressing all facets of its emergency procedures. Without a good database management system with reliable data, it will remain difficult to comply with the Settlement Agreement. With a good database system, many of the issues currently negatively impacting the treatment of individuals would be readily identified and could be, addressed, monitored for improvement, and the impact of treatment documented. However, without a strong database, the medical QA program was nonexistent or in the very initial stages of development. Non-Facility physician review had not occurred. However, a schedule had been created, and a review was expected to occur in the near future. Policy and clinical guideline development remained in the draft stage.

#	Provision	Assessment of Status	Compliance
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, physician participation in team process, routine care and preventative care, medical management of acute and chronic conditions, mortality reviews, Do Not Resuscitate (DNR) Orders, and mock drills. <u>Staffing</u> At the time of the Monitoring Team visit, there was a full complement of primary care practitioners. The Medical Department was composed of the Medical Director, three staff physicians, one locum tenens physician (who had applied for a staff position), and one nurse practitioner. Caseloads were distributed with the newest physicians having the smallest caseloads. There was discussion that the caseloads would become equalized as the new physicians adapted to the system. Currently, the caseloads of the staff physicians and nurse practitioner ranged from 57 to 106. The Medical Director had a smaller caseload of 20, but these individuals were considered medically complex individuals. Continuing education credits were submitted for the primary care practitioners for the past six months. The topics covered a wide range of primary care topics. The Medical Director should ensure an agreed upon percentage of the continuing medical education credits focus on disease prevention and treatment that can be applied to the population at ABSSLC. Topics such as aspiration pneumonia, GERD, osteoporosis, decubitus care,	Noncompliance

#	Provision	Assessment of Status	Compliance
		chronic constipation, seizure management, etc., should represent a portion of the continuing medical education coursework completed. In reviewing the continuing medical education certificates and topics, there were two PCPs for which no information was provided. The Medical Director should ensure all the PCPs have accumulated continuing medical education credits in relevant topics. Additionally, certification in CPR training was submitted for the Medical Department. Information submitted indicated all staff physicians and dentists remained current in CPR certification. The status of the locum tenens physician concerning CPR certification was not submitted. <u>Physician Participation in Team Process</u> As mentioned with regard to Section G.1, a daily morning medical meeting was being held each business day of the week. It included all the PCPs, psychiatry staff, Habilitation Therapies Director, and several nurses. As discussed earlier, there were no written minutes of these meetings. Several concerns were discussed at each of the meetings observed, but there was no way to track and document closure of the issues raised. Further, an update on those individuals hospitalized, as well as those with acute or complex medical concerns across the campus who were listed on the 24-hour nursing report should be included in the review and discussion. Logistically, the meeting could begin in a conference room with distribution of the previous day's minutes for review and comment, and then proceed through an agenda of hospitalized individuals, individuals in the Infirmary, and campus concerns. This also would be the time for updates on clinical pathways and other clinical issues. Rounds in the Infirmary focusing on new or complex health problems could follow. In response to a member of the Monitoring Team attending morning rounds, there was an initial attempt to create minutes. Such minutes should be succinct and focus on areas needing closure. Documentation of closure should include the date, a brief description of the steps taken, and the outcome. A member of the Monitoring Team observed rounds conducted in the Infirmary on 2/15/11, 2/16/11, and 2/17/11. Individuals admitted to the Infirmary during that time included Individual #265, Individual #250, Individual #100, Individual #311, Individual #103, Individual #19, Individual #485, Individual #362, Individual #417, Individual #405, Individual #418, Individual #364, Individual #353, Individual #26, Individual #498, Individual #178, and Individual #36. A number of concerns and issues were identified, including the following: ▪ Individual #100 was hospitalized approximately six months prior for severe pneumonia, and more recently developed severe pneumonia following abdominal surgery. In both cases, he required a ventilator for a period of time,	

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		and currently had a G-tube. On entering the room during rounds, he was found to be lying flat. On inquiry, he had not been worked up for GERD, which is commonly found in this population and might be a cause of recurrent pneumonias. ▪ Individual #26 had a decubitus ulcer, with a history of prior ulcers. There was no nursing tracking form being used to identify progress or worsening. Periodic photos would have been helpful to document healing status. ▪ Individual #250 represented a complicated case in which there were both medical and psychiatric components associated with recurrent vomiting. Work-ups were discussed and ordered. This case would particularly benefit from formal tracking of the recommendations, and follow-through to closure. ▪ Individual #417 had functional decline and discussion included the possibility of dementia and the need for a review by psychiatry to determine the diagnosis and potential medical treatment. ▪ Individual #353 was being transferred to a new residence, having healed a Stage 4 decubitus. The concern noted in the morning medical meeting was the need for assurance that the receiving residence would have the background information and the current supports to accommodate this individual. ▪ Individual #265 required additional medications for a colonoscopy preparation, and the findings of a mass led to a discussion of next steps. This case would also benefit from formal documentation of the recommendations, and documented follow-through to closure. <u>Routine and Preventative Care</u> Routine and preventive care can be measured in a number of ways. The following provides a description of the reviews conducted to determine if ABSSLC was providing individuals with adequate routine and preventative care. The last two annual medical summaries and physical examination evaluations were submitted for 20 individuals. It was noted that these two documents (medical summaries and physical examinations) were recorded as if done simultaneously. The annual reports were reviewed to determine timeliness based on the earlier examination. The following individuals had timely annual evaluations completed within 365 days of the prior evaluation: Individual #19 (11/20/09, and 11/16/10), Individual #126 (1/4/10, and 10/29/10), Individual #129 (1/13/10, and 10/14/10), Individual #480 (1/11/10, and 11/17/10), Individual #55 (11/6/09, and 11/2/10), Individual #452 (11/16/09, and 11/4/10), Individual #108 (1/21/10, and 11/17/10), Individual #257 (11/17/09, and 11/9/10), Individual #53 (11/9/09, and 10/15/10), Individual #467 (11/10/09, and 10/29/10), Individual #24 (1/6/10, and 11/17/10), Individual #215 (12/16/09, and 11/8/10), Individual #275 (11/17/09, and 11/4/10), Individual #225 (12/21/09, and 11/12/10), Individual #117 (1/4/10, and 10/27/10), Individual #536	

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		(12/21/09, and 10/4/10), Individual #527 (12/18/09, and 11/30/10), and Individual #512 (1/6/10, and 12/2/10). There were two annual medical summaries and physical examinations that were overdue: Individual #138 (10/12/09, 11/30/10) and Individual #272 (11/5/09, 11/9/10). Compliance was 18/20 (90%). For routine care, another parameter that was reviewed was thyroid testing in those with Down Syndrome. The Facility was asked to submit all those with a diagnosis of Down Syndrome, and then was asked to submit the date of the last thyroid test that was completed. Ten names were submitted and each had a thyroid test completed during the year 2010, suggesting 100% compliance with the standard. All had occurred within the last 365 days. It was not confirmed if the list included 100% of the population at ABSSLC with Down syndrome. Osteoporosis was a common diagnosis at ABSSLC. A list of 208 individuals was submitted who were actively treated with osteoporosis medications. This represented 208 individuals out of a census of 447 individuals (46.5%). It indicated a proactive stance on the part of the Medical Department. All treatment appeared to include a form of a bisphosphonate exclusively. The list did not include calcium or vitamin D supplements, or other medications indicated for osteoporosis. Calcium and vitamin D supplements are generally based on osteopenia and osteoporosis prevention and treatment guidelines, as well as daily-recommended allowances from professional medical/health organizations. Several bone densitometry reports were reviewed and then compared to the treatment list. The following summarizes the results of the review: ▪ Those confirmed as having osteoporosis by the densitometry report and prescribed medication at dosages recommended for osteoporosis included: Individual #497 on 8/13/10, Individual #143 on 9/24/10, Individual #424 on 6/19/08, Individual #84 on 8/3/10, Individual #201 on 8/9/10, Individual #194 on 8/4/10, and Individual #540 on 7/28/10. ▪ Those confirmed as having osteoporosis by the densitometry report and not prescribed a bisphosphonate included: Individual #184 on 7/19/10. ▪ Those confirmed as having osteopenia and on a bisphosphonate at a dosage recommended for osteopenia included: Individual #5 on 11/15/10, Individual #532 on 8/2/10, and Individual #167 on 7/15/10 (in 2009 she was prescribed a dosage of alendronate used in treating osteoporosis). ▪ Those confirmed as having osteopenia, but not on any bisphosphonate included: Individual #398 on 8/3/10, Individual #165 on 8/9/10, Individual #279 on 10/21/09, and Individual #178 on 8/4/10.	

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		▪ Those confirmed as having normal bone density and appropriately not prescribed a bisphosphonate included: Individual #546 on 8/5/10. The submitted information was incomplete and interpretation was limited. There were two requests regarding the prevention and treatment of osteopenia/osteoporosis. A request was made for a list of individuals with osteoporosis/osteopenia with medications and dosage. This should have included calcium and vitamin orders with dosages per day, as well as other medications used for these diagnoses (Miacalcin, etc.). However, only bisphosphonates were listed. If an individual was not prescribed a bisphosphonate, it was not possible to determine the adequacy of osteopenia treatment, since they could have been ordered other medications to address it. The other concern involved receiving only 16 bone densitometry reports, when the request included such reports for any one over 50 that had a test completed in the prior six months. These tests should be repeated every two years. With 208 individuals on medications for osteopenia/osteoporosis, one would expect approximately 50 tests to be completed every six months to keep up with the needs of the population. It could be that a large number were completed but not submitted, which made interpretation of submitted information difficult. Preventive care was reviewed using two preventive medicine tools (colonoscopies, and mammograms), determining the eligible population, and determining those in that population that received the preventive screening. For mammograms, a list was submitted for all women over the age of 50 with the date of the last mammogram. The Facility identified 120 women as age 50 or over. Of these, 89 (74%) had a mammogram completed in the last two years. Eighteen individuals (15%) were overdue for a mammogram, and 13 individuals (10%) had a documented reason for not having a mammogram completed. There did not appear to be a standard agreed upon by the PCPs at ABSSLC with regard to the age and frequency at which mammograms should be completed. The submitted policy reflected a preventive service schedule based on the recommendations of the United States Public Health Task Force (USPSTF), which were outdated. It listed the current expectation as a mammogram beginning at age 40, and then every one to two years thereafter. The updated recommendation of the USPSTF was not reflected in the submitted document (mammograms every two years beginning at age 50). Because there was little guidance or decision regarding which recommendation to use from which professional medical organization, each PCP was using an appropriate standard, but there were many standards from which to choose. The HCG, which had been the ABSSLC standard, provided a more rigorous standard than the more recent USPSTF standard. The preprinted "Annual Physician Orders" still had an order for "annual	

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		mammogram at age 40 or older." If the Facility was going to adopt the USPSTF protocol, then the "Annual Physician Orders" needed to be updated, or this could be considered a nursing error for not following through on orders. The State Office should provide a clear guideline for this area of preventive care. Names of individuals over the age of 50 were submitted, along with their most recent date of completion for a colonoscopy. Across the campus, 177 names were identified. Based on the above number of 120 women were over the age of 50, it should be noted that only 57 men were identified as being over the age of 50, indicating this might be an incomplete list. Additionally, the list of individuals residing at ABSSLC as of 1/10/11 indicated 194 individuals were over the age of 50. Based on the submitted information, of the 177 individuals listed, 116 had completed a colonoscopy. This represented 66% of the target population. Nineteen individuals (11%) had no colonoscopy listed, but a documented reason could be identified. For 36 individuals (20%), there was no reason identified for not having a colonoscopy. This is particularly concerning given that close to 20 individuals were not included on the list at all. Additionally, six individuals had colonoscopies pending, representing (3%) of the group. Additionally, for one individual that had died at the age of 70, there was no evidence she had ever undergone a preventive colonoscopy. This is a baseline from which improvement can be demonstrated. Once a systematic approach is implemented to track those 50 years of age or older who have not had a screening colonoscopy in the last ten years, action can be taken to address this deficiency. <u>Medical Management of Acute and Chronic Conditions</u> Seizure management was reviewed. The seizure management protocol stated that for seizure activity that was continuous for three to five minutes that staff were to call the Facility's emergency number, 4444. However, the range of time was problematic. If nursing or other medical personnel are not notified until five minutes have passed, then the seizure is apt to continue for one or more minutes before arrival of a nurse, and then subsequent administration of a parenteral antiepileptic agent. It might be important for the observer/staff to seek assistance three minutes into the seizure, so that the seizure is treated, if it continues, by the fifth minute. The list of those with status epilepticus in the past six months only included one person, Individual #54, who had two episodes of status epilepticus. Additionally, there was one individual who utilized the ER for uncontrolled/prolonged/new onset seizures in the prior six months. This was Individual #259, the event occurring on 10/21/10. Neurology clinic was held twice each month. A dictated consultation report was completed, including a review of the most recent seizure record, a review of medication, assessment, and plan. From the list of individuals who had seen the neurologist since	

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		September 2010, it would appear all had seen the neurologist at least annually, and many had been seen at much more frequent intervals (from one month to nine months). Many were prescribed multiple anti-epileptic medications. Eighty-three individuals were prescribed two antiepileptic medications, 38 were prescribed three antiepileptic medications, and six individuals were prescribed four antiepileptic medications. Additionally, 28 individuals had a vagal nerve stimulator implanted. At the time of the submission of the vagal nerve stimulator list, there was an additional individual being referred for evaluation of VNS placement (Individual #498). A list was submitted entitled "Intractable (Refractory) seizure list." It defined intractable as difficult to manage or control, and defined controlled as having had no seizures in one year following the last seizure. The total number of individuals considered to have intractable seizures was 142 individuals. There were 245 individuals on antiepileptic medication, indicating there were many who were controlled according to the definition, or many were on these medications for other reasons (psychiatric diagnosis, etc.). As there was only one individual recorded as having status epilepticus in the past six months, this was one indicator of excellent care and seizure control across the campus. A number of other specialty clinics were held at ABSSLC in the six months prior to the Monitoring Team's visit. These included the specialties of Urology, Otolaryngology, General Surgery, Gynecology, Podiatry, Dermatology, Ophthalmology, Visual Acuity, Dental Surgery, and Pap and Pelvic clinic. A list of those with enteral feeding tubes was submitted. Of these, the following had J-tubes: Individual #271, Individual #208, Individual #75, Individual #53, Individual #359, Individual #114, and Individual #83. The names of these individuals were then matched to their drug regimen review profiles as well as drug utilization report for antibiotics. None of these individuals in the last six months had received Cipro or other Quinolone antibiotics. The pharmacy had listed medications that were poorly absorbed by the J-tube route in the allergy section, along with an entry for the type of feeding tube present. This was an excellent system to ensure that these medications were not administered. If they were inadvertently prescribed by the PCP or covering PCP, then the pharmacy would alert the prescriber to this information for a change of order. Pica is a difficult challenging diagnosis and requires ongoing cooperation from different disciplines. As of the time of the Monitoring Team visit, there were 17 individuals with a diagnosis of pica. Some of the pica behaviors appeared to be severe. For example: ▪ Individual #312 required hospitalization and surgery for removal of a foreign body (object was not identified in the documents provided) on 11/29/10. ▪ Several individuals had documented pica events several times in the last six months. These included Individual #105 (two episodes), Individual #242 (five	

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		episodes), Individual #272 (six episodes), Individual #440 (46 episodes), Individual #205 (nine episodes), Individual #120 (10 episodes), Individual #229 (three episodes), and Individual #141 (three episodes). Behavior support plans were submitted for these individuals. For example: ▪ For Individual #272, there was a behavior support plan developed on 1/7/10, with a behavior support committee review date of 3/23/10, human rights committee approval on 4/6/10, and implementation date of 4/26/10. There was no further plan addendum submitted based on the repeated successful pica events. It is recommended that at each completed pica event or cluster of pica events (the PST should identify the threshold number), the team reconvene to determine those aspects of the plan that were successful and those that need to be changed. Information was only submitted from October through December 2010, suggesting his pica behavior was not well controlled. ▪ For Individual #440, there was a behavior support plan developed on 10/29/09, with behavior support committee review on 12/11/09, human rights committee review on 1/5/10, and implementation date of 4/12/10. There was an additional behavior support plan addendum, dated 6/17/10, which focused on changes in medication specifically, and another behavior support addendum on 7/23/10, addressing further changes in medication. There was a behavior support plan dated 8/23/10, which did provide detail concerning pica behavior and staff response. This was implemented on 9/15/10. For those with frequent pica behaviors, the PST might need to meet frequently to review the event(s) and provide further adaptations by way of BSP addendums. The last submitted plan was implemented on 9/15/10. With 46 pica events from October through December 2010, the plan did not seem adequate to meet his needs. Prior information was not available to determine if this was an improvement in frequency reduction of pica events, but his pica habit was not resolved/successfully minimized by December 2010. ▪ Individual #312 required hospitalization and surgery to remove a foreign body (not identified in submitted documents) on 11/29/10. The behavior support plan implemented on 11/10/10 included the following comment: "on 12/15/10, the PST met and decided to discontinue this monitoring plan as there are no documented incidents of pica." This statement is problematic, as he had a serious pica ingestion requiring abdominal exploration for removal of an object from his stomach. Further, the hospitalization and surgery occurred on 11/29/10, and approximately two weeks later, the PST wrote the statement that there was no pica incident documented. This individual is at high risk for recurrence of pica, yet either the team was not aware of the hospitalization (indicating poor communication), or the team did not understand the reason for the hospitalization. No further plans were submitted to indicate there was an	

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		appropriate plan in place to address the pica after his hospitalization. Without a plan, and a successful plan, he is apt to require hospitalization and surgical consultation again. The last plan was not sufficient to prevent his serious successful pica event. The PCP should meet promptly with the PST to begin to implement an amended plan to address the pica to reduce the likelihood of recurrence. <u>Mortality Reviews</u> There were eight deaths in the past six months at ABSSLC. None of these had undergone a clinical mortality or administrative mortality review. The last clinical mortality review was completed in 5/10. As of the end of December 2010, there remained 16 death reports were incomplete or outstanding. The clinical death review committee had not met on these cases, because the reports had not been finalized. It is highly recommended that these be completed in a timely manner. Much information can be gained through such reviews, including the identification of systemic concerns. The outcome could be potential improvements in the overall care and treatment provided to individuals residing at ABSSLC. Further, the autopsy rate was 17% (three autopsies on 18 deaths for the calendar year 2010). The following records were reviewed for individuals that died since the last Monitoring Team visit: ▪ Individual #473 was 68 years old with causes of death listed as anoxic encephalopathy, respiratory failure, and pneumonia. She had a brief illness, and staff noticed subtle status changes. This prompted a PCP evaluation, with the finding of a urinary tract infection. Her constipation also was evaluated with an abdominal x-ray, as well as a chest x-ray because of a mild cough. Antibiotic treatment was started for her UTI, as well as medication for potential pain. She was found pulseless and apneic. CPR was performed, and she was admitted to the hospital. However, she had little to no EEG activity. A hospital ethics committee met, and she was subsequently considered a DNR candidate and taken off the ventilator. The hospital ethics committee presented an objective thoughtful approach to this case in a timely manner. It reflected the good working relationship of ABSSLC with the regional hospital. The autopsy also noted a small subarachnoid hemorrhage, but this was not listed in the death certificate. Despite the outcome, she was considered to have received excellent medical care due to early recognition of health status change. The nursing review indicated concerns related to direct support staff professionals and consistency of supervision, but the autopsy did not reflect an adverse outcome from this irregularity in supervision. ▪ Individual #491 had a downhill course over several months, associated with abdominal pain, poor oral intake, and weight loss. All possible tests available	

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		through the local hospital system were completed. There was a problem of test result interpretation showing increased pancreatic enzymes levels in the blood, but Computed Tomography (CT) scans and an esophagogastroduodenoscopy (EGD) were done with no findings. In the hospitalized setting, a specialist's review indicated all tests and procedures did not provide a reason for her abdominal pain, poor intake, and weight loss. There was also the belief that she would have the tendency to pull out any feeding tube and was not a candidate for this procedure. She was placed on hospice services with comfort care measures taken. An autopsy did not confirm pancreatitis as the cause of death, which was one of the potential presumed causes contributing to her abdominal pain, weight loss, and anorexia. This was a difficult case which challenged all PCPs and specialists involved. Many individuals with challenging behaviors have feeding tubes, and it was not clear if the PST met to determine what steps could have been taken to assist in her acceptance of the feeding tube. At least as a trial (1:1 supervision, mittens, ace wrap, etc.) would have determined if the feeding tube would have resolved any of the pain or would have had no effect on the pain. Additionally, when there is a complex case in which the work-up provides no clarity as to cause, such cases should be considered in need of a second opinion at a tertiary care center, with close communication and provision of updated information between attending physicians. ▪ Individual #208 had a J-tube in place. He had had a number of aspiration pneumonias. He had a history of repeated vomiting when given adequate maintenance fluid and nutrition. He was eventually placed on hospice and expired. There were orders to "check J-tube residual before each med pass," as well as bolus water flushes/supplements at 350 milliliters (ml) four times daily. The day shift RN and case manager RN for the residence in which this individual lived were interviewed for this case review. The nursing policy and procedure indicated in bold print: "Do not attempt to aspirate content from a J-tube." In so doing, the jejunal wall could be traumatized, adding discomfort and potential vomiting. Additionally, the jejunal lumen is narrow and not conducive to bolus fluid orders, which would cause distention, cramping and vomiting. These were symptoms problematic in this individual's last weeks of life. It is recommended that there be an in-service for PCPs and all nurses that provide J-tube care and maintenance in order to ensure proper procedures are followed in ordering medication, formula, and flushes through a J-tube, and to ensure measuring for residuals are not attempted through a J-tube. It is additionally recommended that there be a monitoring process in which J-tube care and maintenance is reviewed for all individuals to ensure the orders and observation of the nursing care provided are consistent with the nursing policy and procedure manual. ▪ Individual #116 had a worsening clinical course of congestive heart failure. Because of continued hypoxia, a cardiologist saw him. However, he was sent to	

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		the ER for further evaluation and found to have a pulmonary embolism. He also was found to have a left lung mass, but his poor health precluded further work-up. His hypoxia eventually could not be treated with oxygen administration and he expired. Medical care was appropriate. ▪ Individual #114 had a complicated history of vomiting after bolus feedings. She had both a J-tube for feeding, as well as a G-tube for aspiration of stomach contents. She returned from a post hospitalization and prolonged rehabilitation with the J-tube clogged, and all feedings were to go through the G-tube. She returned to ABSSLC on 5/13/10. She then developed wheezing a few months later, and was hospitalized eventually with poor oxygen saturations, a chest x-ray suspicious for aspiration pneumonia, and blood work suggesting sepsis. She died from this constellation of problems. Given her prior problems of repeated aspiration, associated reflux/vomiting and prior placement of a J-tube to resolve these concerns, the reason to not pursue further J-tube replacement was not documented, nor were the reasons to pursue other life saving procedures, such as replacing the J-tube, or considering a fundoplication, or tracheal esophageal diversion. ▪ Individual #317 had a G-tube placed 10/1/98, and also had a long history of hyperactive airway disease. She was prescribed a number of respiratory medications and inhalers. On 10/25/10, she had an x-ray completed, and was found to have aspiration pneumonia. On 11/9/10, she was admitted to hospice for palliative treatment of her respiratory failure. On review of the record, there was no indication that a work-up had been completed for GERD as a potential cause of her bronchospasm, and the repeated aspiration pneumonias. She might have benefited from surgical or medical intervention for GERD. ▪ Individual #433 had a history of colon polyps in the past, with colonoscopies completed in 1995 and 1998. He was due for a repeat colonoscopy. He had a diagnosis of GERD. He was on a pureed diet, but according to a modified barium swallow study, there were no restrictions of liquid consistencies. He was to be upright in the chair while eating. He was scheduled for a colonoscopy, and a nasogastric (NG)-tube was placed for Colyte administration. After the first two to three glassfuls, he developed intermittent gagging and vomiting. He then developed aspiration pneumonia. He progressively declined. A Peripherally Inserted Central Catheter (PICC) line was placed for antibiotic administration, but he developed PICC line sepsis. He did not survive. Medically, the unfortunate aspiration of the Colyte was not anticipated. He did have a history of GERD, as well as a large hiatal hernia. It is recommended that there be discussion with the gastroenterologists to determine an optimal preparation with less risk for those with GERD and hiatal hernias, and/or additional steps that could be taken to minimize risk. It also was not clear from the information reviewed the position of the individual during Colyte administration. As an	

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		additional option for consideration for those with large hiatal hernias, an x-ray taken prior to the start of colonoscopy preparation administration would verify correct placement by ensuring that the tip of the NG-tube extends into the stomach, and that there is no coiling back up the esophagus or into a hiatal hernia. ▪ Individual #143 had a diagnosis of dysphagia and advanced Parkinson' disease. She had a Percutaneous Endoscopic Gastrostomy Tube (PEG)-tube placed on 11/23/10. She appeared to have an uneventful recovery from the procedure, and tolerated the feeding well for several days. She then developed a low-grade fever spike, followed by no further fever. However, her blood sugars were noted to be elevated the following day, and within eight hours she was found diaphoretic, with rapid pulse (to 127 per minute), and rapid respirations with a pulse oximetry reading of 88%. Her blood pressure rapidly declined, and she was sent by 911 to the hospital, where she was admitted for sepsis. She did not survive. The record review did not indicate whether or not she had GERD, or if a work-up had been completed for GERD, as a G-tube placement can aggravate GERD and exacerbate reflux with aspiration. Further, there were subtle clinical changes present prior to her quick downhill course, such as the fever and elevated blood glucose levels, which might have led to earlier treatment. Information reviewed did not suggest the PCP was informed. There was documentation of clinical assessment by the nurse. However, there was less documentation of critical thinking by nursing interpreting the findings of a low grade fever and elevated blood sugars, or documentation of a plan identifying the next step (watchful waiting, serial vital signs every four hours, contact the PCP if blood sugar remains over 300, or fever recurs, etc.). Based on the Monitoring Team's reviews of the deaths that occurred over the last six months, a number of issues or questions were identified that required follow-up. As noted previously, the Facility's failure to conduct such reviews itself was limiting its ability to potentially proactively prevent other deaths in the future, and generally improve the healthcare treatment provided at ABSSLC. <u>Do Not Resuscitate Orders</u> ABSSLC continued to have a significant number of individuals with a DNR order. As of 1/27/11, there were 50 individuals with a DNR order residing at ABSSLC. Based on a prior list updated on 12/12/10, there were 49 individuals remaining with DNR Order, and DNR Orders had been rescinded for four individuals. Based on a list entitled "Individual whose DNR has been rescinded as of February 17, 2011," for the entire calendar year of 2010, there were a total of five individuals for whom the order was rescinded. This represented five out of 55 of the total individuals who had DNRs in place. Each of the lists, dated 12/12/10 and 2/17/11, included the name of an individual for	

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		whom a DNR was rescinded, but who was not included on the other list. Specifically, on the 12/12/10 list, the name of Individual #192 appeared as having had a DNR rescinded, but the 2/17/11 list did not include this person's name. On the 2/17/11 list, Individual #100 appeared, but this name did not appear on the 12/12/10 list. Given the implications for such an important guiding order, it was problematic not to have information that agreed. It is recommended that these lists be clarified. Presumably, the appropriateness of a DNR order was reviewed annually at the time of the annual PSP meeting, but less than five were believed to require rescinding. Given that this represented only nine percent of all the DNRs in place, DADS State Office might need to provide further guidance on this issue to ensure all Facilities are interpreting the guidance DADS previously provided on the related state statutes in the same way. One recent case, Individual #513 represented a relatively young man who had a DNR order placed in the past by the mother. The team more recently believed he no longer qualified for a DNR order. The mother passed away two years ago, and a sister wanted to continue the mother's wishes. At the initial discussion during the Monitoring Team visit, there was no information about whether or not the sister had pursued guardianship. Later during the visit, it was learned that the sister, as next of kin, could make decisions such as DNR for her brother. Again, later, it was learned she had obtained guardianship, and had been invited to participate at a meeting concerning her brother. The PCP and the PST should have known the current status of the sister to legally make decisions regarding DNR orders for her brother. Perhaps more importantly, it was puzzling that the sister would be offered continuation of a DNR order when he was considered by the team not to be eligible for this order/request. The Facility had continued to offer a DNR for consideration when the individual did not meet the criteria for a DNR. This remained problematic. <u>Emergency Medical Care</u> Information from individuals' medical records was submitted for those who were sent to the emergency room or those who were admitted to the hospital. The Monitoring Team focused its review on care prior to the transfer to the emergency, as well as follow up care on transfer back to ABSSLC. As the examples below indicate, there were both instances of appropriate care and good follow-up, as well as instances in which questions regarding the care provided arose: ▪ Individual #306 had a seizure disorder, and recently had adjustments in his Keppra to provide more consistent blood levels, and his Tegretol had been increased. He fell backwards during a seizure hitting a wall, and sustained a laceration to his head on 11/10/10. Bleeding was controlled at the time. He required 11 staples in the emergency room. He also received a CT of the head in the ER to rule out intracranial trauma, for which he required IV Versed. He was	

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		kept over night in the Infirmary, placed on one-to-one supervision, the nurse did Neurochecks, and he returned to his residence on 11/11/10. He was to have follow-up Keppra and Tegretol levels. Sutures were removed on 11/23/10. Care appeared to be timely and appropriate. ▪ On 9/23/10, Individual #426 had an episode of loss of consciousness for approximately six to seven minutes. There was no obvious seizure activity at the time except twitching of an arm. He was wearing a soft helmet. He also was noted to have an irregular heartbeat. He had a seizure disorder, and initial impressions were that it was an atypical seizure, but due to the presentation, he was sent to the ER to rule out cardiac or neurological etiologies. The diagnosis from the ER was a seizure. Given the findings of irregular heartbeat, the transfer showed good clinical judgment in ensuring other causes were ruled out. Upon return he was started on Depakote at bedtime, and there was an order for Ativan pro re nata (PRN, or "as needed") for seizure activity, as well as an order for a neurology consultation. ▪ On 10/20/10, Individual #429 was sent to the ER. She was observed to have a change in mental status following morning programming. She slept most of the morning, at times staring, and was described as "very still." She required a sternal rub to be awakened by the nurse to take her medication, then went back to sleep. The nurse did a head-to-toe assessment. Her VNS was used, as the assessment included possible atypical seizure. She was brought to the treatment room for evaluation. In the treatment room, she did not respond to a sternal rub and was found to be flaccid in all extremities. She was sent to the ER for evaluation. It was determined that she had a urinary tract infection, for which she was prescribed Levaquin. The unresponsive state might have been due to a post ictal state following seizure activity, which might have been exacerbated or triggered by the UTI. Upon return to ABSSLC, she was observed overnight in the Infirmary. On 10/21/10, she was discharged back to her residence. En route, she had a five-minute seizure, which responded to activation of her VNS. By the time the nurse arrived, the seizure had ended. The nurse completed vital signs and pulse oximetry. Individual #429 was alert and responsive, and was able to remain in the residence. The physician IPN of 10/21/10 indicated that if the seizure activity continued after the treatment of the UTI was completed, adjustment in anti-epileptic medication would be considered. Staff that was familiar with her were able to notice changes in mental status that led to rapid evaluation and treatment of infection in this case. Medical care was appropriate. ▪ Individual #259 had onset of vomiting associated with seizure activity. She had not had a seizure since 2008. Her formula feeding was stopped, and she was switched to Pedialyte. She did well for several hours, followed by further seizures and additional vomiting. Her oxygen (O2) saturation dropped to 26%. She was placed on oxygen supplementation, was suctioned and was sent to the	

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		ER on 10/21/10. She was given Ativan 2 milligrams (mg) intramuscular (IM) with resolution of the seizure. She returned to the Infirmary with additional orders to have the head of the bed elevated. Her respiratory rate remained elevated. A chest x-ray was completed on 10/22/10, and did not show any acute changes. By the morning of 10/24/10, her respiratory rate had returned to normal and she was titrated from her oxygen down to one liter (L) per minute. Her feeding formula was resumed. She then began to vomit, and the feeding tube was placed to drainage, at which time 200 cubic centimeters (cc) of drainage was measured. Her clinical exam changed, with increased respiratory rate, coarse breath sounds throughout the lungs, and a distended and hard abdomen. She was maintained on intravenous (IV) fluids. A chest x-ray on 10/26/10 indicated pneumonia. She received antibiotics. Her clinical course improved. She was discharged from Infirmary to her residence on 11/1/10, once the IV course of antibiotic was completed. This individual was tube fed and had vomiting at intervals, it was unclear why there was no work-up for GERD, which could be causing or aggravating the symptom of vomiting. The two months later, Individual #259 had vomiting again. She was placed on Pedialyte through her G-tube. Examination on the morning of 1/3/11 indicated resolution of abdominal distention. However, later that evening, she had projectile vomiting. She was then transported to the ER. She was diagnosed with constipation. She had a large bowel movement on return to the Infirmary. She then returned to the residence. She was observed, and on 1/5/10, in the early morning, the G-tube was placed to drainage and 500 ml was returned. Breath sounds were noted to be coarse and her breathing was more rapid. Her abdomen was again distended. She was started on Pedialyte. She had a nonproductive cough. A Bisacodyl suppository was given. Her PCP saw her that morning and clinical concerns had resolved. Her rate of Pedialyte was increased. Her formula feeding was resumed on 1/6/11. She then vomited the formula. The Dilantin level was found to be elevated at 56.8 (therapeutic range 10 to 20). This was held and her condition improved. She had been started on Dilantin with the first dose IV in the ER in 10/10. There was no information provided as to whether the level was monitored, and at what frequency since the Dilantin had been started. For newly prescribed medications (either from an ER, hospitalization, or at the Facility) with narrow therapeutic ranges, it is recommended there be a guideline for serial drug levels at a frequency agreed upon by the physicians and clinical pharmacist to ensure maintenance of a therapeutic level. The frequency should be sufficient to determine if the level is increasing toward the toxic range. ▪ On 12/1/10, Individual #335 was seen in the ER for alteration of her mental status. She was noticed to be lethargic in the residence. In the residence, she did	

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		respond to a sternal rub. However, her sleepiness continued, and it was associated with a lowering of her blood pressure. She was then sent to the ER for evaluation. It was determined that her lethargy was due to her antiepileptic medication. Trileptal and Keppra were held. Her ammonia level was elevated mildly, and she was noted to have hypothermia, and the hypothermia protocol was put into place. Subsequently, she was admitted overnight to the Infirmary. Staff that knew this individual were able to identify and track her change in health status, which led to prompt evaluation. ▪ On 12/9/10, Individual #124 tripped over her own feet sustaining a laceration to her right lower lip and a fractured nose. She was sent to the ER, and on 12/10/10, returned to the Infirmary. She refused many meals and fluids, and an IV sustained her hydration until she recovered. On 12/15/10, She was discharged to her residence. There were several days of progress notes submitted, but there was no information to suggest the PST met concerning her fall with serious injuries. It would be expected that the PST would meet promptly, and that decisions from this meeting concerning changes in risk plans pertaining to falls would be included in the progress notes. If she had a risk plan for falls in place, it did not work and additions and/or changes to this plan would be appropriate. ▪ Individual #290 was sent to the ER for nausea and vomiting associated with respiratory distress. She also had a rigid and distended abdomen. A nasogastric tube was placed and removed 1000 cc from her stomach. A CT scan of the abdomen and pelvis indicated a "large amount of retained fecal material which could be related to fecal impaction with a resultant colonic ileus." She was admitted and found to have aspiration pneumonia probably due to vomiting as a result of the constipation and possible ileus. She stabilized in the hospital. On 10/6/10, she was readmitted to ABSSLC to the Infirmary. She was on IV fluids, kept nothing by mouth (NPO), and there was a head to toe nursing assessment. Although nursing care in the Infirmary appeared to be aggressive and appropriate, the residence needed to review the reason for her constipation, as well as the reason it was missed until complications occurred that required hospitalization. If there was bowel tracking, it was not adequate, and if there was not bowel tracking, then an important health-monitoring step was missed for this individual. With good preventive care and monitoring, this hospitalization might have been avoided. Although she spent several days in the Infirmary, the IPNs did not reflect the results of any PST meeting to quickly address her bowel management to ensure a repeat ER visit did not occur. ▪ Individual #23 developed nausea and vomiting with a distended and tense abdomen on 9/27/10. He had a prior history of gastrointestinal (GI) bleeding. Initial labs were done at ABSSLC and suggested infection or inflammation. He was transferred to the hospital. He was found to have a UTI. He also had a small	

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		bowel obstruction, which resolved on conservative treatment. When he returned to ABSSLC on 10/4/10, IV antibiotic was continued. Additionally, on 10/4/10, the PCP noted that he was on Cogentin, and after discussion with the psychiatrist the dosage was lowered to minimize GI side effects. A PICC line was placed 10/6/10 as a reliable IV site for medication administration. Medical care was appropriate. There was critical thinking about the potential cause of his obstruction, which led to coordination between psychiatry and the PCP. ▪ Individual #378 developed a distended abdomen on 12/26/10. There was consideration of constipation, and a suppository was given without results, followed by an enema with no immediate results. Her tube feeding was switched from formula to Pedialyte. On 12/27/10, the physician saw her, advised she be monitored closely for the next few hours. Later that day when there was no resolution of her abdominal distention and discomfort, she was transferred to the ER. She was hospitalized from 12/27/10 to 12/30/10, and found to have a volvulus, which was reduced successfully by decompression. She also had a UTI and an ileus. The hospital admission history and physical documented the attendant from ABSSLC was not able to provide needed clinical information. ▪ Individual #311 developed increasing abdominal distention and discomfort on 12/12/10. His G-tube was placed to drainage. There was a thorough nursing evaluation on 12/12/10 with contact to the PCP, who then saw the individual in the morning clinic. The exam in the treatment room indicated a tight abdomen. A rectal tube was placed and there were immediate results, but it did not reduce the distention. An x-ray was done, and the reading indicated obstruction or ileus. At that point, he was transferred to the ER. He was found to have a volvulus, which was reduced on 12/13/10, and he was discharged back to the Facility on 12/14/10. Evaluation at ABSSLC was completed within approximately nine to 10 hours, with x-rays and close monitoring, and referral was timely, based on repeat evaluations and the x-ray report. ▪ On 12/28/10, Individual #67 had an episode of emesis followed by labored breathing that did not resolve. Vitals signs indicated a temperature of 99.4, heart rate of 96, and respirations of 20. A pulse oximetry reading was 94% on room air. She was given O2 by nasal cannula at two liters per minute (LPM). Her abdomen was soft and non-tender, and without distention. She was encouraged to change to the side lying position, but she refused (she had a preference to lie on her stomach). With continued lack of improvement, the on-call PCP was contacted, and she was sent to the ER for vomiting with possible aspiration pneumonia. She was found to have a right lower lobe infiltrate on chest x-ray. She was given a dose of IV Levaquin, and then discharged back to ABSSLC. The PCP saw her in the treatment room, and after examination, a chest x-ray was ordered, and she was placed in the Infirmary. She was observed for	

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		further hypoxia, but did not have any further problems. She continued with six more days of antibiotic. She was discharged back to her residence on 12/29/10. On 12/30/10, the nurse documented that an acute care plan had been started for her pneumonia, as well instructions provided to the direct support professionals concerning care and adverse reactions. There was a nursing notation on 12/31/10 that the morning medication was found in the drawers which was interpreted as missed medication. Missed medications were listed in the IPN, but did not include Levaquin. Assessment and care prior to and immediately after transfer appeared to be well documented and thorough. The Medication Administration Record (MAR) for 12/31/10 was not available, but from the IPN, it appeared the individual did not miss a dose of Levaquin. ▪ Individual #236 had a G-tube, most recently changed on 8/3/10. She suddenly developed hypoxia and wheezing with pulse oximetry readings down to 82%. She had considerable coughing with this episode. Prior to this, there were no reported signs and symptoms. The nurse started suctioning, but there was no improvement. Supplemental oxygen was administered by mask, with some improvement in the O2 saturation, but she still coughed and struggled. Her O2 improved to 95%. A breathing treatment with Albuterol was administered. She was sent to the ER. In the ER, a chest x-ray did not indicate any acute findings. Her blood work was normal and did not suggest an infection (i.e., no elevation of the white blood cell count). In the ER, she was noted to have no respiratory distress. She returned to ABSSLC in stable condition. In the Infirmary, her G-tube was placed to gravity drain. She was ordered PRN nebulizer treatment. She was able to tolerate her tube feeding with continued good pulse oximetry reading. She returned to her residence on 8/9/10 in stable condition. The acute onset of distress suggested aspiration, and it was assumed she choked on her secretions. However, as GERD is common in this population and a source of intermittent wheezing and bronchospasm in some individuals, this should have been mentioned in the differential or stated that GERD was recently worked up and ruled out. The submitted documents did not mention GERD or a work-up for GERD. It is recommended that the PCP review the clinical history and consider a GERD evaluation, if not already completed. ▪ Individual #120 tripped over an object and fell, sustaining a laceration to his right eyelid. He was sent to the ER. He returned to the treatment room, and was sent to his residence. On 8/16/10, he had a follow up x-ray of his abdomen, as he had swallowed pebbles on 3/29/10, and this was a follow up monitoring test. The reading was interpreted as no foreign bodies. According to the medical record, on 9/3/10, he fell in the shower and hit an end table, sustaining a laceration to his left cheek and a second laceration between his eyes. First aid was given. His level of consciousness was monitored. The last submitted progress notes indicated he might have ingested a cap from a disposable razor.	

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		Through this series of injuries, as well as the potential pica behavior, there was no QMRP note in the IPN documenting a team meeting to discuss strategies to reduce injuries, etc., or to evaluate the pica, and make changes, as necessary to strategies used to address it. The Facility had a Hospital Nurse Liaison, who made rounds at the area hospital during each business day, and provided both a written document for the medical record, as well as email communication to a number of team members assigned to the individual (e.g., case manager, QMRP, PCP, residence supervisor, nurse manager, and unit director). A number of examples of the daily summaries were submitted for review on the following individuals: Individual #407 for 11/8/10 to 11/12/10, Individual #390 for 11/18/10, Individual #318 for 12/29/10 to 12/31/10, Individual #312 for 11/30/10 to 12/1/10, Individual #114 for 12/6/10 to 12/8/10, Individual #311 for 12/13/10 to 12/14/10, Individual #344 for 12/15/10 to 12/20/10, Individual #378 for 12/28/10 to 12/30/10, Individual #37 for 12/27/10, and Individual #346 for 12/16/10 to 12/17/10. Included in the documents were admitting diagnoses, vital signs for that day, medications, and brief entries on relevant clinical organ systems. Lab and progress entries were also present. They were helpful to the PST members in providing a snapshot of the current status, and allowed for discharge planning to occur prior to the transfer, which assisted providing continuous quality care. Additionally, it was clear the Hospital Nurse Liaison provided crucial information to the hospital nurses, as in the case of Individual #344 on 12/16/10. Another example was the information provided to the charge nurse and RN on the hospital unit about positioning during feeding for Individual #114 on 12/7/10. Since this information is maintained in the record, there should be a key at the bottom or side of the note indicating the definition to the abbreviations used, as many who read these in the IPNs might not be familiar with some of the abbreviations. Providing essential background information in selected areas would also reduce confusion. For instance, from a different listing of feeding tubes, Individual #114 was listed as having a J-tube (as well as a G-tube). This also was recorded on the note of 12/6/10, but subsequent notes mentioned only a G-tube, and there was no further follow up concerning closure to the problem of the drainage from the J-tube site. Other records indicated the J-tube had been clogged in the past and was not being used, but without this background information, the progress note would appear confusing. If an individual has both a J and a G-tube, it is recommended that there be a preface statement indicating both exist so as to provide clarity to what is discussed in the narrative. Additionally, blanks in the narrative sections need correction before distribution (e.g., Individual #344 for 12/17/10). <u>Mock Drills</u> A review of 239 Medical Emergency Drill Checklists from August 2010 through	

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		December 2010 indicated that ABSSLC appeared to be conducting emergency drills in alignment with the State's policy. Specifically, drills were to be conducted monthly in each of the homes on every shift. However, there was not a succinct tracking system that demonstrated that drills were being conducted in all required areas of the Facility. Included with the Facility's Medical Emergency Drill Checklists for August 2010 were forms that listed the home numbers and the month, shift, and date the drill was conducted. For the September 2010 drills, a different form was included that listed the home, month, date, time (which was left blank), and if the drill passed or failed. For October, November, and December 2010, no tracking forms were provided. The Facility should implement a consistent system for tracking Medical Emergency Drills to ensure that they are being conducted according to policy. Based on the last review, the CNE had reported that in conjunction with the Medical Emergency Drills, nurses also were to be observed demonstrating the use of the emergency equipment. However, a review of the drills found no documentation supporting this. The documentation the Nursing Educator provided indicated that only 33 competency checklists for Emergency Equipment were conducted in September 2010, one in October 2010, and two in January 2011. There was no indication that the staff's skills regarding the use of emergency equipment were being checked regularly. Based on discussions with the RNs that conducted the Medical Emergency Drills and consistent with the findings of the past two reviews, most of the drills only included a simulation of the use of the emergency equipment and did not incorporate the actual use of the emergency equipment during drills. The Facility should ensure that nurses are familiar with the operation of all emergency equipment through demonstration at least quarterly of the use of this equipment, as well as during Medical Emergency Drills. This is essential to ensure that when an emergency arises, the equipment is available and the nurses are familiar with the equipment. In addition, Facility staff reported that when conducting Medical Emergency Drills, the Facility did not actually activate all the steps of their emergency systems. For example, the nurses conducting the drills reported that most of the time they did not involve the switchboard in the Medical Emergency Drills, which would be what should happen during an actual emergency. Part of the purpose of conducting Medical Emergency Drills is to ensure that all emergency systems are functional in the event of a real emergency. The Facility should ensure that all emergency systems are activated during Medical Emergency Drills. A review of ABSSLC's Medical Emergency Drill Checklists (239 checklists) from August through December 2010 found the following issues: ▪ A number of drills did not indicate if the drill was passed or failed. They were noted as "other;"	

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		▪ Drills that contained problems such as slow responses from staff, or missing or broken equipment were scored as a "passed" drill; ▪ Drills that contained problematic issues did not consistently include documentation indicating that the problem was actually resolved. Moreover, the Medical Emergency Drill Checklist form only included a section for date to be completed for problematic issues, and did not include a section indicating when problems were actually resolved; ▪ Staff did not consistently respond to drills appropriately; ▪ All of the drills conducted consisted of Cardiopulmonary Resuscitation (CPR), and limited scenarios. No other scenarios such as heat stroke, bee stings with anaphylactic shock, head injuries, or scenarios addressing first aid issues were included; and ▪ There was no documentation of physician participation in the drills reviewed. Specifically, as found during the previous two reviews, some of the comments found on the drill reports indicated that there continued to be significant problems. The following provide examples of some of the issues noted on the drill forms: ▪ No backboard was available for CPR in home 6400; ▪ Staff and a Licensed Vocational Nurse (LVN) did not respond appropriately to a drill. They walked slowly to the code and did not get the Ambu bag or backboard immediately; ▪ Staff said they did not know what to do; ▪ "An LVN walked leisurely to the Emergency Drill [but] did not direct staff to physically participate;" ▪ Staff showed no sense of urgency when participating in drill; ▪ Psychologist walked by during drill, but did not participate; ▪ No backboard on home 6360; ▪ No backboard on home 6350; ▪ Clutter such as purses and sodas had to be removed from cart with suction machine; ▪ Staff did not know how to use Automatic External Defibrillator (AED); ▪ Ambu bag kept coming apart; ▪ Staff needed to be reminded to bring emergency bag, as well as of the proper placement of the Ambu bag and use of the AED; ▪ Staff in break room did not respond to drill; ▪ No nasal cannula found; ▪ Staff sitting at the table eating required several prompts to obtain Ambu bag; ▪ Night Supervisor watched staff's unresponsiveness to the drill; ▪ Poor response time and lack of knowledge; ▪ First staff that was on the scene hesitated for about two minutes; ▪ Drill stopped due to poor performance;	

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		▪ Red emergency bag was missing from home; ▪ Correct procedures for CPR not followed; ▪ One staff member stayed on the couch and continued to watch TV during the drill, and another staff member stated she was not feeling well so she could not react to the situation due to taking medication; ▪ Regulators on oxygen tanks not placed on correctly; ▪ Had to give instructions for AED use due to language barrier with two staff; ▪ Nurses did not assess the adequacy of compressions and ventilations; ▪ Nurse waited for Ambu bag to give rescue breaths; and ▪ LVN did not respond to drill immediately and had to be coaxed to start the drill. As noted previously, there was no indication that any corrective actions were timely and appropriately taken addressing many of the issues listed above. Again, consistent with the findings of the past two reviews, there was no system in place for regular review of the Facility's Medical Emergency Drills and procedures. The only documentation provided included the number of drills conducted during August 2010 through January 2011, and the number of drills that passed or failed. There was no analysis of the drills regarding problematic trends, which should have generated systemic corrective actions. In addition, it appeared that neither the Nursing Department nor the Medical Department, or any designated committee, had conducted a formal review of the results of the drills, especially regarding the lack of responsiveness by staff. The Facility's policy regarding Medical Emergency Response indicated that: "Data must be reviewed at least monthly and trends must be analyzed quarterly," and trend analysis reports and corrective actions shared with the State Office Quality Assurance Coordinator. The documentation provided to the Monitoring Team did not adequately address this requirement. As noted in the Monitoring Team's previous reports, 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 in executing emergency procedures. The Facility should promptly develop and implement a system for reviewing and analyzing emergency procedures, and the data generated from the emergency medical drills, and, as necessary, implement timely plans of action to correct deficiencies identified. In September 2010, the Facility began having the Program Compliance Monitors present at some of the Medical Emergency Drills, which was a positive addition. The PCMs scored the drill checklists in an effort to establish inter-rater reliability. Some of the comments noted on the PCMs' drill reports included: ▪ RNs conducting the drills did not allow staff members to complete the entire cycle of CPR uninterrupted; ▪ Drills were more of a coaching exercise than an actual medical emergency drill; ▪ RNs conducting drills scored items as being done correctly when staff did not	

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		perform them correctly; ▪ RNs conducting drills might benefit from formal training on how to conduct a drill; ▪ There were inconsistencies between how each RN was conducting the drill; ▪ LVN, Psychologist, and QMRP did not respond to drill; and ▪ RNs conducting the drill were passing the drill when staff had required a number of prompts. Although the Facility provided graphic data for Emergency Medical Response Drills PCM responses, the data could not be accurately interpreted. The reports indicated that the graphs represented compliance and noncompliance with some of the items found on the Medical Emergency Drill Checklists. However, there was no indication regarding how many drills the data represented, or if these data were a comparison with the RN data from the same drills. Because the data was confusing in its current presentation, the Facility should modify the presentation so that there is clear identification of what the data represent. Aside from this issue, implementing this system of PCM audits of Medical Emergency Drills was an excellent idea. It helped the Facility to identify some of the problematic issues that the Monitoring Team identified during past and current reviews. Although the Nursing and Quality Assurance Departments met in November 2010 to discuss the PCMs findings, at the time of the review, the QA Department developed a training curriculum to address some of the problematic issues found during the drills, but the Nursing Department had taken no action regarding the findings. In fact, Nursing Administration indicated that they disagreed with the PCMs' findings that staff's inaccurate performance of CPR was a reason to fail a drill. Expecting anything less than perfect execution of an emergency procedure during a drill defeats the purpose of conducting drills in preparation for an actual emergency. It is not clinically acceptable to have lower expectations for medical emergency drills than what would be expected in a real emergency, or to not insist that the practice drills incorporate the appropriate emergency procedures. The Facility should develop and implement a system to address the discrepancies found between the PCM and RN data regarding Medical Emergency Drills, and, as appropriate, develop plans of correction that include the responsible person(s), dates of implementation, expected outcomes, and on-going monitoring activities. From review of an actual Code for Individual #202, the Facility did not use any form such as the Medical Emergency Drills form to record the timelines and processes of an actual medical code. The Facility's policy regarding Medical Emergency Response noted that: "Copies of the Medical Emergency Drill Checklist will be kept near each Automated External Defibrillator (AED) to serve as a review tool during actual emergencies." The	

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		Facility should implement a form to record actual medical emergency codes, and formally review this information to identify strengths and weaknesses in the Facility's emergency response systems. Observations of emergency equipment use by staff in the Infirmary and Building 6521 found the same problems during this review as were found during the last two reviews. There were no lists of the equipment contained in the emergency red bags that were taken to emergencies to ensure that all the equipment was present. In addition, the alarm was not operational for the AED in the Infirmary, which was consistent with the last review's findings. It appeared that this issue had not been addressed since the last review, because the staff did not react when the AED was removed and no alarm sounded to indicate that they understood this was problematic. The staff was not able to say when they last noted that the alarm had sounded when the AED was removed from its case. In addition, there were a number of blanks found on the check sheet for the AED indicating that it was not being consistently checked to ensure it was operational. Although the nurses on both units were able to demonstrate appropriate use of the oxygen, suction machine, and AED, consistent with the past review findings, the backup suction and the portable suction machines were not being checked. In fact, one of the portable suction machines was inoperable since it was missing a canister to collect the material being suctioned. In addition, consistent with the past reviews' findings, there were a number of blanks on the emergency equipment check logs for each unit indicating that the oxygen had not been consistently checked. As noted from the past review, the forms used by the units were very difficult to read, and did not include all the equipment/back up equipment used for emergencies. The emergency equipment log forms should be revised so that the information regarding the checking and testing of the Facility's emergency equipment is clearly documented. In addition, a system should be developed and implemented to ensure that nurses are checking all emergency equipment and documenting these checks daily. Since the last review, the only improvement made addressing medical emergencies was the addition of the PCMs monitoring the Medical Emergency Drills. Overall, the Facility showed a lack of urgency in addressing a system that is crucial to the safety of the individuals residing at ABSSLC. The Facility should promptly develop and implement systems addressing all facets of its 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	At the time of the Monitoring Team Visit, there had not been any non-Facility physician case reviews. A schedule had been established, and ABSSLC was due to have a medical peer review in April 2011. At this point in time, the final methodology for the physician case review had not been provided (e.g., number of records/cases to be reviewed per visit, types of cases chosen, selection process, aspects of care reviewed, etc.).	Noncompliance

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	physician case review and assistance to facilitate the quality of medical care and performance improvement.		
L3	Commencing within six months of the Effective Date hereof and with 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.	At the time of the review, there was no medical quality assurance program in place. There was a database available, but it was incomplete, and was not being used for quality assurance purposes. There was no evidence that a comprehensive set of clinical indicators had been developed, or that the data available was being used to identify issues requiring the development of corrective action plans. As is discussed in further detail below, while a more comprehensive medical quality improvement system is being developed and implemented, existing data should be utilized to begin to make changes that would positively affect outcomes for individuals. In determining trends and prioritizing efforts to improve the quality of medical care, several databases that were already available could be used. For example, a list of those who were admitted to the Infirmary was provided. From this list, it could be determined which individuals had been hospitalized and returned to the Infirmary for post hospital convalescence before returning to their residence. This list did not include those that expired in the ER or during a hospital admission, those who might have been transferred elsewhere following hospitalization, those that were discharged, but did not need Infirmary admission because they were sufficiently stable to resume care in the residence, or those that had been hospitalized in a psychiatric hospital. However, the list did include the typical spectrum of cases that represent the bulk of return readmissions to ABSSLC. In order to decrease hospitalization rates, consideration needs to be given to earlier interventions in the health care process and decision tree, including preventive care and attention to early changes in health status. However, the information in the current database would be useful in focusing attention on the majority of hospital admissions from ABSSLC. Since August 2010, there were 64 individuals documented as having required hospitalization/treatment, and then admission to the Infirmary. Of these, 28 individuals (44%) had gastrointestinal problems. Respiratory illness was responsible for 13 (20%) of the Infirmary admissions after hospitalization. Genitourinary illness was responsible for seven (11%) of the Infirmary admissions following hospitalization. These three categories represented the bulk of post hospital admissions to the Infirmary, and should provide guidance in prioritizing completion of clinical guidelines and in–service training to all levels of staff. The same prioritization and trend analysis could be done with all Infirmary admissions since August 1, 2010, but this would not focus attention on those most acutely ill, specifically, those that required hospitalization. However, given that there were 108 admissions to the Infirmary from August 1, 2010 through December 31, 2010, it would add further guidance in prioritizing programs and projects for medical	Noncompliance

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		quality improvement. An area of ongoing concern was the rate of respiratory illness. Based on information submitted, there were 39 cases of pneumonia in the prior six months. Of these, 15 were considered to be aspiration pneumonia. The recent in-service training for PCPs concerning decision-making regarding a diagnosis of aspiration pneumonia versus non-aspiration pneumonia might result in more accurate diagnoses, which would change the numbers in each category of pneumonia. However, based on the system in place at the time, of the 39 diagnoses with pneumonias, 21 of the individuals had feeding tubes. Of the 15 aspiration pneumonias, nine individuals had feeding tubes. For those with aspiration pneumonia and feeding tubes, it is recommended that GERD be ruled out as a contributing cause, because G-tube feedings might aggravate GERD, and a J-tube, if coiled back into the stomach, might also contribute to GERD. If there were GERD, then further medical and/or surgical treatment would need to be considered. For the individuals with non-aspiration pneumonias, with or without a feeding tube, GERD also should be reviewed as a potentially contributing cause of pneumonia, especially if they have a history of periodic bronchospasm or treatment for asthma. These individuals also should be screened to determine if they might have dysphagia as a contributing cause, as silent aspiration might be elusive. Whatever the type of pneumonia, critical review should include ruling out reasons why pneumonia would have occurred, to prevent repeat pneumonia. In addition, treating the pneumonia at the earliest presentation of signs and symptoms is necessary to minimize morbidity. In reviewing the incidents of pneumonia, reviewing the days prior to beginning treatment might indicate the need for further training of the direct support professionals on changes in health status. In follow-up to the in-service training on the types of pneumonia, the Medical Director should develop and implement a valid and reliable database system from which to analyze trends in respiratory illness, and begin to look at contributing causes. When reviewing the numbers of pneumonia cases per month, it appeared from the 2010 data that there was a double peak in February/March and September/October. It would be helpful to determine if data prior to 2009, and future date indicate similar trends. If that double peak remained valid, then this would be an additional opportunity for medical quality improvement. The cases could be reviewed, as well as the environment, and community illness rate to help define causes of such seasonal increases in pneumonia. Another area needing intensive medical oversight and quality improvement efforts was decubitus care and prevention. A list was submitted of the numbers of decubiti per month. For October 2010, there were 15 decubiti; in November 2010, there were 13 decubiti; and in December 2010, there were 12 decubiti. Although the incidence rate based on the entire population residing at ABSSLC was low, the mere presence of decubiti is of major concern. There are conditions in which decubiti are expected	

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		entities, such as in cases of spina bifida. However, for most individuals, decubiti are preventable. The Facility should develop a database to track decubiti to determine if these are occurring in the hospital (this would require documentation of a head to toe skin assessment before and after transfer to the ER to provide evidence for this fact) and are returned with decubiti, or whether they are associated with diagnoses in which decubiti are not preventable. The database also should track the stage of the decubiti, the date of healing, and the building in which it developed if it occurred at ABSSLC. An example of a decubiti that was preventable was found with Individual #353 who recently transferred out of the Infirmary. While in the residence, she developed a Stage 4 decubitus, which eventually needed surgical intervention to assist in healing. These events were preventable, and a tracking system for decubiti should be part of the medical quality improvement system. Further, if there remain a large number of decubiti in the Facility, there should be one nurse who has expertise in decubitus care who can be consulted, providing options as to products available for treatment, how they should be applied, and when they should not be used. This nurse could track independently the progress of healing, not depending on the subjectivity and variation of staff assigned to the residence. Focus on decubiti would also allow for removal of misdiagnosis. Not all ulcers are from pressure, such as venous stasis ulcers, and this easily could nullify data that is entered into the database. If there is a trend toward pressure ulcer formation in the hospital setting, then the Medical Director and Chief Nurse Executive should meet with their counterparts at the hospital to assist in resolving this concern. Another area that would benefit from medical quality improvement is the field of chronic cardiovascular disease. A list was submitted identifying the individuals in the last six months who were newly diagnosed with hypertension, congestive heart failure, or diabetes mellitus. This number will increase as the population ages in place, and begins to manifest not only the sequelae of congenital, metabolic, and genetic disorders, but also the geriatric syndromes and diagnoses common to any aging person. To ensure there is good control of hypertension, heart failure, and hyperglycemia across the campus, the Medical Director should develop and implement a database, which is updated regularly and accessible at any time. It would assist in identifying those individuals needing further evaluation, treatment, and monitoring, and assist in complying with the Settlement Agreement concerning quality care. Information from this database could be discussed as a teaching opportunity at the morning medical meetings.	
L4	Commencing within six months of the Effective Date hereof and with	A number of clinical guidelines had been developed and were nearing the final draft stage. DADS State Office had distributed them for review and comment, according to the	Noncompliance

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	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.	Medical Director. The Medical Director provided the following guidelines in draft form: ▪ *Clostridium difficile* Management Pathway; ▪ Anticoagulation protocol; ▪ Venous Thromboembolism Screening and Prophylaxis Protocol with VTE Risk Assessment Screening Form; ▪ Aspiration Pneumonia/ Identifying Risk, Treatment, and Prevention of Aspiration Pneumonia/ Evaluation of Suspected Aspiration Pneumonia/Adult Aspiration Pneumonia Prevention Algorithm; ▪ Constipation Prevention and Management Protocol; ▪ Management of Hyperlipidemia; ▪ Screening and Treatment of Reduced Bone Density; and ▪ Clinical Guidelines for skin lesions. Once these guidelines are finalized and approved, there will need to be training of all PCPs for each guideline, which should be documented. The Medical Director will need to spend considerable time reviewing PCPs' progress in adhering to these guidelines, as a unified approach to care had not occurred on campus previously. As mentioned previously, there was urgent need for a GERD clinical guideline.	

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

1. In relation to continuing medical education, the Medical Director should ensure:
    a. All PCPs participate in the required education; and
    b. An agreed upon percentage of the credits focus on disease prevention and treatment of diagnoses commonly seen at ABSSLC.
2. Either before or after the Infirmary rounds, the morning medical meeting also should include a round table discussion, including, for example, discussion of new clinical pathways, discussion of hospitalized individual and individuals who were required on-call intervention since the last meeting, and discussion about how to prevent reoccurrence of an illness, etc.
3. Individuals with recurrent pneumonia should be considered for a GERD work- up.
4. Serial photos should be used to document the healing or further breakdown of a decubitus ulcer. A measuring device should be included in the photo by which to measure the size of the lesion.
5. For those with decline in mentation or function not associated with delirium from an acute illness, consideration should be given to a dementia work -up.
6. The State Office should provide guidance in determining the clinical guideline to be used for preventive mammogram screening.
7. A database should be created to track such preventive care tests as mammograms and colonoscopies.
8. The seizure management policy should be reviewed with focus on the timing of when to call the nurse. It might be more proactive to contact the nurse for a seizure lasting three minutes so that timely administration can be provided by five minutes, rather than waiting until five minutes to contact the nurse.
9. If an individual is hospitalized for a complication of pica and eventually returns to the Infirmary, the PCP should meet with the PST to review and amend, as appropriate, any prior plan designed to address the pica, and take additional aggressive steps to ensure safety before discharging the individual to the residence.

10. Clinical death reviews should be completed in a timely manner, preferably within 30 days. Autopsy results can be added when available, but should not delay the clinical death review. As was recommended in the previous report:
    a. Mortality reviews should be completed in a timely manner. A brief medical or clinical review should occur within 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;
    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.
11. When the hospital medical team determines a medical course of action, especially in not offering such options as feeding tubes, there should be a mechanism for the PST to meet to discuss this information, with the guidance of the PCP, to assist in determining options and implementation of those options.
12. When the cause of a life threatening illness remains elusive despite the use of local consultants and the resources of the local hospital system, a referral to a tertiary care center should be considered prior to an individual being considered terminal. This would require close ongoing communication with the tertiary care center physicians for provision of test results already completed, details of the clinical history and chronology of events, as well as for receiving frequent updates.
13. 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.
14. PCPs and all nurses that provide J-tube care and maintenance should be provided in-service training to ensure proper procedures are followed in ordering medication, formula, and flushes through a J-tube, and to ensure measuring for residuals is not attempted through a J-tube.
15. A campus-wide monitoring process should be implemented through which J-tube care and maintenance is reviewed for all individuals to ensure the orders and provision of nursing care are consistent with the nursing policy and procedure manual.
16. It is essential that for individuals with complex medical needs that PCPs constantly challenge themselves to think critically about next steps, necessary assessments, and a wide array of potential treatment. For example:
    a. If an individual has a G-tube and a history of repeated vomiting, appropriate assessments and critical analysis should be completed until the cause is determined, treatment is provided, and monitoring indicates that the problem has resolved or stabilized.
    b. If an individual has severe GERD or repeated vomiting with aspiration, and a J-tube is no longer considered viable because of a history of clogging, then critical thinking should lead to alternative approaches to address the severe GERD and prevent future aspiration (e.g., replacing the J-tube, fundoplication, or tracheal esophageal diversion, further medical treatment, etc.).
    c. For those with a history of bronchospasm/reactive airway disease, and aspiration pneumonias, critical thinking should include steps to prevent both recurrent reactive airway disease and aspiration pneumonia. A work up for GERD is often a part of this process.
17. The Medical Director or designee should discuss with gastroenterologists an optimal preparation with less risk for those undergoing colonoscopies, especially for those with GERD and hiatal hernias. For select high-risk individuals, a protocol/checklist might be beneficial with focus on areas of importance, such as meticulous attention to positioning, and verification that the tip of the NG-tube is in correct placement, and to ensure there is no recoiling back into the esophagus.
18. When nursing staff or PCPs find abnormalities on clinical exam, the rationale for the next step should be recorded in the Integrated Progress Notes, especially if watchful waiting is the clinical decision.
19. Changes in health status should be a frequent in-service training topic to direct support professionals, at least yearly or more frequently, as indicated. As recommended previously, this training should include but not be limited to what to observe, how to describe observations, how

to document observations, and when to contact the nurse.

20. The list of rescinded DNRs should be identical across campus. The Facility should research the reasons for the discrepancies between the lists.
21. ABSSLC should conduct a review of all individuals with a DNR Order in place, and for anyone for whom the DNR order is to be continued, justification should be provided using the State guidelines. The Monitor is requesting that by May 31, 2011, the State provide her with a report showing each of the individuals for whom a DNR order was in place at the time of the February 2011 review, the date the review was conducted, the results of the review, and for any individual for whom the DNR order is continued, the justification.
22. DADS State Office might need to provide further guidance on the DNR issue to ensure all Facilities are interpreting the guidance DADS previously provided in the same way.
23. For newly prescribed medications (either from an ER, hospitalization, or at the Facility) with narrow therapeutic ranges, it is recommended there be a guideline for serial drug levels at a frequency agreed upon by the physicians and clinical pharmacist to ensure maintenance of a therapeutic level. The frequency should be sufficient to determine if the level is increasing toward the toxic range.
24. If an individual is hospitalized for complications of fecal impaction, or seen in the ER for fecal impaction, this should trigger a PST response, including consideration of bowel movement logs, training of direct support professionals concerning requirements of documentation, serial assessment by nursing, review of medications by the pharmacist, behavior supports, if there are concerns of noncompliance or inability to cooperate, and close monitoring by the PCP.
25. Whenever possible, informed staff should accompany the individual to the ER.
26. The Hospital Nurse Liaison should add a brief key for abbreviations used to enhance the understanding of the content for both clinical and nonclinical members of the PST. Additionally, for select complex individuals, providing brief background information would allow better understanding and interpretation of the clinical course.
27. With regard to Medical Emergency Drills:
    a. A consistent system for tracking Medical Emergency Drills should be developed and implemented to ensure that they are being conducted in accordance with the Facility policy;
    b. All emergency systems should be activated during Medical Emergency Drills;
    c. A system should be promptly developed and implemented for reviewing and analyzing emergency procedures, including data generated from the emergency medical drills, and, as appropriate, plans of action should be timely implemented to correct deficiencies identified;
    d. The presentation of the Program Compliance Monitors' data regarding medical emergency drills should be modified so that it is clear what the data represent;
    e. The discrepancies found between the PCM and RN data regarding Medical Emergency Drills should be reviewed and addressed; and
    f. A form should be developed and implemented to record actual medical emergency codes. This information should be reviewed formally to identify strengths and weaknesses in the Facility's emergency response systems.
28. With regard to the use of emergency equipment:
    a. On at least a quarterly basis and during Medical Emergency Drills, nurses should be required to demonstrate that they are familiar with operation of all emergency equipment;
    b. The emergency equipment log forms should be revised so that the information regarding the checking and testing of the Facility's emergency equipment is clearly documented; and
    c. A system should be developed and implemented to ensure that nurses are checking all emergency equipment and documenting these checks daily.
29. The Medical Director should develop and implement a database to track the types of pneumonia, and begin to consider contributing causes.
30. A database should be developed and implemented to track decubitus ulcers to determine if these are occurring in the hospital and individuals return with new decubiti, whether the decubiti begin at ABSSLC, or whether they are associated with diagnoses for which they are not preventable. Such a database also should allow tracking of the stage of ulcer and length of time until healing.

31. A nurse with expertise in decubitus care would be a valuable addition to the health care system at ABSSLC, and could be used as a consultant to monitor all the ulcers on campus, providing updated treatments and training, and providing objective documentation based on findings and progress.
32. To ensure there is good control of hypertension, heart failure, and hyperglycemia across the campus, there should be a complete and accurate database, which is updated regularly and accessible to any PCP at any time.

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 Services Policy: Medication Preparation for Therapeutic Home Visits, dated 12/1/10; o Nursing Services Policy: Transportation and Security of Medications, dated 12/8/10; o Nursing Services Policy: Management of Acute Illness/Serious Injury, dated 12/10/10; o Nursing Proposal for Staffing; o ABSSLC's nursing staffing information; o Nursing QA data, September through December 2010; o QA training curriculum and presentation regarding conducting Medical Emergency Response Drills; o QA graphic data for Nursing's monitoring data, from September through December 2010; o Revised Nursing monitoring tools, dated 12/27/10; o Document addressing Quality Assurance activities, from August 2010 through January 2011; o Nursing Retreat training curriculum and training rosters, from August 2010; o ABSSLC's Nursing Monitoring raw data, September 2010 through January 2011; o ABSSLC's lists of individuals who were seen in the emergency room, hospital, and Infirmary; o ABSSLC's Nursing Education's Training Manual; o Monthly Infection Control Reports, from September through December 2010; o Drug Utilization Discrepancy Report data; o Training rosters for Infection Control Data Reliability and Integrity Tracking; o Procedures for Infection Control Data Reliability; o The Nurses' Meeting minutes, meeting rosters, and handouts, dated 9/10, 10/10, and 11/10; o Infection Control Committee meeting minutes, dated 10/27/10, and 1/13/11; o Pharmacy and Therapeutic Committee minutes, dated 10/28/10; o List of individuals identified as being current regarding their immunizations; o Post Exposure Documentation; o Infection Control Monitoring Tool and data, from September through December 2010; o Documentation addressing outbreaks at ABSSLC; o The medical records for the following: Individual #199, Individual #19, Individual #311, Individual #317, Individual #378, Individual #468, Individual #353, Individual #92, Individual #426, Individual #290, Individual #435, Individual #343, Individual #124, Individual #395, Individual #143, Individual #259, Individual #119, Individual #7, Individual #361, Individual #75, Individual #91, Individual #212, Individual #53,

	Individual #492, Individual #253, Individual #359, Individual #270, Individual #497, Individual #385, Individual #186, Individual #468, Individual #542, Individual #447, Individual #267, Individual #170, Individual #383, Individual #112, Individual #167, Individual #503, Individual #510, Individual #241, Individual #231, Individual #268, Individual #478, Individual #417, Individual #388, Individual #73, Individual #370, Individual #360, Individual #347, Individual #528, Individual #362, Individual #203, Individual #410, Individual #78, Individual #86, Individual #392, Individual #376, Individual #235, Individual #315, Individual #373, Individual #85, Individual #489, Individual #216, Individual #311, Individual #235, Individual #20, Individual #100, Individual #181, Individual #345, Individual #240, Individual #299, Individual #252, Individual #24, Individual #399, Individual #297, Individual #5, Individual #204, Individual #344, Individual #40, Individual #8, Individual #109, Individual #403, Individual #49, Individual #189, Individual #452, Individual #162, Individual #76, Individual #54, Individual #110, Individual #504, Individual #19, Individual #467, Individual #199, Individual #480, Individual #70, Individual #33, Individual #266, Individual #519, Individual #238, Individual #192, Individual #327, Individual #395, Individual #145, Individual #21, Individual #285, Individual #117, Individual #505, Individual #272, Individual #479, Individual #481, Individual #138, Individual #514, Individual #223, Individual #246, Individual #384, Individual #342, Individual #306, Individual #126, Individual #501, Individual #219, Individual #277, Individual #12, Individual #479, Individuals #386, Individual #7, Individual #100, Individual #130 Individual #106, Individual #384, Individual #530, Individual #387, Individual #123, Individual #517, Individual #15, Individual #26, Individual #505, Individual #215, Individual #289, Individual #13, Individual #272, Individual #457, Individual #154, Individual #8, Individual #139, Individual #304, Individual #123, Individual #23, Individual #332, Individual #365, Individual #229, Individual #67, Individual #281, Individual #407, Individual #538, Individual #212, Individual #112, Individual #126, Individual #10, Individual #185, Individual #1, Individual #346, Individual #381, Individual #176, Individual #545, Individual #160, Individual #390, Individual #201, Individual #337, Individual #77, Individual #240, Individual #147, Individual #213, Individual #128, Individual #186, and Individual #385; 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 risk lists for health indicators; o Minutes of the Medication Error Committee, dated 7/28/10, 8/25/10, 9/22/10, 10/26/10, 11/24/10, and 1/26/11; o ABSSLC's medication variance data, from August through December 2010; and o Medication Observation Report-November 2010. ▪ **Interviews with**: o Jim Kluza, RN, BA, Chief Nurse Executive (CNE);

	○ Mary White, RN, MSN, Quality Assurance Nurse; ○ Krista Hamilton, RN, BSN, Infection Control Nurse; ○ Marilyn Branson, RN, Infection Control Manager; ○ Elizabeth Greer, RN, Nursing Educator; ○ Tracyl Gandee, Settlement Agreement Coordinator; ○ David Daniels, Program Compliance Coordinator; ○ Teresa Lowry, RN, Nurse Manager; ○ Dana Selbert, RN, Case Manager; and ○ Chasidy Tomlin, LVN. ▪ **Observations of**: ○ Medication Administration in the Infirmary; and ○ PSP meeting for Individual #468, on 2/17/11.
	Facility Self-Assessment: Based on a review of the Facility's POI with regard to Section M of the Settlement Agreement, the Facility found that it remained out of compliance with the all of the indicators, which was consistent with the Monitoring Team's findings. Although the Facility included data in the POI to substantiate its findings, as is explained in greater detail below, the data was of questionable reliability. In addition, it often was unclear specifically to what the data referred. For example, for Section M.1 of the Settlement Agreement, which includes a number of requirements, the Facility provided one overall statement regarding the data collected. Specifically, the POI stated: "1/2011--Current monitoring results: 65% compliance from 74 reviews since 9/2010." It was unclear specifically what component of Section M.1 this data was intended to measure. Since January 2011, the Facility began using the newly modified monitoring tools. Although the tools had associated guidelines, the guidelines should be reviewed to determine if additional instructions are needed to ensure that specific criteria that constitute compliance with each item are identified clearly. At the time of the review, the auditing process was not measuring the quality of the care and supports provided. In addition, although the Facility reported that inter-rater reliability was established for some of the nursing tools, the Facility did not have a written procedure outlining the process to determine inter-rater reliability, and ensure it was executed appropriately and consistently. In addition, the percentages of inter-rater reliability were not reported for each tool as would be necessary in evaluating the reliability of the overall data collected. The Nursing Department had generated data for each of the Nursing tools, which a variety of auditors had completed without first establishing inter-rater reliability or ensuring clinical competency in the areas being audited. Consequently, the data generated was of questionable reliability. The usual progression for this process would include developing instructions for the tools, and then establishing inter-rater reliability before initiating auditing activities to ensure that the data generated accurately reflected the indicators being audited. In addition, establishing an appropriate structure to guide the entire monitoring process would ensure that all disciplines were using the same procedure so that data across disciplines was accurate and reliable. Without accuracy and reliability, the analysis and interpretation of the data could easily be skewed and trends not accurately identified.

	In addition, the Facility should develop a unified system to present the data from the monitoring tools so that the data can be easily analyzed and trends identified. In addition, a unified system would allow data to be easily reviewed and interpreted between disciplines and departments. As noted in previous reports, the presentation of data should include the total population being reviewed (N), and the sample of the population that was audited (n) to yield a percent sample to indicate the relevance of the compliance scores. Without this information, data cannot be accurately interpreted, analyzed, or accepted as valid reflections of the practices being measured. Once this data presentation system is developed, the Facility will then need to use these data to justify their compliance status for the various monitoring indicators. The Facility's POI for Nursing should include much more information regarding the actions taken since the last review, with specific dates of implementation and updates on the status of the systems. In addition, the Presentation Book addressing the Settlement Agreement requirements should include all of the Nursing Department's supporting documentation to provide a comprehensive overview of the steps taken, progress made, and movement toward compliance.
	Summary of Monitor's Assessment: The Monitoring Team continued to identify numerous examples of a lack of clinical competence with regard to nursing skills essential to ensuring the health and safety of individuals at ABSSLC. In order for the Risk System, as well as other health care systems to successfully result in positive clinical outcomes, it is imperative that the Facility expediently addresses the nursing staff's overall lack of clinical competency. At the time of the review, ABSSLC continued to have an adequate complement of nurses. As reported by the Chief Nurse Executive, the department continued to have 82 positions allotted for RNs and 104.5 positions for LVNs, with two RN vacancies and no LVN vacancies. Thus, the Facility had not needed to use any agency nurses and used voluntary overtime for situations when the Facility needed to augment nursing coverage due to issues such as sick calls, leaves, or vacations. The Nurse Recruiter, who worked part time with the Quality Assurance Department, and the Hospital Nurse Liaison also had been given some assignments to assist the QA Department. These reallocations continued to be in place at the time of the review, and were still considered to be temporary assignments. ABSSLC's QA Nurse, Program Compliance Monitors, and Nursing Department had begun using the newly modified monitoring tools in January 2011. Although the tools had associated guidelines, they should be reviewed to determine if additional instructions are needed to ensure that specific criteria that constitute compliance with each item are identified clearly. This system was in the initial stages of development, and the data generated from the auditing was not yet addressing the quality of the areas audited. As this system is developed, the Facility also should develop and implement a procedure for establishing inter-rater reliability at 85% or above. Consistent with the findings from past reviews, a number of significant issues continued to be found regarding the identification of changes in status and the nursing documentation addressing complete and adequate nursing assessments. There continued to be problems noted regarding the lack of adequate

	documentation when an individual began showing symptoms of a status change, consistent follow-up for symptoms, and assessments conducted prior to the transfer to an off-site medical center as well as upon return to the Facility. The Nursing Department's auditing data was not reflective of the problems the Monitoring Team found, especially regarding the quality of nursing assessments and documentation. Since the last review, the Facility had developed written procedures clearly outlining a formal system to ensure the reliability of the Facility's IC data. A review of the newly implemented procedures addressing IC data reliability using the Drug Utilization Discrepancy Report revealed an excellent system that generated valuable data, which timely alerted the Facility to problematic trends. The next steps would be to develop formal plans of action addressing any problematic trends, and to incorporate this data into the Infection Control Committee Meeting minutes. Also consistent with the findings of previous reviews, there had been no improvement regarding the quality of the Nursing Assessments and Nursing Care Plans. The Facility had provided some training in these areas, but none of the training was competency-based. At the time of the review, the Facility had not developed a competency-based training curriculum addressing Nursing Assessments or Nursing Care Plans. Since the last review, the Nursing Department and the Pharmacy had been working together to review the medication administration system. In addition, the Facility had been working on identifying issues related to medication variances in order to implement interventions to decrease these errors.

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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 assurance 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 Settlement Agreement. The Facility's medical emergency systems, including related nursing issues, are discussed in the section of the report that addresses Section L.1 of the Settlement Agreement. <u>Staffing</u> At the time of the review, ABSSLC continued to have an adequate complement of nurses. As reported by the Chief Nurse Executive, the department continued to have 82 positions allotted for RNs and 104.5 positions for LVNs, with two RN vacancies and no LVN vacancies. Thus, the Facility had not needed to use any agency nurses, and used voluntary overtime for situations when the Facility needed to augment nursing coverage	Noncompliance

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		due to issues such as sick calls, leaves, or vacations. However, the CNE reported that in March 2011, the department would lose one RN position and two LVN positions due to the closing of building 5961. If possible, the Facility should consider utilizing these positions to complete some of the monitoring activities that are required. In addition, since the baseline review, the CNE had planned to increase through attrition nursing coverage during the 4 p.m. to 12 a.m. shift from four nurses to eight nurses. Also, he had recently submitted a proposal for moving some of the nursing positions to increase RN coverage on the 12 a.m. to 8 a.m. shift, and on the weekends to have three RNs available for the campus as well as at least one RN in the Infirmary. At the time of the review, there had been no response yet to the proposal. As noted in the last report, in February 2010, the Facility had reallocated one position, the Nurse Recruiter, to work part time with the QA Department, and the Hospital Nurse Liaison also had been given some assignments to assist the QA Department. These reallocations continued to be in place at the time of the review, and were still considered to be temporary assignments. As noted previously, in the event these positions become permanent, job descriptions/job duties addressing these newly allocated positions would need to be developed, and policies, procedures and/or protocols would need to be developed/modified addressing the integration of these positions into the QA Department. In addition, since the last review the Nursing Department assigned two Nurse Case Managers to work with the Physical Nutritional Management team (PNMT). The Facility continued to host nursing students from the local area for clinical training, and had begun a dialogue with Texas Tech regarding the possibility of hosting nursing students from their School of Nursing. ABSSLC should continue its efforts in recruiting, maintaining, and evaluating reallocations of nursing positions to meet the needs of the individuals residing at the Facility, as well as the requirements of the Settlement Agreement. At the time of the review, ABSSLC had a census of 447 individuals. The overall structure of the Facility's nursing services remained basically the same since the previous reviews: ▪ Five of the residential buildings had 24-hour nursing care, specifically buildings 6521, 6510, 6480, 6500, and the Infirmary. ▪ Building 5961 was scheduled to close in March 2011. ▪ 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, 12 Infirmary nurses, and 14 administrative nurses. ▪ The Chief Nurse Executive continued to directly supervise the Hospital Nurse	

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		Liaison, Nurse Educator, the Infection Control Nurse, the Nurse Operations Officer, two Administrative Assistants, and one Unit Nurse Manager/Campus RN Supervisor. ▪ 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 the census, individuals' acuity, and staff workload related to individual or staff activities. <u>Quality Assurance Efforts</u> Based on interviews with the QA Nurse, since that last review, monitoring data had been generated from the initial monitoring tools and in January 2011, revised nursing monitoring tools were implemented. The revised tools included: Urgent Care/Emergency Room Visits, and Hospitalizations; Nursing Care-Documentation; Medication Administration and Documentation; Nursing Care-Prevention; Nursing Care-Acute Illness and Injury; Infection Control; Annual Nursing Care Plans; Nursing Care-Seizure Management; Annual Nursing Assessment; Nursing Care-Management of Chronic Respiratory Distress; Nursing Care-Pain Management; and Skin Integrity Assessment. She reported that due to the numerous changes made in the monitoring tools, the current data could not be accurately compared to the data generated from the previous monitoring tools. Thus, data generated from the newly revised monitoring tools were being viewed as the Facility's baseline data. The Facility should ensure that each monitoring tool has appropriate instructions, which identify the specific criteria that constitute compliance with each item. The new monitoring tools included guidelines that were specific to the Settlement Agreement, and the Health Care Guidelines. However, there were no Facility-specific instructions found addressing which documents were to be monitored for the various items, and what specific criteria constituted compliance. Although the Facility reported that some inter-rater reliability percentages were established for some of the nursing tools, no written procedure had been developed outlining the process. The Facility should develop and implement a procedure for establishing inter-rater reliability to ensure it is executed appropriately and consistently. In September 2010, the Facility's Program Compliance Monitors (PCMs) had begun completing oversight monitoring of the medical emergency response drills. A number of problematic issues were identified and are described in detail with regard to Section G.1 of the Settlement Agreement. Several discrepancies in the scoring of the drills were noted between the nursing staff and the PCMs. In September 2010, Nursing and QA met to discuss these issues. It was decided that rather than using the drills as a teaching tool, drills would be conducted to assess the participants' knowledge and ability to perform emergency procedures, and scored as such. Teaching opportunities would then be	

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		initiated as needed after the results of the drills were assessed. This would result in the data accurately reflecting the execution of the emergency response and procedures. In addition, as a result of this joint process between the Nursing and QA Departments, the QA Department determined that both the nurses and PCMs needed training regarding conducting medical emergency drills, the documentation of action plans, and definitions of failed drills. At the time of the review, the training had not yet been implemented, but the curriculum had been completed. A review of the training materials found it to be exceptional. From discussions with the QA Nurse, it was anticipated that the Medical Emergency Response Drill training would be implemented in March 2011. In addition, by the next review, the Facility planed to have the Training Department completed additional monitoring, which would include audits for a small sample of the medical emergency response drills. Also, the Facility provided graphic data for Emergency Medical Response Drills PCM responses. However, the data could not be accurately interpreted. The graphs represented percentages of compliance and noncompliance with some of the items found on the Medical Emergency Drill Checklists. The data did not include how many drills the data represented, or if these data were a comparison between the Nursing Department's data and the PCMs data from the same drills, or if it was reflective of the PCM data for the specific month. Although the data in its current presentation could not be interpreted, some simple modifications to the presentation of the data would make it clear what it represented. Aside from this issue, the implementation of the PCM audits of Medical Emergency Drills was an outstanding example of how monitoring activities facilitated the identification of problematic issues that might have otherwise gone unrecognized. This process ultimately should lead to positive outcomes regarding the Facility's emergency response systems. From discussions with the Facility's Settlement Agreement Coordinator and the Program Compliance Coordinator, the Facility's had been entering the departments' monitoring data into a database and was able to generate graphs reflecting compliance percentages per monitoring tool, and the specific items on each monitoring tool by month. A review of these graphs for September through December 2010 for the nursing monitoring tools found that they were valuable in viewing the data at a glance, and comparing compliance scores for specific items on the monitoring tools. However, pertinent information was not included on the graphs to allow accurate interpretation of the data. Specifically, the graphs did not include the total population being reviewed (N), or the sample of that population that was audited (n) to yield a percent sample to indicate the relevance of the compliance scores. Sample size needs to be established, and in doing so, the ability to apply the findings to the overall population needs to be considered. Without this information, data cannot be accurately interpreted, analyzed, or accepted as valid	

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		reflections of the practices being measured. In addition, the Facility's Settlement Agreement Coordinator and the Program Compliance Coordinator reported that the State had plans to implement a new statewide database system. This was a very positive step that should allow the format and presentation of the data to be consistent and easily reviewed at the Facility and among Facilities. At the time of the review, the Facility had no consistent system in place addressing the structure of how data was presented for interpretation. The Facility should develop a unified system to present the data from the monitoring tools so that the data can be easily analyzed and trends identified. In addition, a unified system would allow data to be easily reviewed and interpreted between disciplines and departments. The table below is one possible example of a system for the Facility to consider as a simple structure for standardizing the presentation of the data.	

Name of the Health Care Monitoring Tool
Established Inter-rater reliability percentage range

Month/year data collected	1/11	2/11	3/11	4/11	5/11	6/11	Mean
N							
n							
% Sample							
# ITEM 1 (Item # on tool and the Item being monitored)	Compliance scores for item #1 by month						Mean Compliance score for item #1
# Item 2	Compliance scores for item #2 by month						Mean Compliance score for item #2
# Item 3	Compliance scores for item #3 by month						Mean Compliance score for item #3

N = Number of total population being reviewed (for example: Total number of individuals with hypertension) in the review month.
n = Number of records audited (for individuals with hypertension).

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Item #	Mean Previous Review Period	Mean Current Review Period
#1		

Based on interviews with the QA Nurse and review of documentation, it was clear significant efforts were invested into implementing processes for monitoring and reviewing data. In addition, from these processes, the Facility was able to identify problematic issues regarding medical emergency response drills and timely communicate these to the Nursing Department and develop some strategies that have yet to be implemented to address these issues. As the Facility continues to define the monitoring responsibilities between QA and the Program Compliance Monitors, the next steps would entail formalizing the inter-rater reliability process, and establishing a unified structure for presenting the data generated from the newly revised Health Care Monitoring tools. The QA Nurse, Program Compliance Monitors, and the Nursing Department should continue regular discussions regarding the data generated from the monitoring process to ensure that all areas are being critically audited, and focused on the quality of the nursing services provided and not the just completion of required documentation.

<u>Assessment and Documentation of Individuals with Acute Changes in Status</u>
Although the Facility had begun using the newly modified monitoring tools in January 2011 regarding Acute Illness and Injury, the Facility had been conducting audits since the last review for this area. However, there were no instructions found for any of the initial nursing monitoring tools or the newly revised tools. The newly revised tools referenced the Settlement Agreement/Health Care Guidelines, and the ICF/MR regulations, but did not include instructions to ensure that compliance scores accurately reflected specific criteria determined to constitute compliance with each item.

A review of 16 individuals' medical records (Individual #199, Individual #19, Individual #311, Individual #317, Individual #378, Individual #468, Individual #353, Individual #92, Individual #426, Individual #290, Individual #435, Individual #343, Individual #124, Individual #395, Individual #143, and Individual #259), who had been transferred to a community hospital, emergency room, or the Infirmary found that there had been no noted improvement since the baseline review regarding the nurses' assessments and documentation. The significant problematic issues found included the following:

- A lack of recognition that the symptoms the individuals experienced were signs of changes in status, and warranted nursing assessments and documentation of the findings from assessments;
- A lack of documentation of appropriate nursing assessments at the time of onset of the symptoms;

#	Provision	Assessment of Status	Compliance
		▪ A lack of clinical competency regarding conducting complete and appropriate nursing assessments; ▪ Significant gaps in nursing documentation when changes in status were initially noted and throughout the acute event; ▪ The type of temperatures taken not consistently documented; ▪ Several inappropriate abbreviations; ▪ Inconsistent follow-up from issues noted in previous nurses' progress notes; ▪ A lack of specific descriptions regarding size, and exact location of injuries, skin abnormalities, or bruises; ▪ The lack of analysis of contributing problematic issues impacting a change of status; ▪ Lack of adequate assessments and follow-up for pain; ▪ A lack of lung sounds routinely assessed and documented for respiratory issues; ▪ A lack of neurological checks documented for individuals with a significant change in mental status and levels of consciousness; ▪ Lack of mental status assessments documented during periods of status changes; ▪ No indication if oxygen saturations documented were reflective of room air; ▪ A lack of assessment of bowel sounds and palpation of the abdomen for individuals with constipation and receiving PRNs for constipation; ▪ Physician/Practitioner not timely notified when changes in status began to occur; ▪ Nurses' progress notes that lacked specific descriptions of individuals' behaviors and mental status, assuming that all staff reading the progress notes were familiar with the individuals; ▪ A lack of documentation that there was communication with the PNMT regarding changes in status for individuals at risk for aspiration/choking; ▪ Nurses' progress notes that did not indicate exactly when issues occurred in chronological order; ▪ Administration and follow-up for PRNs (as needed medications) not appropriately documented; ▪ A lack of documentation regarding the individual's status and assessment at the time of transfer to and from the Infirmary, emergency room, and hospital; ▪ 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 reason for the individual's transfer; ▪ Inconsistent documentation in the progress notes of the time, date, and/or method of transfer to the receiving facility; ▪ Lack of a complete nursing assessment upon return to the Facility, especially addressing the symptoms that precipitated the transfer;	

#	Provision	Assessment of Status	Compliance
		▪ The lack of on-going follow-up assessments after transfer back to the Facility addressing the symptoms that precipitated the transfer; ▪ Dates and times not consistently documented for progress notes; ▪ 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. Based on a review of 16 records for the individuals listed above who had experienced a change in status that required an admission to the Infirmary, community hospital, or emergency room, there was documentation that: ▪ Nurses promptly and consistently performed a physical assessment on an individual displaying signs/symptoms of potential or actual acute illness in zero (0%). ▪ Licensed nursing staff timely informed the PCP of symptoms that required medical evaluation or intervention in zero (0%) cases. ▪ Appropriate information was communicated to the PCP in zero (0%) cases. ▪ The nurse performed appropriate and complete assessments as dictated by the symptoms in zero (0%) cases. ▪ The nurse conducted frequent assessments of the individual's clinical condition in zero (0%) cases. ▪ A plan of care was developed including instructions for implementation and follow-up assessments in zero (0%) cases. ▪ The documentation indicated that acute illness/injuries were followed through to resolution in zero (0%) cases. ▪ Upon discharge from receiving facility, there was a complete nursing assessment performed in zero (0%) cases. These findings were consistent with the findings from the baseline and the previous review. Based on this most recent review, there was no improvement in the nursing care and documentation regarding acute illnesses. The following provides an example of some of the problems noted: ▪ In the case of Individual #353, she was in the Infirmary in October 2010. Some of her medical issues included having a stage IV decubitus ulcer to her sacrum. She was being treated with a wound vacuum machine, which seals the wound with gauze or a foam filler dressing to prevent it from bursting open, a drape, and a vacuum source that applies negative pressure to the wound bed with a tube threaded through the dressing to promote healing in acute or chronic wounds. Individuals who have a decubitis, especially a stage IV decubitis, are at risk for additional skin break down, and need to have their positions changed frequently. In addition, they need to have their skin checked frequently to	

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		ensure that any areas of pressure on the skin that result in even a slight reddened mark are quickly resolved to prevent further skin breakdowns. Also, attention must be paid to the individual's nutritional status which includes their intake, output, weight, fluid intake, and prevention of dehydration. In addition, Individual #353 had a Foley catheter in place. Some of the risks related to having a catheter can include developing a blockage that can stop the urine from flowing into the collection bag, irritation and/or bleeding at the urethra, and the possible risk of a urinary tract infection. In addition, Individual #353 had a colostomy. Some of the care needed for colostomies include: o Monitoring the stool for consistency and color; o Emptying the colostomy drainage bag several times each day to prevent the bag from leaking and spills, especially when skin integrity had already been significantly compromised; o Frequently observing the stoma and the skin around the stoma for redness, irritation, or signs of infection; o Removing the old colostomy bag at least every four to six days, or more often if necessary; and o Keeping the skin around the stoma, which is usual very tender, clean and dry. Also, Individual #353 had a Peripherally Inserted Central Catheter (PICC), which is a long, flexible tube that is put into a vein in the arm and threaded up into a large vein just above the heart. It is used for giving fluids or drug treatment into the bloodstream. The PICC is usually flushed weekly to prevent it from getting blocked, and the dressing covering the site has to be changed regularly. In addition, the site needs to be observed frequently, and the PICC line itself should be regularly checked to ensure it has not been damaged. Some of the possible complications from a PICC might include: o Occlusion of the catheter; o Phlebitis, which is inflammation of a vein; o Bleeding at the site; o Thrombosis, which is a blood clot; and o Infection. In addition, Individual #353 also had Osteomyelitis, which is bone infection that can be caused by bacteria (more common) or fungi (less common). The infection might spread to a bone from infected skin, as in Osteomyelitis that occurs under a chronic skin ulcer. Some of the associated symptoms of	

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		Osteomyelitis include: bone pain, fever, general discomfort, uneasiness or malaise, local swelling, redness and warmth, chills, excessive sweating, and, low back pain. She also had been hospitalized in 9/10 for pneumonia, and was noted to have moderate dysphagia, dehydration resulting in Infirmary admissions, osteoporosis, and weight loss of more than 10% of her body weight from May to August 2010. Clearly, Individual #353 had a number of medical issues that would require a great deal of clinical intensity and on-going monitoring from the nursing staff. A review of the progress notes from 10/23/10 through 11/5/10 found the following problematic issues: o There was no documentation indicating that her skin was being observed regularly for signs of potential breakdown. Moreover, a nurse's note dated 10/23/10 indicated Individual #353 was in bed "crying out." The note indicated that when she was turned over, her right leg was lying on the clamp to the wound vacuum machine and had a "deep, red impression of the clamp on her leg." There was one subsequent nurse's note found after this incident, which was five hours later, indicating that her leg was rechecked and was noted to be "better, but slightly yellow." There was no other documentation found indicating that her right leg or her overall skin was assessed for pressure areas. o There was no nursing documentation indicating if her position was being regularly changed due to her already compromised skin integrity. o There was no regular documentation indicating that the colostomy site was being observed, the colostomy bag was being regularly changed, and/or the consistency of the stool was consistently being monitored. The same nurse's note mentioned above, dated 10/23/10, indicated that her colostomy bag was "full of soft stool to the point it ruptured the bag," indicating that it was not being regularly checked. o There was no documentation found indicating the condition of the PICC site, that the dressing had been changed, if flushes were being regularly done to the catheter, and/or if the PICC line was intact. o There was no indication that her weight was being monitored. o There was no consistent documentation indicating what her intake and output was for each shift or each day, and if her intake was adequate. o There was no documentation indicating if she was taking any oral food, and if so, how she was tolerating this. o There was no documentation of her mental status or her level of functioning compared to her baseline functioning. o Several nurses' notes indicated that she had dark, yellow urine in her	

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		Foley catheter bag, but there was no documentation to show that the nurses obtained vital signs or conducted an assessment. o Several nurses' notes stated: "continue plan of care." However, the nursing care plans did not provide any individual-specific instructions that defined what issues were to be assessed, how frequently, where they were to be documented, and parameters as to when to notify the physician of changes. o A nurse's note, dated 10/26/10, indicated that Individual #353 had an elevated temperature of 100.9. The type of temperature taken was not recorded, and there was no documentation indicating that her vital signs were rechecked later that day. o A physician's note, dated 10/27/10, indicated that Individual #353 was sent to the Emergency room for elevated temperature (101.7) with mild respiratory distress. There were no nurses' notes found documenting the change in status, or a note indicating that Individual #353 was sent to the Emergency Room on 10/27/10, and admitted to the hospital. No assessment of her status was conducted prior to her leaving the Facility. Her diagnosis at the hospital was Sepsis Syndrome (Urosepsis) Urinary Tract Infection. This case is a glaring example of why the Nursing Department needs to have protocols and procedures in place guiding the needed clinical assessments and criteria for documentation. Of the medical problems listed above for Individual #353, none of them were adequately addressed by nursing staff. They were either not documented on at all, or inconsistently documented. In addition, the nurses' involved in her care did not identify her dark urine as a symptom that needed to be assessed and followed as a potential sign of a Urinary Tract Infection. A review of the Facility's raw data regarding acute illness and injuries found that the scores on the monitoring tools did not accurately reflect the problems the Monitoring Team identified regarding the quality of the nursing assessments, the nursing documentation, and the timeliness of the notification of the physician of changes in status. The Facility's POI for this section of the Settlement Agreement indicated that compliance was at 65% from 74 reviews since 9/10. However, there was no indication as to how the score was determined, or what exactly it represented. In addition, no plans of action were implemented addressing any areas that the Facility found as problematic based on their own data. To accurately audit Acute Illness and Injuries and assess the care provided, the auditor needs to review the progress notes at least a few weeks prior to an admission to a	

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		community hospital, emergency room, or the Infirmary to determine when symptoms actually began. The auditor(s) for this area should be clinically competent in acute nursing care. They should read the "clinical story" first, and then score the monitoring tool. While on site, Individual #353 records were reviewed with some of the nurses that audit this particular area. The nurses involved reported that they had not been conducting audits based on first reviewing the clinical story. They indicated that after reviewing Individual #353 records, they would have scored many of the items differently based on the quality and completeness of the documentation. Reading only selective notes from the time of the individual's transfer does not provide an accurate assessment of compliance with the requirements for addressing changes in status for acute illnesses. Based on the Monitoring Team's review, there had been no progress made in addressing the numerous significant issues regarding individuals who experience a change in status and acute illness and injuries. Based on the number of medically compromised individuals at ABLLSC, this area should be considered a priority for implementation of plans of actions designed to address the significant deficits in nursing care. <u>Availability of Pertinent Medical Records</u> At the time of the review, all of the medical records at the Facility had been completed regarding the process of transitioning the medical records to a unified record. Consistent with the last review findings, there were significantly fewer documents that were not found in the charts as compared to the baseline review. There were however, some Nursing Quarterly Assessments and Nursing Care Plans that were not found in the records, and had to be located. 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. <u>Infection Control</u> Since the last review, ABSSLC continued to have two registered nurses with various infection control experience who were responsible for the Infection Control (IC) duties for the Facility. There had been no additional clerical or clinical employees added. Based on a review of ABSSLC's Infection Control data, the Infection Control Nurses 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. In addition, since the last review, the Facility had developed written procedures clearly outlining a formal system to ensure the reliability of the Facility's IC data.	

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		Also, the IC staff had implemented the Drug Utilization Discrepancy Report, which was used to record and track any discrepancies in Infection Control surveillance data found among the systems. Due to the implementation of this form, the IC Nurses were able to identify that there were significant discrepancies and omissions on the Monthly IC Reports that the homes provided. The Drug Utilization Discrepancy Reports were being sent to the RN Case Managers, RN IIs, and RN supervisors for review. The RN Case Managers had four days to update and return the Drug Utilization Discrepancy Reports to the IC Nurses. The IC Nurses reported that when the Drug Utilization Discrepancy Report was initially implemented in the July/August 2010, they found that there were roughly 46 data omissions on the Monthly IC Reports. Since that time, they were finding that the discrepancies had decreased. They also were able to identify trends, such as which homes were not consistently reporting infection control issues on the Monthly IC Reports. A review of these newly implemented procedures addressing IC data reliability using the Drug Utilization Discrepancy Report revealed an excellent system that generated valuable data, which timely alerted the Facility to problematic trends. The next steps would be to develop formal plans of action addressing any problematic trends, and to incorporate this data into the Infection Control Committee Meeting minutes. By developing and implementing this essential first step of ensuring the reliability of IC data, the Facility could now timely and accurately identify where training on appropriate IC practices was needed, or identify IC trends where corrective interventions might be needed. At the time of the review, the Facility had not developed a schedule regarding when the immunization status of the Individuals would be evaluated and updated if needed. However, discussions with the IC Nurses and review of the IC Committee Meeting minutes indicated that the initial auditing results for this area found that there were a number of problems making this process difficult. Some of these included: ▪ Dates of immunizations were not consistently found in the records; ▪ Dates of immunizations were not consistently found in the computer health records; ▪ Dates did not match between the records and the computer health records; ▪ Some Medical Summaries and Histories and Physicals noted that the immunization status had been evaluated and were current when the immunization data were not completed; and ▪ The immunization section in the Preventative Flow Sheets was not consistently completed. On a positive note, the auditing process that the IC Nurses implemented identified these issues making it possible to implement interventions to address them. In response to	

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		these issues, the IC Committee noted that an updated quarterly information sheet regarding immunizations would be implemented to help staff identify individuals who were due for a vaccine. In addition, physicians were to be reminded to thoroughly evaluate and document the immunization status of individuals to ensure that individuals had received the necessary immunizations. The Facility submitted a list of individuals who were identified as being current regarding their immunizations. However, based on the information above, it was unclear if this list was accurate. The Facility should continue to implement strategies to address the barriers identified to ensure that all individuals at ABSSLC are current regarding their immunization status. Regarding Infection Control policies and procedures, from discussions with the IC Nurses and the Facility's POI, a two-day meeting that included many of the IC practitioners from the SSLCs was held in November 2010 to develop standardized IC policies and procedures. The POI indicated that the State and the Infection Control Workgroup would be finalizing the Statewide Infection Control Manual in early March 2011, and would be distributing them to the Facilities at that time. As noted in the Monitoring Team's last report, the positive modifications made to the structure and format of the IC Committee Meeting had resulted in a more thorough representation of the information discussed during the meeting. However, as noted previously, there was still significant missing information, such as an indication of when issues were actually resolved. For example, the IC Committee Meeting minutes dated 10/21/10, indicated that when using certain procedures to detect C-difficile in a stool sample, the sample had to be transported within two hours or refrigerated or the integrity of the test might be compromised. The minutes indicated that RNs and LVNs needed to be made aware of this and that an in-service was to be conducted. However, there was no indication that an in-service was actually provided. In addition, the IC Committee Meeting minutes from the next meeting on 1/13/11 did not address if the in-service training had ever been conducted. Including the date the in-service was held in the minutes would verify that the action plan was initiated and completed. As another example, there was analysis of IC data noted for an increase in Conjunctivitis in August 2010 at the Facility, finding that the origin was most likely due to an employee coming to work with the infection. The interventions that were generated from the analysis were appropriate, however, there was no documentation contained in the minutes indicating that they were actually implemented. The Facility should continue to conduct analyses on the IC data, implement plans of action addressing problematic issues, and document when the interventions were actually implemented. In addition, since the last review, the IC Nurses implemented the use of Root Cause Analysis (RCA) to review and assess two trends identified by the Facility, including the increase in Conjunctivitis and an increase in Aspiration Pneumonia in November 2010. Root Cause Analysis is a process of problem-solving methods aimed at identifying the	

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		etiology or root causes of problems or events. The practice of RCA is predicated on the belief that problems are best solved by attempting to address, correct or eliminate root causes, as opposed to merely addressing the immediately obvious symptoms. By directing corrective measures at root causes, it is more probable that problem recurrence will be prevented. However, it is recognized that complete prevention of recurrence by one corrective action is not always possible. Conversely, there may be several effective methods that address the root cause of a problem. Thus, RCA is often an iterative process, and is frequently viewed as a tool of continuous improvement. This is an excellent process to use for analyzing problematic issues or potential problematic issues to determine all the areas that need to be addressed to prevent or decrease the problem from reoccurring. Although RCAs conducted by the IC staff were initial attempts at using the process and need to be expanded, some of the issues that were brought forward were valuable and required further intervention to adequately address the issues. For example, the RCA addressing the increase in aspiration pneumonia found that not all staff were continuously and timely implementing the precautionary PNM supports, such as proper positioning, at all times for individuals as risk of aspiration. However, there was no intervention generated to address this significant finding. In addition, since the last review and while the Monitoring Team was on site, the Facility had experienced an outbreak of gastrointestinal symptoms and had placed a number of homes on restriction. Although the Facility had documentation of the actions that were taken once the symptoms were identified, there was no system to organize the documentation, and no analysis of the information found in any of the documentation reviewed. The Facility had just recently implemented the use of a timeline for documenting such events, which should provide a clearer picture of the order and timeliness of interventions, as well as to assist in the analysis of the Facility's response to the events. The Infection Control Committee Meeting minutes should include a comprehensive analysis of the trends identified in the IC data, and describe inquires into problematic trends, corrective actions addressing any problematic trends, the process for monitoring outcomes, as well as the interventions of the Infection Control Department in conjunction with the practices on the units. In addition, the Facility should continue to expand on its use of the Root Cause Analysis process and generate interventions in alignment with the findings using an interdisciplinary approach. At the time of the review, the IC Nurses had not yet implemented "real time" audits to ensure that appropriate treatment practices were being implemented regarding acute infectious 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 that staff were actually	

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		following the appropriate precautions. Due to the acute nature of infectious diseases and the potential for spread, auditing for this area needs to be conducted while the acute infection is active. Only conducting retroactive auditing does not allow for immediate amelioration of problematic issues. Since the last review, the IC staff had implemented a number of interventions to attempt to meet the requirements of the Settlement Agreement. Guidance and clear direction should be provided to the Facility so that the efforts and actions of the IC staff are focused on priority issues, and result in complete implementation of systems that positively impact IC practices throughout the Facility. Based on the positive steps taken since the last review, the IC staff had demonstrated their commitment to reaching sustainable compliance. As noted from previous reports, additional expertise in Infection Control is needed to assist in implementing systems to effectively operationalize the Infection Control program 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.	The CNE reported that group training was conducted in August 2010 at a Nursing Retreat regarding Nursing Assessments (Quarterly and Annual). The CNE reported that the focus of the training was on the analysis section of the assessment process. However, from a review of the provided materials from the training, there was no adequate content found regarding this issue. At the time of the review, there was no curriculum developed or a plan in place for when competency-based training regarding Nursing Quarterly and Annual Assessments would be provided to the nurses. The Facility's POI indicated that they had an 88% compliance score based on 52 reviews conducted since September 2010. However, there was no indication how the compliance score was generated, and/or what it represented. As noted in the previous report, building competency in this area is critical for nursing. The Quarterly Nursing Assessments of 68 individuals were reviewed, including: Individual #119, Individual #7, Individual #361, Individual #75, Individual #91, Individual #212, Individual #53, Individual #492, Individual #253, Individual #359, Individual #270, Individual #497, Individual #385, Individual #186, Individual #468, Individual #542, Individual #447, Individual #267, Individual #170, Individual #383, Individual #112, Individual #167, Individual #503, Individual #510, Individual #241, Individual #231, Individual #268, Individual #478, Individual #417, Individual #388, Individual #73, Individual #370, Individual #360, Individual #347, Individual #528, Individual #362, Individual #203, Individual #410, Individual #78, Individual #86, Individual #392, Individual #376, Individual #235, Individual #315, Individual #373, Individual #85, Individual #489, Individual #216, Individual #311, Individual #235, Individual #20, Individual #100, Individual #181, Individual #345, Individual #240, Individual #299, Individual #252, Individual #24, Individual #399, Individual #297,	Noncompliance

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		Individual #5, Individual #204, Individual #344, Individual #40, Individual #8, Individual #109, Individual #403, and Individual #49. ▪ Of the 68 nursing quarterlies reviewed, 50 (74%) were timely completed. Assessments that were not timely completed included: Individual #241, Individual #100, Individual #20, Individual #478, Individual #49, Individual #345, Individual #399, Individual #297, Individual #417, Individual #503, Individual #510, Individual #231, Individual #268, Individual #447, Individual #170, Individual #383, Individual #112, and Individual #542. ▪ Consistent with the findings from the August 2010 review and the baseline review, the quality of all were poor and none of the 68 (0%) assessments were adequate, specifically regarding the nursing summary section. ▪ Overall, none (0%) of the Nursing Summaries contained an adequate analysis of the health/mental health data between the previous and current quarters. Overall, there were some improvements noted in the information provided in the body of the assessments in the areas of the current active medical diagnoses, consults, diagnostic testing/screening, the medication review, and in some of the summary sections for the different areas on the assessments. However, these improvements did not have an impact on improving the nursing summary section in the 68 assessments reviewed. Although there were a number of different formats used to write the summaries, it was clear that the nursing staff completing the assessments were struggling when trying to write an analysis of the health/mental health issues for the individuals reviewed. In many of the assessments, the nurses included considerably more information, but nothing related to an analysis of the information. For example, several summary sections included numerous quoted nurses' notes without any analysis. In other assessments, the nurse used the nursing care plans as a format for the summary sections. However, the information was about the care plan rather than the individual's status. In addition, there were also a number of nursing summaries that contained narrative summaries that actually made no sense. For example: ▪ The Quarterly Nursing Assessment dated 11/12/10 for Individual #241 stated in the Nursing Summary: *[Individual #241] has had a better quarter this period. After her dilation was done, she has had no issues with choking and only once did she have an issue with liquids. Sometimes when she is angry she will hold her food/liquids in her mouth for whatever reason and she will turn blue, but this has also occurred less this quarter. She is about as stable as she is normally.* The summary for Individual #241 showed that the nurse was trying to make an attempt to complete an analysis. However, the summary contained no actual analysis of the individual's health issues, and without providing details of the	

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		individual's status and a comparison of actual clinical data, the narrative summary was difficult to understand. The following provides other examples: ▪ The Quarterly Nursing Assessment dated 9/2/10 for Individual #53 stated: *One thing I have noticed is that I will review with the Dr. on the current bowel regimen for [Individual #53] as I understand she is having some constipation issues. I will initiate a bowel management health promotion care plan. All staff continue to help [Individual #53] understand the type of foods that are food for her. She has recently spoken with the dietician and expressed her likes and dislikes over her snacks and there have been some changes made to please her. She still seems to have a lot of episodes where she gets very upset with staff when they have done nothing, but she just doesn't understand that they are just doing their job. She continues to be afraid of the sling, but she is unable to transfer any other way. PT has worked with staff over this, but [Individual #53] remains afraid. I am not sure, but we have discussed this with our Psychiatrist to see if she wants to do anything different with her meds. The Celexa just doesn't seem to be doing what it needs to do for her. She had her EDG and her colonoscopy and tolerated the prep fairly well and biopsies were taken. She basically has gastritis and we are treating this. She also has hemorrhoids which is another reason we may need to go up on fiber. Recent dental surgery went without problems. She has undergone a total hysterectomy and did well. She was hospitalized due to bronchitis, anemia, and did well during this also.* Again, the nurse seemed to be trying to summarize the individual's status during the past quarter, but without a consistent process and structure in place to guide the analysis process, the summary was disorganized, disjointed, lacked focus on priority issues, and was not reflective of the individual's progress or lack of progress regarding her health and mental health issues. In addition, the problematic issues that were reflected in the summary such as constipation, episodes of being upset, and fear of being transferred were left unresolved. Without incorporating clinical objective data into the Nursing Summaries, it is impossible to determine if progress is being made when only antidotal information is provided. ▪ The Quarterly Nursing Assessment dated 12/3/10 for Individual #100 indicated that his team had identified him as being at high risk for aspiration. However, aside from this statement, there was no mention, much less an analysis of this critical health issue contained in the Nursing Summary. ▪ The Quarterly Nursing Assessment, dated 10/14/10, for Individual #85 had each of the nursing problems/diagnoses listed in the Nursing Summary	

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		section, which included: Gastrostomy/Impaired Skin Integrity; Potential for Injury; Potential impaired skin integrity; Vomiting; Self Administration of Medication (SAMS); Altered sensory perception; Bowel Management; and Health Status Review. However, listed under each problem were summaries of nurses' notes without any analysis indicating if progress was being made. A more appropriate process would have been for the nurse to review the notes, summarize them for each of the health issues, compare them to a summary of the nurses' notes from the previous quarter, analyze the information to determine if the individual was making progress, then write the Nursing Summary using this information as well as other clinical data, such as laboratory work to support the nurse's findings related to progress or lack thereof. The Annual Nursing Assessments of 35 individuals were reviewed, including: Individual #189, Individual #452, Individual #162, Individual #76, Individual #54, Individual #110, Individual #504, Individual #19, Individual #467, Individual #199, Individual #480, Individual #70, Individual #33, Individual #266, Individual #519, Individual #238, Individual #192, Individual #327, Individual #395, Individual #145, Individual #21, Individual #285, Individual #117, Individual #505, Individual #272, Individual #479, Individual #481, Individual #138, Individual #514, Individual #223, Individual #246, Individual #384, Individual #342, Individual #306, and Individual #126. The review showed the following: ▪ Of the 35 Annual Nursing Assessments reviewed, 31 (89%) were timely completed. Annual Assessments that were not completed timely included: Individual #110, Individual #504, Individual #199, and Individual #285. ▪ None of the 35 (0%) assessments were adequate, specifically regarding the nursing summary section. ▪ None (0%) of the Nursing Summaries included an adequate analysis of the health/mental health data between the previous and current year. Similarly to the findings regarding the Quarterly Assessments, several Annual Nursing Assessments contained pages of quoted nurses' notes without any type of analysis indicating the progress or lack of progress regarding health/mental issues from the previous year. Given the variety of formats found in the Nursing Summary sections of the Annual Assessments, the lack of direction and structure regarding how to analyze and present data and information was evident. The Discharge Nursing Assessments of four individuals who transitioned to the community were reviewed, including: Individual #501, Individual #219, Individual #277, and Individual #12. Based on this review, the Facility appeared not to have an adequate and consistent procedure regarding the requirements for nursing and nursing	

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		documentation. Although a Comprehensive Nursing Assessment was completed for all four individuals, it appeared that these assessments were actually the most recent quarterly Nursing Assessment, and not an assessment for someone who was being discharged from the Facility, where they had resided for a number of years. An appropriate Nursing Discharge Assessment would include an analysis of each of the individual's health/mental health issues since admission, including diagnostic tests that were conducted, and the results; treatments, and their effects on the health/mental health issue; frequency of laboratory work and the most current results; consultations with other specialty areas and the recommendations generated; the positive and negative effects of medications prescribed; the strategies from the Nursing Care Plans that were effective; and, any other information that would assist the providers receiving the individual to continue care and services that promoted optimal health/mental health, and that prevented the complications of these issues. Consistent with the finding above, none of the four (0%) Comprehensive Nursing Assessments for individuals transitioning out of the Facility were adequate. In addition, a review of the nurses' progress notes for these four Individuals found that none of them contained a discharge note at the time the individuals actually left the Facility. Consequently, without referring to other Facility documents, there was no way to determine the actual date when the individuals were discharged. For example, the nursing progress note for Individual #501, dated 10/12/10, indicated that nurse completed a "head to toe skin assessment for discharge to community placement." This seemed to indicate that the individual was being discharged that day. However, a subsequent nursing note, dated 10/18/10, indicated that the individual had his vital signs taken, had no constipation requiring PRN treatment, had a five-pound weight loss and weight gain from September 2010, and "will continue monthly nursing data sheets." That was the last note recorded in the individual's record. Documentation the Facility provided indicated that Individual #501 was discharged on 10/12/10. The note on 10/18/10 appeared to have been written after the individual transitioned to the community, but included what appeared to be current information. The Facility should review its nursing discharge procedures and documentation requirements to ensure that documentation addressing discharges is adequate. Based on this most recent review, there continued to be problems in the Nursing Summary section of the Comprehensive Nursing Assessments regarding the analysis of data as compared to past data. When conducting a nursing analysis, the nursing staff should ask the same questions for each health/mental health issue the individuals experience: "is the individual doing better, worse, or maintaining from the previous quarter or year and why?" The "why" forces the nurse to review the effectiveness of the Nursing Care Plan interventions; address noncompliance issues; review physician's orders; review the effectiveness of the other disciplines interventions; review the	

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		nursing progress notes, physician notes, and direct support professionals' notes for unidentified trends; review lab work results, diagnostic testing results, recommendations from consultants; and review other documents that might contribute to answering the "why" question. Thus, the analysis is based on supporting clinical data and not just on antidotal information. From an overall review of the records and the findings with regard to Section M.1 of the Settlement Agreement, the inconsistencies found in the nursing documentation regarding the lack of regular follow-up on health issues through to resolution coupled with the lack of nursing protocols made it difficult for nurses to accurately analyze the contributing factors that affected the progress or lack of progress related to health and mental health issues. It is imperative that the Facility develop and implement an appropriate competency-based training curriculum regarding Comprehensive Nursing Assessments. Based on the information that the State's Nursing Services Coordinator previously provided regarding the State's plan for enhancing the Facilities' competency-based training for nursing assessments and care planning, the Nurse Educators in the Facility were providing competency-based training regarding nursing skills and care planning. In addition, the State was planning to purchase materials including the Mosby/Elsevier Nursing Diagnosis Handbook, Eight Edition. The materials included in this package were textbooks, lab manuals, and online resources. Nurse Educators, Case Managers, RN IIs and RN IIIs would be required to participate in the training. The RNs would complete the course under the supervision of the Nurse Educators with the Nursing Services Coordinator and the Nurse Practitioner Consultant providing oversight. In addition to the course work, and the competency-based skills check off the Nurse Educators already were using, nurses or advanced practice nurses with expertise in clinical assessment would randomly select and evaluate Facility nurses on their nursing assessment and care planning skills. The State proposed this program to improve nursing care and encourage critical thinking during assessments and in developing nursing care plans. A discussion with the Nurse Practitioner Consultant while on-site at ABSSLC indicated that there was a competency-based nursing skills/assessment training program being developed that included having three Nurse Practitioners provide a day of classroom training, and a day of skills competency testing. This training would be provided initially to the CNEs, NOOs, RN cases managers, and Nurse Educators. The training would be followed up with a competency review of each nurse who participated in the class. This training at the Facility-level would be done in conjunction with the requirement that the RNs complete the Mosby/Elsevier Nursing Diagnosis Handbook, Eight Edition, nursing assessment online course. This proposed competency-based training is a very promising idea that would ensure that nurses are clinically competent regarding basic skills, and	

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		assessments, and would then be augmented by the online course. As discussed with the Nurse Practitioner Consultant and Director of Operations, the State should consider including Infirmary nurses at Facilities that have infirmaries in the initial training, since this is the area where nursing competency is crucial. In addition, the State should consider initially concentrating the focus of the training on the high-risk areas, such as respiratory issues, feeding tubes, and skin issues. In addition, at the Facility level the clinical information from the online course should be integrated into case reviews to reinforce the clinical content in "real time". Although the additional competency-based training described above was significantly needed at the Facility, the current competency-based training regarding nursing skills and assessments at the Facility was inadequate. For example, there was no competency-based training at ABSSLC for obtaining lung sounds. Consequently, there was no validation that the nurses at the Facility could accurately identify the lobes of the lungs or the sounds heard during an assessment. As a result, there was no system in place to identify nurses who required additional training to be able to competently perform this crucial skill. This deficit was extremely concerning particularly for a Facility that operates an Infirmary and is responsible for the care of a high number of individuals with respiratory risk factors. From a review of the records of a number of individuals who had acute respiratory issues, most of the nurses' notes contained no assessment of lung sounds while others contained statements such as "lung sound abnormal," indicating that the nurses were not able to identify what they heard or where they heard it, or did not recognize the importance of documenting their specific findings. In the State's initial competency-based training proposal, the competency of the staff overseeing the training and course work was assumed. However, the examples noted above and the continued lack of adequate competency-based training curriculum regarding Nursing Assessments and the Nursing Care Plans questions this assumption. The significant problematic issues found in the nursing practices at ABSSLC during the past two reviews as well as the current review indicated that the purchase of the Lippincott Manual of Nurse Practice, 9th Edition for Nursing Procedures and Protocols, and the Health Care Protocols: A handbook for DD Nurses had not improved the quality of the nursing care in any area reviewed. Thus far, the use of textbooks as initial solutions to problematic areas in nursing had not proven effective. Based on the description of the additional nursing competency-based training the State proposed, it is hoped that more investment will be made in providing "hands on" interventions at the Facility level. The State indicated that in January 2011, the SSLC Nurse Educator Workgroup met to finalize the SSLC Nurse Education Handbook, which will standardize competency-based training throughout all Facilities. This is an encouraging step forward. However, the	

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		State in conjunction with the SSLC Nurse Educator Workgroup should ensure that the actual process of assessing competency is appropriate and adequate. Consistent with the past two reviews as well as the current review, the lack of clinical assessment of critical health indicators, the lack of follow up on unresolved issues, the lack of an analysis of health/mental issues and clinical risks, and the lack of critical thinking was found in all the nursing assessments reviewed. The Facility remained out of compliance with this provision of the Settlement Agreement.	
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 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.	From discussion with the Chief Nurse Executive, there had been no competency-based training provided addressing Nursing Care Plans since the last review. However, in August 2010, during a Nurse Retreat, some general training had been conducted regarding care plans. At the time of the review, the Facility had no plan for when competency-based training curriculum would be developed and implemented. The Facility should develop and implement a clinically sound competency-based training curriculum to ensure nurses' are appropriately trained, and are able to develop clinically adequate nursing care plans. The records of 23 individuals, who the Facility identified as being at high risk for specific health indicators, were reviewed, including: Individual #479 and Individuals#386, for Osteoporosis; Individual #7 and Individual #100, for Aspiration; Individual #130 and Individual #106, for seizures; Individual #384 for weight issues; Individual #530, Individual #387, Individual #123, and Individual #517 for behavior; Individual #15 for medical; Individual #26, Individual #505, and Individual #215 for skin issues; Individual #289 for injury; Individual #13 for urinary tract infections; Individual #272, Individual #457, and Individual #154 for Gastrointestinal issues; Individual #8 and Individual #139 for diabetes; and Individual #304 for hypothermia. Of the 23 individuals' Health Management Plans (HMPs) reviewed: ▪ Seventeen (74%) individuals were found to have a HMP addressing their high-risk health/mental health indicator. Those that did not have a relevant HMP included: Individual #387, Individual #123, Individual #517, Individual #289, Individual #272, and Individual #386. ▪ None (0%) of the nursing interventions contained in the HMPs indicated who would implement the intervention, how often they were to be implemented, where they were to be documented, how often they would be reviewed, and/or when they should be considered for modification. ▪ None (0%) of the HMPs were found to be clinically adequate. ▪ None (0%) of the HMPs included proactive interventions addressing the health indicator. ▪ None (0%) of the HMPs were adequately individualized.	Noncompliance

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		Consistent with the findings from the previous reviews, the HMPs lacked individual-specific interventions based on the individuals' needs, and provided little to no direction for caring for individuals who were identified as being at high risk. Also, consistent with previous findings, the nursing interventions contained in the HMPs were not geared toward prevention or minimizing the specific health risks. For example: ▪ Individual #384 was identified as high risk for weight loss. His HMP for this issue stated: *Nursing Diagnosis: Potential for weight loss and nutritional deficiency related to recent history of weight loss.* *Objective: Nutritional intake is adequate and normal weight is maintained. His recommended weight range is 122-150 pounds.* *Plan:* *Provide [Individual #384] with an appropriate diet as ordered (diet may change) with ample variety and choices to stimulate appetite.* *Work with Dietician on food selections.* *Monitor percentage of meals consumed daily.* *Monitor weight monthly.* *Notify the Physician, Dietician and, RN of undesirable weight trends.* *Documentation will be done as per Nursing Procedure Manual.* This HMP included no individualized information such as the individual's current weight, how much weight the individual already had lost, the specific diet he was on, what specific foods he preferred, and/or what interventions should be implemented during the times he was not eating adequately. Also, there was no specific information addressing strategies that had been successful to possibly prevent a decrease in appetite, and ultimately weight loss. In addition, for an individual at risk for weight loss, obtaining routine monthly weights would be inadequate. In addition, the objective contained in the HMP was meaningless. An objective should state the precise action for accomplishing a particular nursing goal. The objective included in this HMP provided no specific action regarding the prevention of weight loss and nutritional deficiencies. The HMP provided no guidance for preventing Individual #384 from losing weight. As a result, the HMP indicated that the only time nursing was to take any action was when the individual was experiencing weight loss. In other words, it was reactive as opposed to proactive. From discussions with the CNE, the Nursing Department was struggling with developing adequate and individualized HMPs while trying to work within the structure of the nursing protocols that had been adopted as templates for HMPs. The HMPs should be	

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		modified to reflect interventions addressing prevention, health maintenance, and health promotion. In addition, the Health Management Plans should include appropriate goals, objectives, and should be significantly individualized. Collaboration with other disciplines regarding care plans should occur regardless of the format, so that an interdisciplinary team approach is used consistently, and interventions from other disciplines are integrated in all health management plans as required by Sections G and F of the Settlement Agreement. Consideration should be given to the use of an integrated health management plan that would incorporate all clinical disciplines' goals and interventions into one plan. An additional sample of individuals' records was reviewed to determine if individuals with infectious diseases had appropriate care plans to address their needs. Specifically, a review was completed of 30 individuals diagnosed with a variety of infectious diseases, including: Individual #123, Individual #23, Individual #332, Individual #365, Individual #229, Individual #67, Individual #281, Individual #407, Individual #538, Individual #212, Individual #112, Individual #126, Individual #10, Individual #185, Individual #1, Individual #346, Individual #381, Individual #176, Individual #545, Individual #160, Individual #390, Individual #201, Individual #337, Individual #77, Individual #240, Individual #147, Individual #213, Individual #128, Individual #186, and Individual #385. The following represent the findings from this review: ▪ Of the 30 Nursing Care Plans reviewed addressing infectious diseases, none (0%) were found to be adequate. Some of the deficiencies noted included: o The significant lack of individualization of the Nursing Care Plan template; o The lack of criteria for documentation regarding who was to document, how often, where the documentation was to be maintained, who was to review the documentation, and how often it would be reviewed; o The lack of interventions addressing teaching and education for staff and the individual; o The lack of proactive interventions; and o The lack of documentation demonstrating that interventions were actually being implemented. For example, the Nursing Care Plan for Individual #23 was merely a copy of the nursing protocol for Hepatitis B. The only individualization of the care plan was the addition of the individual's name, which was inserted in some of the sentences. However, the Nursing Care Plan contained the name of a different individual that was scratched out and Individual #23's name was written in. From discussions with the IC Nurses, they had initiated reviews of some of the nursing care plans addressing infectious issues, but had not created a formal database to track	

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		this. They reported that they had minimal cooperation thus far from nursing regarding the implementation of some of the recommendations they had made regarding care plans. It is imperative that nursing staff responsible for the development of care plans for individuals with infectious diseases collaborate with the IC Nurses. This is particularly essential due to the clinical ramifications of not having adequate nursing care plans addressing infectious and communicable diseases. Consistent with the previous reviews findings, there continued to be no system in place that ensured that individuals with infectious diseases were being provided the appropriate infection control measures, or clinically appropriate interventions to prevent the spread of infections. Nursing administration and the Infection Control nurses should develop and implement a system to ensure that the Nursing Care Plans addressing infectious and communicable diseases are adequate and are consistently being implemented.	
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.	Since the last review, the Facility had obtained the Lippincott Manual of Nurse Practice, 9th Edition for Nursing Procedures and Protocols. From discussions with the CNE, there had been no modifications made to the procedures and protocols contained in these resource books to bring them into alignment with ABSSLC's structure and systems. In order for the Facility to be in compliance with this requirement, modifications would need to be made to include specifics such as the responsibilities of disciplines, clear and appropriate timeframes for initiating nursing assessments, the type and frequency of assessments that should be conducted, and the timely reporting of symptoms to the practitioner/physician. Since the last review, the Facility had revised three policies addressing: Medication Preparation for Therapeutic Home Visits, dated 12/1/10; Transportation and Security of Medications, dated 12/8/10; and Management of Acute Illness/Serious Injury, dated 12/10/10. The policy addressing Management of Acute Illness/Serious Injury did not include some information, such as the completion of a nursing assessment prior to a transfer to the Infirmary or to the Community Hospital, or adequate timeframes for nursing assessments of signs and symptoms of acute illnesses and injuries. As noted with regard to Section M.1, further development/revision of Facility-specific procedures and protocols are needed and should be integrated and cross-referenced with the Facility's policies. Having Facility-specific policies, procedures, and protocols in place ensures that responsibilities and appropriate timeframes are clearly outlined for various health issues. At the time of the review, neither the CNE nor the POI indicated what the plan was for when the procedures and protocols would be modified, staff trained, and the policies and procedures implemented. Based on the significant problematic findings described in detail in Section M.1 related to the nursing assessments and documentation of individuals with acute changes in status, it was clear that nurses did not know what	Noncompliance

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		assessments to conduct and the frequency of those assessments in response to a variety of signs and symptoms. Along with these issues, the lack of timely communication with the physicians regarding individuals' changes in status demonstrated the critical need for the Facility make the appropriate modifications to the procedures and protocols contained in the resource textbooks obtained by the Facility to provide clear clinical directions regarding health issues. Although the Facility's POI indicated they were not in compliance with this requirement, which was consistent with the Monitoring Team's findings, the POI noted a 50% compliance rate based on 14 reviews conducted since 9/10. Given the complexities of the Settlement Agreement, citing one compliance score for any area, particularly without any explanation of the data, was meaningless. In addition, there was no supporting data provided demonstrating how this score was determined. The Facility should make the appropriate modifications to the procedures and protocols contained in the resource textbooks obtained. They should be individualized to reflect the Facility's structure and systems, including defining the specific responsibilities of disciplines, and setting forth clear and appropriate timeframes for initiating nursing assessments, the type of assessments that should be conducted, and the parameters for the timely reporting of symptoms to the practitioner/physician. The State had completed a draft Nursing Protocol addressing Seizure Management, dated December 2010, which was found to be thorough and comprehensive with clear parameters for documentation requirements and notification of the practitioner/physician. In addition, the responsibilities for each discipline were clearly outlined. This protocol could be used as an example of the elements that need to be included in the modified procedures and protocols for nursing practices to define the expectations within the context of the Facility's systems. The specific details discussed above with regard to Sections M.1, M.2, and M.3 of the Settlement Agreement validated that the Facility continued not to have an adequate nursing assessment processes in place, written parameters for notification of the practitioner/physician, clinically appropriate health management plans, and adequate procedures and protocols in place to guide nursing care. Consistent with the previous two reviews, the Facility was failing to adequately and timely address the health care needs of the individuals at ABSSLC.	
M5	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall develop	Since the last review, the State and the SSLCs had developed a policy for At-Risk Individuals, dated 11/2/10. Risk Guidelines, which contained criteria to assist the teams in determining risk levels for a number of risk factors, were included in the policy. In addition, the assignment and review of risks was to be conducted during the PST	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.	meetings. The Facility reported that all individuals would have their risk assessments and risk rating completed at their regularly scheduled quarterly PST meetings. The new policy indicated that nursing in conjunction with the PCP was responsible for assessing risk factors in the following categories: ▪ Aspiration; ▪ Respiratory Compromise; ▪ Cardiac Disease; ▪ Constipation/Bowel Obstruction; ▪ Diabetes; ▪ Gastrointestinal Problems; ▪ Osteoporosis; ▪ Seizures; ▪ Skin Integrity; ▪ Infections; ▪ Fractures; ▪ Fluid Imbalance; ▪ Hypothermia; ▪ Urinary Tract Infections; and ▪ Circulatory. At the time of the review, ABSSLC had just begun the implementation of the new At-Risk Individuals policy. From observations of a PST meeting for Individual #468 on 2/17/11, the team was actively using the Risk Guidelines during the meeting when discussing the specific risk indicators. In addition, the team was noted to discuss more objective data, such as the actual DEXA Scan score and lab values, in order to make decisions regarding risk levels. There was considerable more discussion of clinical issues in this PST than there had been in some of the Health Status Team meetings observed during the past reviews. Although the team assigned appropriate risk levels to some of the health indicators such as fluid imbalance, falls, fractures, and challenging behaviors, it was clear that the team had a lack of understanding regarding dysphagia and risk of aspiration. In spite of the fact that Individual #468 had severe GERD and had a Nissan Fundoplication in 1992, had a G-Tube due to frequent episodes of aspiration pneumonia, took three medications for Asthma, was reported to frequently cough when eating, warranted PRN oxygen and bronchodilators to assist in maintaining good air flow to her lungs, was taking a medication for significant drooling, and was coughing throughout the entire PST, the team saw her only as a moderate risk for aspiration. In addition, the team reported that since she had a G-Tube she was less of a risk for aspiration, and reported that she had not been showing any signs of aspiration. Unfortunately, the team was under the misconception that once an individual received a tube, they no longer were at significant risk of aspiration. The team also did not recognize that her episodes of coughing while eating were symptoms that warranted concern and assessment. This was clearly	

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		demonstrated when Individual #468 was consistently coughing during the meeting and no one from her team saw the need to conduct an assessment. The team stated that she was probably hot since the room was so small and it was her Asthma that was causing her coughing. Thus, the only action the team took was to move her into the hallway and continue with the meeting. Although the PST observed used the Risk Guidelines and integrated more clinical objective data into decisions regarding risks, there was a significant lack of clinical understanding regarding the risks and risk factors regarding aspiration. This knowledge deficit threatens the integrity of the Risk Process, and will continue to result in the inappropriate identification of clinical risks and incorrect assignment of risk levels, especially for individuals at risk for aspiration. The Facility should provide all staff with competency-based training regarding aspiration and risk of aspiration. During the review, several of the Facility's staff from different disciplines reported that there was a resistance to assigning an individual a risk level of "high," because of the additional documentation and meeting time that was required for this level of risk. If this is accurate, the Facility must address and remediate this unacceptable practice immediately. The Risk System is the essential foundation that identifies those individuals who warrant the most clinical attention and intensity. A number of examples have been provided throughout the findings in Section M.1, M.2, and M.3 of the continued consistent misidentification of individuals who were at risk. In order for the Risk System, as well as other health care systems to successfully result in positive clinical outcomes, it is imperative that the Facility expediently address the nursing staff's overall lack of clinical competency. In addition, the PSTs need to continue to conduct integrated team reviews, and develop plans to address identified areas of risk. ABSSLC's POI indicated that they were not in compliance with this requirement of the Settlement Agreement, 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	From discussions with the Nurse Educator, she reported that the Nursing Department was behind in conducting the medication administration audits and had not been able to conduct observations on each nurse every quarter due to other obligations. However, she reported that in response to being behind, other nurses were assigned to conduct some of the medication observations. She reported that inter-rater reliability had not been established with the additional nurse auditors and that when she reviewed the data from the medication observations, she found that her audits were the only audits that had identified some problematic issues. As a result, it appeared the data from the Medication Administration Observations was unreliable. The Facility should establish	Noncompliance

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	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.	inter-rater reliability regarding the Medication Administration Observations to ensure the data generated from this monitoring system is reliable and representative of the medication practices at the Facility. A review of 192 Medication Administration Observations found that a majority of them found that there were no problems, which did not comport with the Monitoring Team's observations. Some of the problematic issues that the Facility audits found included the following: ▪ Medication cart left unlocked when the nurse was not present; ▪ Temperatures not consistently recorded for refrigerators in the medication rooms; ▪ Medication cart not clean; ▪ Nurse did not instruct staff to keep individuals with tubes in upright position after receiving medications; ▪ Nurses did not verify the individuals appropriately prior to administering medications; ▪ Nurses not washing hands between administering medications to individuals; and ▪ Tubes were not flushed with 30 cubic centimeters (cc) of water before medications administered and between medications. Consistent with the findings of the past reviews, there was no formal report summarizing the issues found from the medication observations that were conducted. From a review of the Medication Error Committee meetings, the meeting for November included some information regarding the Medication Administration Observations. However, subsequent meeting minutes did not contain any information or data addressing the observations. The Facility should review and analyze the data from the Medication Administration Observations to identify trends and generate plans of correction. The Facility should develop a system for aggregating this data so it becomes usable to facilitate the identification of trends, analysis of the data, and development, as appropriate, of corrective actions. When observing medication administration while on site for individuals in the Infirmary, the following significant issues were identified, most of which placed the individuals involved at risk. Specifically, the nurse did not: ▪ Wash her hands consistently between individuals receiving medication; ▪ Flush tubes with 30 cc of water between each medication given; ▪ Use gloves when manipulating tubes; ▪ Tell individuals what she was doing and what medications she was administering;	

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		▪ Lock the medication cart when it was left unattended; ▪ Check the PNMP for positioning when administering medications; ▪ Provide appropriate privacy when administering medications; and ▪ Ensure the individual was in the proper positioning after the medications were administered. During the observation, a nurse who had conducted many of the medication administration observation audits accompanied the Monitoring Team member. 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 did not check the PNMP prior to administering medications. In fact, when the reviewer asked to see the PNMP for one of the individuals who was administered medication, the staff could not locate it since it had not been brought over with the individual when he was admitted to the Infirmary. Therefore, none of the staff in the Infirmary was aware of the interventions that were contained in this individual's PNMP, and thus, none of them were being implemented. In addition, during the last review, it was determined that nurses were counting the narcotics at change of shift with direct support professionals. However, from a review of the Medication Error Committee minutes, this practice had not been modified. As stated in the previous report, 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; ▪ August: 58 reported variances; ▪ September: 114 reported variances; ▪ October: 57 reported variances; ▪ November: 70 reported variances; ▪ December: 202 reported variances; and ▪ January 2011: 124 reported variances. A review of the minutes of the Medication Error Committee Meetings indicated that consistent with the last review, 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 minutes indicated that homes that the pharmacy had to provide double medications fills due to pharmacy staff not being available to provide a home medications at the next regularly scheduled medication	

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		exchange were noted to be the ones having the highest number of variances. Although a plan of correction was included with the minutes dated 9/22/10, the interventions could not be interpreted. In addition, the minutes of the Medication Error Committee were very superficial, and did not contain enough detail to determine what actions were actually being initiated regarding medication errors. The Facility should include more information in the Medication Error Committee discussion and minutes, such as detailed analyses of the variance data, problematic trends identified, correction actions taken and when initiated, and the resulting outcomes. Consistent with the previous findings, the Facility was very weak in the area of analyzing the medication administration and variance 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 evaluate the possibility of utilizing nursing positions that might be lost due to a building closing for some of the monitoring activities that are required.
3. The Facility should ensure that each monitoring tool has appropriate instructions, which identify the specific criteria that constitute compliance with each item being monitored.
4. The Facility should develop and implement a procedure for establishing inter-rater reliability to ensure the process is executed appropriately and consistently.
5. 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.
6. Data and data graphs should include the total population being reviewed (N), and the sample of that population that was audited (n) to yield a percent sample to indicate the relevance of the compliance scores.
7. The Facility should develop a unified system to present the data from the monitoring tools so that the data can be easily analyzed and trends identified.
8. The QA Nurse, Program Compliance Monitors, and the Nursing Department should continue regular discussions regarding the data generated from the monitoring process to ensure that all areas are being critically audited, and the focus of the monitoring is on the quality of the nursing services provided and not the just completion of required documentation.
9. Based on the number of medically compromised individuals at ABLLSC, addressing the numerous significant issues regarding individuals who experience a change in status and acute illness and injuries should be considered priorities for implementation of plans of action.
10. The Facility should implement strategies addressing identified barriers to ensure that all individuals at ABSSLC are current regarding their immunization status.
11. The Infection Control Committee Meeting minutes should include a comprehensive analysis of the trends identified in the IC data, and describe inquires into problematic trends, corrective actions addressing any problematic trends, the process for monitoring outcomes, as well as the interventions of the Infection Control Department in conjunction with the practices on the units.

12. The Facility should continue to expand on its use of the Root Cause Analysis process and generate interventions in alignment with the findings using an interdisciplinary approach.
13. As recommended in past reports, additional expertise in Infection Control is needed to assist in implementing systems to effectively operationalize the Infection Control program in alignment with IC standards of practice, as defined in the Health Care Guidelines and the Settlement Agreement.
14. The Facility should review its nursing procedures and documentation requirements for individuals who transition to the community and/or are discharged from the Facility to ensure that documentation addressing discharges is adequate.
15. It is imperative that the Facility develops and implements an appropriate competency-based training curriculum regarding Comprehensive Nursing Assessments.
16. The State should include the Infirmary nurses in the proposed initial competency-based training, since this is an area where nursing competency is crucial.
17. The State should consider initially concentrating the focus of the training on the high-risk areas, such as respiratory issues, feeding tubes, and skin issues.
18. At the Facility level, the clinical information from the online course should be integrated into case reviews to reinforce in "real time" the clinical content.
19. The Facility should develop a clinically sound competency-based training curriculum to ensure that nurses are appropriately trained, and are able to develop clinically adequate nursing care plans.
20. The Health Management Plans should be modified to reflect interventions addressing prevention, health maintenance, and health promotion. In addition, the Health Management Plans should include appropriate goals, objectives, and should be significantly individualized.
21. Nursing administration and the Infection Control nurses should develop and implement a system to ensure that the Nursing Care Plans addressing infectious and communicable diseases are adequate and are consistently being implemented.
22. The Facility should make the appropriate modifications to the procedures and protocols contained in the resource books obtained to reflect the Facility's structure and systems, including defining the specific responsibilities of disciplines, and setting forth clear and appropriate timeframes for initiating nursing assessments, the type of assessments that should be conducted, and the parameters for the timely reporting of symptoms to the practitioner/physician.
23. The Facility should provide all staff with competency-based training regarding aspiration and risk of aspiration.
24. Staff's resistance to assigning individuals a "high" risk level because of the additional documentation and meeting time that is required must be addressed and remediated as soon as possible.
25. In order for the Risk System, as well as other health care systems to successfully result in positive clinical outcomes, it is imperative that the Facility expediently addresses the nursing staff's overall lack of clinical competency.
26. In addition, the PSTs should continue to conduct integrated team reviews, and develop plans to address identified areas of risk.
27. The Facility should revise and/or implement policies/procedures/protocols with regard to medication administration monitoring to:
    a. Implement the quarterly medication observations required by State policy;
    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 and analysis of the data, develop action plans to address issues regarding the medication administration system so that medications are administered appropriately and safely to individuals; and
    e. Address the change of shift narcotic count.
28. As required by Section N.8 of the Settlement Agreement, the Facility should develop a medication variance system, because this would expand the scope of the review of the Facility's medication systems.
29. 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.

30. The Facility should include more information in the Medication Error Committee discussion and minutes, such as detailed analyses of the variance data, problematic trends identified, correction actions taken and when initiated, and the resulting outcomes.

The following are offered as additional suggestions to the State and Facility:

1. Consideration should be given to the use of an integrated health management plan that would incorporate all clinical disciplines goals and interventions into one plan.

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 Medication Error Committee meeting minutes: for 7/28/10, 8/25/10, 9/22/10, 10/26/10, 11/24/10, 12/22/10, 1/26/11, and 2/16/11; o Report from Marla Knight, Pharm D, to the Medication Error Committee, dated 12/22/10; o Memorandum from RN Nurse Educator to RN CNE, dated 12/22/10, and 2/10/11 re: Medication Observation Report November; o Various data reviewing medication errors, including: Graphs of medication errors by category 9/09 to 11/10, medication error type from 2/10 to 11/10, medication errors by node 12/09 to 11/10, medication errors sorted by severity 12/09 to 11/10, medication errors by shift 12/09 to 11/10, medication errors by unit 12/09 to 11/10, medication errors by residence 12/09 to 11/10, and various graphs of unreconciled errors and total errors from 2010 to 2011; o Lists of medication errors by type (1/10 to 11/10), node (1/10 to 11/10), severity (1/10 to 11/10), shift (1/10 to 11/10), unit (1/10 to 11/10), residence (12/09 to 11/10), nurse (3/10 to 11/10), and individual (3/10 to 11/10); o Quarterly Drug Regimen Reviews (QDRRs) for the following: Individual #25 on 11/5/10, Individual #126 on 11/15/10, Individual #282 on 11/5/10, Individual #517 on 11/23/10, Individual #540 on 12/20/10, Individual #180 on 11/5/10, Individual #319 on 11/23/10, Individual #74 on 9/21/10, Individual #518 on 11/15/10, Individual #105 on 11/15/10, Individual #32 on 11/18/10, Individual #509 on 12/20/10, Individual #209 on 11/15/10, Individual #499 on 11/5/10, Individual #371 on 11/5/10, Individual #75 on 12/13/10, Individual #185 on 11/5/10, Individual #366 on 12/10/10, Individual #303 on 12/8/10, Individual #188 on 11/23/10, Individual #455 on 12/1/10, Individual #276 on 11/15/10, Individual #505 on 12/8/10, Individual #481 on 11/23/10, Individual #48 on 12/2/10, Individual #457 on 11/15/10, Individual #503 on 11/18/10, Individual #247 on 11/23/10, Individual #507 on 11/15/10, Individual #342 on 11/15/10, Individual #231 on 11/18/10, Individual #465 on 11/5/10, Individual #461 on 11/18/10, Individual #486 on 9/21/10, Individual #529 on 12/10/10, Individual #363 on 12/1/10, Individual #287 on 11/5/10, Individual #348 on 11/15/10, Individual #169 on 11/5/10, Individual #98 on 11/23/10, Individual #245 on 11/5/10, Individual #384 on 11/15/10, Individual #150 on 11/5/10, Individual #284 on 11/5/10, and Individual #246 on 11/15/10; o Drug Regimen Review Schedule (TX-AB-1102-XI.29); o Psychotropic Polypharmacy Review Committee minutes, dated 10/4/10, 11/1/10, 12/20/10 (TX-AB-1102-XI.5); o Psychotropic Polypharmacy Review Committee minutes, dated 1/24/11 (TX-AB-1102-WZ.8.7); o Pharmacy and Therapeutics Committee Meeting minutes, dated 10/28/10 (TX-AB-1102-XI.4), and 1/26/11 (TX-AB-1102-WZ.8.4);

	o Notice of inspection, Texas State Board of Pharmacy, dated 8/11/10 (TX-AB-1102-XI.2); o List of chemical restraint use August 2010 through December 2010 (TX-AB-1101-XI.34); o Chemical restraint forms: Administration of Emergency Medication Protocol (chemical restraint), Face-to-Face Assessment, Debriefing, and Reviews for Crisis Intervention Restraint, and Restraint Checklist for following: Individual #199 on 12/9/10 at 12:12 p.m., Individual #43 on 8/2/10 at 11:45 a.m., Individual #43 on 8/25/10 at 2:10 p.m., Individual #43 on 9/2/10 at 8:25 a.m., Individual #43 on 10/21/10 at 10:50 a.m., Individual #43 on 10/25/10 at 4:25 p.m., Individual #43 on 10//26/10 at 5:25 p.m., Individual #43 on 10/27/10 at 6:40 p.m., Individual #43 on 12/15/10 at 9:40 a.m., Individual #505 on 10/16/10 at 12:45 p.m., Individual #505 on 12/30/10 at 6:38 p.m., Individual #293 on 8/2/10 at 5:30 p.m., Individual #313 on 12/8/10 at 5:00 p.m., Individual #313 on 12/10/10 at 6:18 p.m., Individual #313 on 12/15/10 at 5:40 p.m., Individual #313 on 12/23/10 at 1:15 p.m., Individual #313 on 12/27/10 at 2:50 p.m., Individual #313 on 12/30/10 at 10:30 p.m., Individual #79 on 9/20/10 at 3:30 p.m., Individual # 79 on 9/21/10 at 2:30 p.m., Individual #79 on 9/23/10 at 4:52 p.m., Individual #323 on 1/19/11 at 12; 36 p.m., Individual #94 on 10/17/10 at 5:45 p.m., Individual #37 on 1/6/11 at 1:50 a.m., Individual #260 on 9/2/10 at 4:30 p.m., Individual #260 on 9/14/10 at 2:10 p.m., Individual #260 on 9/24/10 at 4:47 p.m., Individual #260 on 9/30/10 at 10:00 a.m., Individual #260 on 10/4/10 at 5:50 p.m., Individual #260 on 10/8/10 at 9:22 a.m., Individual #260 on 10/9/10 at 6:10 p.m., Individual #260 on 10/14/10 at 12:53 p.m., Individual #260 on 10/20/10 at 2:45 p.m., Individual #260 on 11/2/10 at 1:20 p.m., Individual #260 on 11/3/10 at 3:04 p.m., Individual #469 on 10/23/10 at 1:10 a.m., Individual #324 on 9/14/10 at 8:15 a.m., Individual #324 on 10/2/10 at 9:45 a.m., Individual #324 on 9/16/10 at 9:46 a.m., Individual #324 on 9/24/10 at 10:08 a.m., Individual #324 on 9/26/10 at 8:12 a.m., Individual #324 on 9/27/10 at 7:50 a.m., Individual #324 on 9/27/10 at 8:50 a.m., Individual #324 on 9/27/10 at 11:00 a.m., Individual #324 on 10/2/10 at 9:45 a.m., Individual #324 on 11/8/10 at 8:10 a.m., Individual #324 on 11/30/10 at 7:50 a.m., Individual #324 on 12/22/10 at 8:00 a.m., Individual #510 on 10/12/10 at 10:00 a.m., Individual #510 on 12/3/10 at 12:22 p.m., Individual #510 on 12/8/10 at 12:32 p.m., Individual #510 on 12/9/10 at 8:40 p.m., Individual #510 on 12/22/10 at 3:45 p.m., Individual #510 on 1/26/11 at 9:50 p.m., and Individual #304 on 12/27/10 at 2:40 p.m.; o Monitoring of Side Effects Scale (MOSES) and Dyskinesia Identification System: Condensed User Scale (DISCUS) ratings for the following individuals according to the date of the prescriber review: Individual #246 (MOSES 11/5/10, DISCUS 11/5/10), Individual #384 (MOSES 12/13/10, DISCUS 12/13/10), Individual #348 (MOSES 12/13/10, DISCUS 12/13/10), Individual #342 (MOSES 11/8/10, DISCUS 11/8/10), Individual #507 (MOSES 10/19/10, DISCUS 10/12/10), Individual #276 (MOSES 12/13/10, DISCUS 12/13/10), Individual #209 (MOSES 11/8/10, DISCUS 11/8/10), Individual #105 (MOSES undated, DISCUS 12/13/10), Individual #126 (MOSES 12/15/10), Individual #150 (MOSES 12/9/10, DISCUS 12/9/10), Individual #284 (MOSES 11/12/10, DISCUS 11/12/10), Individual #245 (MOSES 11/12/10, DISCUS 11/12/10), Individual #287 (MOSES

	11/12/10, DISCUS 11/12/10), Individual #465 (MOSES 12/9/10, DISCUS 12/9/10), Individual #371 (MOSES 10/14/10, DISCUS 10/14/10), Individual #180 (MOSES 12/9/10, DISCUS 12/9/10), Individual #25 (MOSES 10/14/10, DISCUS 10/14/10), Individual #231 (MOSES 11/16/10, DISCUS 11/16/10), Individual #503 (MOSES 11/16/10), Individual #75 (MOSES 12/3/10), Individual #247 (MOSES 12/16/10, DISCUS 12/16/10), Individual #481 (MOSES 12/16/10, DISCUS 12/16/10), Individual #188 (MOSES 12/16/10, DISCUS 12/16/10), Individual #517 (MOSES 12/16/10, DISCUS 12/16/10), Individual #319 (MOSES 10/25/10, DISCUS 10/25/10), Individual #48 (MOSES 12/20/10, DISCUS 12/20/10), Individual #457 (MOSES 12/17/10, DISCUS 12/17/10), Individual #518 (MOSES undated, DISCUS 12/21/10), Individual #461 (MOSES 10/25/10, DISCUS 10/25/10), Individual #32 (MOSES 10/25/10, DISCUS 10/25/10), Individual #363 (MOSES 1/10/11, DISCUS 1/10/11), Individual #455 (MOSES 1/10/11, DISCUS 1/10/11), Individual #540 (MOSES 1/11/11, DISCUS 1/11/11), Individual #509 (MOSES 1/11/11, DISCUS 1/11/11), Individual #98 (MOSES 12/14/10), Individual #486 (MOSES 11/16/10), Individual #74 (MOSES 12/15/10, DISCUS 12/15/10), Individual #505 (MOSES undated, DISCUS 1/4/11), Individual #303 (MOSES 1/4/11, DISCUS undated), Individual #282 (MOSES 11/2/10), Individual #185 (MOSES 11/16/10), and Individual #499 (MOSES 12/6/10); o Trend Analysis Report FY 10 August 2010, September 2010, October 2010, November 2010 (TX-AB-1102-XI.33); o Medication Error Reports, dated 8/6/10, and 9/13/10, with pharmacy email 9/15/10, and 9/10/10 (TX-AB-1102-XI.20); o Drug Utilization Evaluation (DUE) Data Collection Form, drug audited: Zostavax for time period August 2010 to October 2010 (TX-AB-1102.3); o Zostavax Drug Utilization Evaluation analysis January 2011; o Follow-up Drug Utilization Evaluation, drug audited: Valproic Acid and Divalproex sodium (Depakene, Depakote), for time period January 2011; o Drug Utilization Evaluation Schedule 2011 (TX-AB-1102-XI.8); o All "single patient intervention reports" in WORx system, since last monitoring visit (TX-AB-1102-XI.11); o Interventions, from 1/1/11 through 1/28/11 (TX –AB-1102-WZ.8.2); o For the past six months, any adverse drug reaction reports (ADR) completed (TX-AB-1102-XI.14); o Pharmacist Review of Quarterly Psychotropic Medication Review for the following: Individual #139 on 2/16/11, Individual #302 on 2/16/11, Individual #339 on 2/10/11, Individual #462 on 2/10/11 (TX-AB-1102-WZ.8.6); and o Physician Psychotropic Medication Review for the following: Individual #139 on 2/15/11, Individual #302 on 2/15/11, Individual #339 on 2/8/11, Individual #462 on 2/8/11, and Individual #74 on 2/10/11. ▪ **Interviews with**: o Marla Knight, Pharm D, Clinical Pharmacist; and o Leah Robinson, R.Ph., Pharmacy Director.

	Facility Self-Assessment: The Facility's POI indicated considerable progress in this Section. The Facility noted compliance with the following: Sections N.2, N.4, N.6, N.7, and N.8. This was consistent with some, but not all of the Monitoring Team's findings. In relation to Section N.1, for any new medication, a step-by-step approach was being used for documentation of communication between the pharmacy and PCP. This was recorded in the pharmacy software program, consistent with the requirements of the Settlement Agreement. However, there was no evidence that all the different areas of review were completed for each medication (review of need for lab, allergy review, etc.). The facility should develop a method to provide evidence that the pharmacy staff review all aspects of new medication orders as stated in this section of the SA. In relation to Section N.2, for the Quarterly Drug Regimen Review, the department incorporated pertinent lab values, especially drug levels. With regard to Section N.4, PCPs were documenting review, and acceptance or not of recommendations. With regard to Section N.6, the system of adverse drug reaction reporting appears to be running smoothly, and adverse drug reactions were reported and recorded in the record and in the computer system. Overall, though, it was not clear whether or not the self-assessment process the Facility was using was adequate. In this section, the POI consistently referenced "52 reviews," and provided data related to these reviews for each provision of the Settlement Agreement. It was not clear to what this data specifically referred. As is illustrated in the Monitoring Team's report for this section, multiple samples were drawn, and information was requested and reviewed. The Monitoring Team then used information gained from these reviews, as well as information gained through interview and other document review to draw its conclusions regarding compliance. Based on the information provided in the POI, the Facility's methodology for making its compliance decisions was not clear. The Monitoring Team did not find the Facility to be in compliance with Section N.7, which requires the completion of Drug Utilization Evaluations. Based on the calendar submitted, a new study was to be completed each quarter, as well as a follow up study based on the previous results. From the submitted information, for the six-month time period, only one new study was completed, and one follow-up study. It was not clear if all the DUE studies for the time period were submitted, but based on the reviewed information, there were several months in which no DUE activity was performed. It was not clear what criteria the Facility was using to determine it was in compliance with this provision. The POI stated: 1/2011--Current monitoring: 100% compliance from 52 reviews since 9/2010. Substantial Compliance noted by SAMT on 8/2010. Quarterly DUE's are being performed and compliance is 100%. The monitoring tool used tracks only 'analysis of DUE results' which implies that the DUE is done." The data referenced 52 reviews, but it was unclear what these 52 reviews measured, because 52 DUEs had not been completed. As the Monitoring Team has done, the Facility should evaluate the DUE process separately, and not include this with other reviews that are completed regarding compliance related to pharmacy supports provided to individuals. With regard to Section N. 8., the pharmacy indicated compliance with medication error documentation,

	review, analysis, and remedial action. However, the large number of unreconciled medication errors, along with medication dispensing errors from the pharmacy that were not recognized or reported in a timely manner suggested the need for further systems improvement. For other areas of the Settlement Agreement, Sections N.3 and N.5, the Facility found noncompliance, but was actively working on these areas. The process of chemical restraint review by the clinical pharmacist had recently been changed to improve compliance. It was too early to determine success with this new system. The MOSES and DISCUS evaluations also were undergoing change, and a new system was being developed.
	Summary of Monitor's Assessment: The Pharmacy Department had made considerable progress in achieving or approaching compliance with several provisions of the Settlement Agreement. This progress included: ▪ The quarterly drug regimen reviews were having a significant impact on the actual practices of the PCPs, and had been an important tool used to assist in reducing the use of anticholinergic and psychotropic medications. ▪ The adverse drug reaction reporting system appeared to be in place. To add practical value, it was being used as a method to record any significant reaction, even if it did not reach the threshold of needing to be reported through the MedWatch system. ▪ Drug utilization evaluations had been scheduled a year ahead of time on a quarterly calendar. Follow-up studies were being completed to determine the impact of previous DUEs. There remained challenges, but even in these areas there had been progress. Chemical restraint review by the clinical pharmacist remained a challenge, because the pharmacy was not receiving the forms required for completion. The QDRRs that required a psychiatry signature needed improved monitoring to ensure compliance with the psychiatrists reviewing and signing the required form. Timely MOSES and DISCUS evaluations fell below acceptable threshold levels. Medication errors remained a challenge, especially with the important category of unreconciled errors. In summary, compliance had been achieved in some areas, but remained a goal in other areas.

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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	On 8/11/10, the Texas State Board of Pharmacy conducted an inspection of the pharmacy at ABSSLC. The main findings were lack of completeness of the policy and procedure manual. The main concern was lack of documentation that technicians completed initial training. This documentation, as interpreted by pharmacy standards, was to be available at all times. To resolve the problem, copies of completed pharmacy technician trainee checklists were submitted, including the signatures of the trainees with dates. It was likely an oversight, but the narrative following the signed checklist referenced the first name of a technician who was to complete a certification exam in July 2003. This appeared to be an oversight, which had been carried over in the training	Noncompliance

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	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 literature.	document. It would be appropriate to revise/remove this paragraph from future training documents. Concerning updating the policy and procedure manual, the State Office had not distributed an updated manual, and the pharmacy at ABSSLC was waiting for this information before updating the Facility policy. For all new orders, the dispensing pharmacist used a pharmacy software program to review potential interactions with the current medication regimen, the side effects of the medication, allergies listed for the individual, and important lab values, such as complete blood counts (CBCs) when Clozaril was to be dispensed, as well as various dosage adjustments of medications. Evidence of adjustment in dosage, notifications of potential allergies, drug interactions, the need for lab, etc. were evident in the submitted documented communication between the pharmacist and PCP. Further, according to the clinical pharmacist, when the new drug order review was completed, the software program provided a monitoring check box to indicate completion. The clinical pharmacist could independently readily determine if the PCP reviewed the new drug order. According to the clinical pharmacist, compliance was 100%. However, there was no evidence provided in the Presentation Book or other submitted documents to verify the pharmacy staff were actually complying with all areas of this section of the Settlement Agreement for each new medication order. There was evidence that this process occurred for those orders that required a pharmacy-to-PCP communication, but there was no information about the majority of orders that did not require a communication. For instance, if the new order was not reviewed in relation to the various requirements, then there would not have been any information or concern that would result in generation of communication between the pharmacy and the PCP. In order for compliance to be substantiated, there needs to be assurance that the pharmacy reviews all orders, even the ones that did not generate a communication. The Pharmacy Department should create a database (which might already be available with the current the software), which shows that all new orders are being reviewed according to the guidelines set forth in the Settlement Agreement. Additionally, little evidence was present that there was a systematic approach used to review the need for laboratory testing based on risks associated with administration of the medication. There were occasional references, in the "patient intervention" entries, to laboratory testing that was needed (especially for Clozaril), but there did not appear to be a review of all medications for any needed or suggested laboratory testing. A document entitled "Interventions from 8/1/10 – 1/4/11" was submitted. This document was a log of all the communications between the dispensing pharmacist and the prescribing PCP, and provided the forum to document all communications between the pharmacist and the PCP. Under the type of communication entitled: "patient	

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		intervention," the date and time of the communication was recorded, as well as the recommendation. The recommendation included the name of the medication, as well as the dosage in most instances, followed by a capsule summary of concern and response from the PCP. It was obvious from the number of communications and changes in orders that this was a valuable resource to the PCPs. It built in a safety review, which benefited the individuals at ABSSLC. In August 2010, there were 26 patient intervention entries. In September 2010, there were 12 entries. In October 2010, there were 26 entries. In November 2010, there were 34 entries. In December 2010, there were 68 entries. Additionally, the database from January 1 through January 28, 2011 indicated there were 29 entries. The continued use and reliance on this system showed its value to both the pharmacist and the PCPs, and also provided a measurement (and documentation) of the interdisciplinary communication and coordination of information completed to produce a better outcome. An additional approach to ensuring appropriate medication use involved the choice of medications for individuals with J-tubes. A procedure had been put in place through which the pharmacy was able to flag those medications that should not be used through a J-tube. (Discussion with regard to Section L.1 provides additional detail regarding review of individual's drug profiles.) This resolved the problem of prescribing such medications as Carafate and Levaquin, which had been prescribed through J-tubes at the last Monitoring Team visit. It also was an excellent example of a systems approach to resolution of an issue.	
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 two quarters. A "Drug Regimen Review Schedule" was submitted, which specified the rotating schedule for QDRR completion among the residences. The individuals in eight residences were reviewed each month, and each residence was reviewed every three months. Based on the medications prescribed, protocols setting forth the type and frequency of laboratory tests were documented and used to determine the requirements for each individual reviewed. The appropriate lab was listed with date of last testing. Important lab values were also indicated. Psychotropic agents as well as anti-epileptic drugs had the date of the results, and either a specific lab value or a determination if it was within the therapeutic range. Based on the protocols and the lab results available, recommendations were made regarding any overdue tests. Also, other tests indicated by the protocols such as EKGs and ophthalmological exams, were also reviewed, and recommendations were made, if they were overdue. Forty-five QDRRs were reviewed, and are listed above in the section describing	Substantial Compliance

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		documents reviewed. All 45 QDRRs addressed laboratory results or overdue testing, as well as specific medication drug levels applicable to the individual. They included the date of most recent lab value, and an indication if it was within the therapeutic range or above or below this range. Compliance was 100%.	
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.	This provision of the Settlement Agreement encompasses a number of requirements. Each of these is discussed below, including the Pharmacy and Medical Departments' roles in addressing the use of "Stat" medications and chemical restraints. This discussion will also include benzodiazepines, anticholinergics, polypharmacy, and monitoring the metabolic and endocrine risks associated with second generation antipsychotics. <u>"Stat" Medications and Chemical Restraints</u> A list of those who required chemical restraint was submitted for the months of August 2010 through December 2010. In August 2010, there were three chemical restraints listed. In September 2010, there were 18 chemical restraints. In October 2010, there were 15 chemical restraints used. In November 2010, there were five chemical restraints. In December 2010, there were 14 chemical restraints used. A few individuals received many chemical restraints during this time and were responsible for most of the chemical restraint administration. Individual #43 received eight chemical restraints. Individual #260 received 12 chemical restraints. Individual #324 received 15 chemical restraints. Individual #79 received four chemical restraints. Individual #510 received five chemical restraints. Individual #313 received six chemical restraints. These individuals needed intensive monitoring and close psychiatry oversight. The clinical pharmacist should provide a historical log of the use of chemical restraints with outcomes, and should recommend other options based on the drug regimen the individuals were normally prescribed. These individuals are at high risk, as evidenced by the repeat need for chemical restraints. The clinical pharmacist should provide options to the PST as well. Separately, copies of the "restraint checklists," along with the Face-to-Face Assessment, Debriefing, and Reviews for Crisis Intervention Restraint forms, were reviewed. However, the numbers did not match the prior list. Documents submitted for individuals for whom chemical restraint was used in September and November 2010 were less than on the lists provided, and more than listed in December. A total of 52 restraint forms were submitted for the months of August through December 2010. Three were submitted for August 2010, 15 were submitted for September (the list indicated 18), 15 were submitted for October 2010, four were submitted for November 2010 (the list indicated eight), and 15 were submitted for December 2010 (the list indicated 14). Of these, the Pharm D reviewed 12 chemical restraints. This resulted in a compliance rate of 23% (12/52).	Noncompliance

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		The pharmacy notes briefly reviewed the prior interventions, and the necessity of using a chemical restraint. A review of documentation for vital signs also was reviewed. There was a comment regarding whether the emergency restraint had been screened to ensure no drug-drug interaction, and there was often a comment about monitoring for additional side effects. For those individuals needing repeat chemical restraint administration over a brief time period, there was a recommendation for further PCP or psychiatry review. Additional helpful information would have been a log of prior use of chemical restraint, including the type and dosage of medication used in the past, the effectiveness of the prior medication and dosage, and whether a future choice would be the same medication or an alternative medication, or alternative dosage. For the months of August through November, there was no review from the Pharmacy Department. All 12 pharmacy reviews occurred in December 2010 (there were 15 chemical restraints in December). These included chemical restraints for Individual #510 on 12/8/10, Individual #510 on 12/9/10, Individual #199 on 12/9/10, Individual #43 on 12/15/10, Individual #510 on 12/22/10, Individual #313 on 12/15/10, Individual #324 on 12/22/10, Individual #313 on 12/23/10, Individual #313 on 12/27/10, Individual #304 on 12/27/10, Individual #313 on 12/30/10, and Individual #505 on 12/30/10. The clinical pharmacist met with Psychology Department staff, and a new system of routing the "Restraint checklist" form was started in December. Three chemical restraint forms were submitted for January. These included forms for Individual #37 on 1/6/11, Individual #323 on 1/19/11, and Individual #510 on 1/26/11. All three had a clinical pharmacist review for drug interactions, side effects, and comments about clinical justification and effectiveness. In one case, a potentially severe drug-drug interaction was identified and the PCP was notified. Together with those in December discussed above, the new system had the promise of being successful, if it could be sustained. For the August through December reviews, it was noted that the average time for the Pharmacy Department to complete a written response was 12 days, with a range of five to 29 days. As some of the chemical restraints were repeated the next day or within a few days, a more rapid review by the Pharmacy Department would provide guidance in a more timely manner. Chemical restraints also were reviewed in a "trend analysis report FY 10." A graph over a three-year time period was included that compared restraint use each month during each of these years. A page was dedicated to recommendations, actions, and person responsible with due dates. One of the upgrades was to include medical and dental restraints in the trend analysis. This was to start in September 2010.	

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		The report also listed individuals requiring the majority of chemical restraints, as well as information concerning multiple admissions to state psychiatric facilities for stabilization and transfer back. Because a few individuals impacted the numbers of chemical restraints used, when those individuals were transferred to the state psychiatric centers, the use of chemical restraint use would be expected to improve. However, this was not reflected in the data analysis or interpretation. It is recommended that a monthly timeline be included that notes dates of hospitalizations for those that have needed chemical restraints. While the graphs might suggest improvement in some months, this might be due simply to high use individuals being transferred elsewhere for a few weeks for stabilization. There was also a comment in the trend report that it only took one or two individuals in the residence to disrupt the other residents, and increase behavioral incidents. It was not clear whether consideration had been given to decreasing the numbers of individuals living together, providing greater supervision, or both. The Facility had a responsibility to protect individuals, as well as to provide adequate treatment. Keeping someone in a residence who would predictably disrupt many other individuals' did not appear to be either a short or long term solution to the problem. Although the report made this statement, it did not offer a clear plan for resolving the issue identified. It was also documented in the November 2010 Trend Analysis Report FY 2011 that a "significantly high number of individuals" required psychiatric hospitalization. Although there has been success at chemical restraint reduction over time, the increase in psychiatric admissions was concerning and potentially reflected the Facility's inability to meet the needs of these challenging individuals. Whether or not the reduction in chemical restraints was balanced by other appropriate measures was not clear from these reports. However, if the reduction of chemical restraints was associated with increased psychiatric hospital admissions, then this was not a positive outcome. Members of the Psychiatry and Psychology Departments, in conjunction with individuals' teams should review the programs currently in place to ensure the Facility is responding adequately to the needs of individuals with behavioral challenges who were frequently psychiatrically hospitalized. <u>Benzodiazepines, Anticholinergics, Polypharmacy, and Second Generation Antipsychotics</u> The Quarterly Drug Regimen Review was the pharmacy's tool to monitor the use of benzodiazepines, anticholinergics, and polypharmacy. Specifically, justification for antipsychotics and benzodiazepines was documented, as well as risks of polypharmacy from any category of medication. For antipsychotic medication, there was an additional focus on metabolic and endocrine risk reflected in specific lab testing and lab results, as appropriate for lipids and fasting blood sugars.	

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		Of the 45 QDRRs reviewed, 27 did not indicate use of benzodiazepines, leaving 18 for which benzodiazepine use was reviewed. All 18 had diagnoses associated with the use of the benzodiazepine prescribed. For target symptoms, reference was provided as to where this information could be found (psychology/psychiatry notes). When applicable, there was mention of risk and other important clinical information (i.e., diazepam known to have a long half life that produces prolonged sedation, etc.) that was helpful to the PCP in treating the individual. Compliance was 100%. For monitoring of anticholinergic effect, all QDRRs included a review of anticholinergic effect. For seven of the 45 QDRRs, anticholinergic effect was not applicable, leaving 38 records in which comments and recommendations concerning anticholinergic effect were documented. Pharmacy comments usually involved a statement regarding the increased anticholinergic symptoms from the use of two or more medications being prescribed at one time. The awareness of the anticholinergic effect was valuable information for the PCP. The comments also listed anticholinergic signs and symptoms, and recommended monitoring for these. This occurred in 100% of the 38 records for which there was potential for anticholinergic effect. Of the 45 QDRRs reviewed, 15 of the individuals did not have polypharmacy, leaving 30 QDRRs in which polypharmacy was identified. In all cases, a list of the medications contributing toward polypharmacy was provided. Most cases involved psychotropic medications. The last psychiatric medication review with the date of the review was identified, with a brief entry concerning monitoring and target symptoms, as well as any recent changes in medications. The psychology/ psychiatry notes were also referenced. Each psychotropic medication had a diagnosis listed for which it was prescribed, and there was one request for clarification of a diagnosis (see below). All medications, not just antipsychotics, had a diagnosis listed. When appropriate, clarification was sought, and the response was written on the QDRR. This occurred with Individual #209 in the QDRR dated 11/5/10, in which GERD was listed as the diagnosis for Lactulose. A note from the PCP indicated the Lactulose had been discontinued. Occasionally, the psychiatrist updated the diagnosis listed in the QDRR. For instance, for Individual #150 in the QDRR dated 11/5/10, the diagnosis for Ativan was listed as oppositional defiant disorder, but was clarified by the psychiatrist as having an alternative psychiatric diagnosis. This indicated good communication between pharmacy and psychiatry, and allowed all departments to access updated information utilizing this form. Similarly, the psychiatrist clarified the diagnosis for the use of Lorazepam for Individual #287 in the QDRR dated 11/5/10. There was also clarification whether a medication was used for a psychiatric condition or for a neurological condition, as for Individual #74 in the QDRR dated 9/21/10. The psychiatrist clarified	

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		the use of Tegretol in this instance, again demonstrating collaboration and the value of the QDRR process. Of all the QDRRs reviewed, there was only one in which the pharmacist identified a psychotropic medication for which a diagnosis was not clear. The pharmacist recommended clarification of this issue, and the psychiatrist responded with a diagnosis written onto the QDRR. Thirty-five QDRRs indicated use of antipsychotic medication. For these, there was monitoring of endocrine and metabolic risk in 100% of the reviews. The focus was on completion of lipid panels and fasting blood sugars. Fasting blood sugars were specifically documented, including whether or not they were in the normal range. The protocol for atypical antipsychotics listed a number of tests to be done at intervals. The QDRRs included a review of the tests available, and if current results could not be found, recommended updating the tests consistent with the protocol. Additionally, serial weights were recorded as part of the review for metabolic risk. Compliance was 100%. There was evidence submitted indicating the impact the QDRRs had at the Facility as a source of information and monitoring regarding PCP practices. As documented in the Psychotropic Polypharmacy Review Committee minutes, dated 11/1/10, for the first three quarters of 2010, the use of psychotropic medications had been reduced by 14%, and the use of anticholinergic medication use had been reduced by 35%. Additionally, according to the Pharmacy and Therapeutics Committee meeting minutes, dated 10/28/10, the PCPs had been provided laminated pocket cards listing "high anticholinergic activity drugs grouped by drug class." As the physician was renewing orders, ordering new medication, or reviewing signs and symptoms suggestive of anticholinergic activity, this information was readily available. From this same Pharmacy and Therapeutics Committee meeting, it was documented that chemical restraint trending had improved for 2010 compared to the prior two years. The average number of chemical restraints in 2008 was 189 per quarter, in 2009 the average number was 104 per quarter, and in 2010 the average number was 41 per quarter. Another collaborative effort to reduce polypharmacy was through the Psychotropic Polypharmacy Review Committee. Minutes were submitted for the meetings on 10/4/10, 11/1/10, 12/20/10, and 1/24/11. Pharmacy staff, PCPs, psychiatrists, psychologists, QMRPs, and psychiatric assistants attended these meetings. Specific challenging cases were reviewed at each meeting with development and agreement of a new plan with updates occurring at subsequent meetings. The minutes provided valuable information concerning the complexities of the case and the response of the team, including closure to previously discussed concerns. Psychotropic medications were also reviewed, including concerns of polypharmacy, through the "Physician Psychotropic Medication Review." Examples were submitted for	

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		Individual #139, dated 2/15/11; Individual #302, dated 2/15/11; Individual #339, dated 2/8/11; Individual #462, dated 2/8/11; and Individual #74. Recent data concerning target behaviors were included. A review was completed of symptoms, past psychiatric medications, current psychotropic medications, recent vital signs, MOSES/DISCUS scores, weights and BMIs, current clinical assessment, recent lab data, and Axis I assessment with any changes indicated. Recommendations were offered. This review included all the essential information, and was recorded on a two-page form. This made it easy to understand and interpret the progress of the treatment, any side effect concerns, as well as document any changes in psychotropic medication. An additional monitoring mechanism consisted of the "Pharmacist Review of Quarterly Psychotropic Medication Review," in which the clinical pharmacist analyzed the psychotropic drug regimen, provided recommendations, and similar to the QDRR, required a signature and date from the reviewing PCP or psychiatrist. Forms were submitted for Individual #139, Individual #302, Individual #339, Individual #462, and Individual #74. Because of the completeness of the QDRR, with incorporation of PCP and psychiatry signatures and dates of review with agreement or disagreement, the "Pharmacist Review of Quarterly Psychotropic Medication Review" might be an unnecessary duplication. It is suggested that the involved departments review the necessity of continuing this form. At the time of the review, the Facility's review of "Stat" medications, or chemical restraints was not adequate. Although it was improving, the Facility remained out of compliance with this provision.	
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 45 QDRRs were also reviewed to determine PCP review, agreement, or if disagreement, the documentation of clinical justification. There was only one QDRR in which there was no documentation of the agreement/disagreement section. This was for Individual #169 with the QDRR dated 11/5/10. There was agreement in the remaining 44 out of 45 QDRRs, and a signature from either the PCP or psychiatrist or both. According to a statement on the QDRR, "the psychiatrist's signature is required only if the client has polypharmacy for psychoactive medication." Of the 45 QDRRs reviewed, 15 QDRRs were not signed by a psychiatrist, but did not need the signature of a psychiatrist. There were 26 QDRRs signed by the psychiatrist. However, there were four QDRRs documenting polypharmacy for psychotropic medications, but without a psychiatrist's signature. It is important for the psychiatrist to review the QDRRs for those with psychotropic polypharmacy, and to determine agreement or not with the pharmacist's recommendations. Out of 30 QDRRs requiring a psychiatrist's signature, four did not have any indication the psychiatrist had reviewed them. This resulted in a compliance rate of 26 out of 30 (87%).	Noncompliance

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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.	Forty-two recently completed MOSES and DISCUS monitoring instruments were submitted. For the MOSES instruments, 21 had irregularities. Several had delays between the examiner date and the prescriber date of review, such as Individual #276 had an examiner date of 11/4/10, but a prescriber review date of 12/13/10; Individual #284 had an examiner date of 11/5/10, and a prescriber review date of 11/12/10; Individual #245 had an examiner date of 11/5/10, and a prescriber review date of 11/12/10; Individual #465 had an examiner date of 9/7/10 and a prescriber review date of 12/9/10; Individual #231 had an examiner date of 11/3/10, and a prescriber review date of 11/16/10; Individual #503 had an examiner date of 11/3/10, and a prescriber review date of 11/16/10; Individual #481 had an examiner date of 11/24/10, and a prescriber review date of 12/1/6/10; Individual #188 had an examiner date of 11/24/10, and a prescriber review date of 12/16/10; Individual #517 had an examiner date of 11/24/10, and a prescriber review date of 12/16/10; Individual #48 had an examiner date of 11/25/10, and a prescriber review date of 12/20/10; Individual #461 had an examiner date of 10/7/10, and a prescriber review date of 10/25/10; Individual #32 had an examiner date of 10/7/10, and a prescriber review date of 10/25/10; Individual #363 had an examiner date of 1/1/11, and a prescriber review date of 1/10/11; Individual #455 had an examiner date of 1/1/11, and a prescriber review date of 1/10/11; Individual #540 had an examiner date of 11/15/10, and a prescriber review date of 1/11/11; and Individual #509 had an examiner date of 11/15/10, and a prescriber review date of 1/11/11. There were a few other concerns. Individual #105 had an examiner date of 12/9/10, but there was no signature for the prescriber review. For Individual #287, there was an examiner date of 11/20/10, which came after the prescriber date of 11/12/10. For Individual #247, the examiner date of 12/18/10 came after the prescriber review date of 12/16/10. For Individual #518, for the examiner date of 12/9/10, there was no date for the prescriber's review. For Individual #505, the examiner date of 1/3/11 had no prescriber signature. The compliance rate was 21 out of 42 (50%). Although a request was made for the previous MOSES forms, they were not submitted. As a result, the timeliness of the quarterly reviews could not be determined. For the DISCUS tool completion, there were 34 recently completed tools submitted, with 20 irregularities noted. Several had delays between the examiner date and the prescriber review date. These included: Individual #276 had an examiner date of 11/4/10, and a prescriber review date of 12/13/10; Individual #284 had an examiner date of 11/5/10, and a prescriber review date of 11/12/10; Individual #245 had an examiner date of 11/5/10, and a prescriber review date of 11/12/10; Individual #287 had an examiner date of 11/5/10, and a prescriber review date of 11/12/10; Individual	Noncompliance

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		#231 had an examiner date of 11/3/10, and a prescriber review date of 11/16/10; Individual #481 had an examiner date of 11/24/10, and a prescriber review date of 12/16/10; Individual #188 had an examiner date of 11/24/10, and a prescriber review date of 12/16/10; Individual #517 had an examiner date of 11/24/10, and a prescriber review date of 12/16/10; Individual #48 had an examiner date of 11/25/10, and a prescriber review date of 12/20/10; Individual #461 had an examiner date of 10/8/10, and a prescriber review date of 10/25/10; Individual #32 and an examiner date of 10/8/10, and a prescriber review date of 10/25/10; Individual #363 had an examiner date of 1/1/11, and a prescriber review date of 1/10/11; Individual #455 had an examiner date of 1/1/11, and a prescriber review date of 1/10/11; Individual #540 had an examiner date of 11/15/10, and a prescriber review date of 1/11/11; Individual #509 had an examiner date of 11/15/10, and a prescriber review date of 1/11/11. For Individual #303, the examiner date of 1/3/11 had no prescriber review signature. The previously completed quarterly DISCUS tools with scores were not submitted. However, on the forms submitted was the date of the last completed DISCUS tool except for three that had no date recorded (Individual #540, Individual #509, and Individual #74). For Individual #507, the examiner date of 10/14/10 was after the DISCUS prescriber review date of 10/12/10. From the recorded dates of the prior completed DISCUS score, there were several current DISCUS scores that were past the 90-day timeframe. These included Individual #284 (prior DISCUS score 8/3/10, current examiner date 11/5/10), Individual #245 (prior DISCUS score 8/3/10, current examiner date 11/5/10), Individual #287 (prior DISCUS score 8/3/10, current examiner date 11/5/10), Individual #371 (prior DISCUS score 7/6/10, current examiner date 10/11/10), Individual #25 (prior DISCUS score 7/6/10, current examiner date 10/11/10), Individual #231 (previous DISCUS score 7/14/10, current examiner date 11/3/10), and Individual #319 (previous DISCUS score 7/2/10, current examiner date 10/22/10). As previously mentioned, there were three with prior dates of completion not recorded, and no prior copies of any of the DISCUS were submitted for verification. Compliance was 14 out of 34 (42%). The lack of signatures and dates suggested there was no routine monitoring to review the forms for completeness. The clinical pharmacist indicated there has been no progress in improving the MOSES and DISCUS completion tools in a timely manner, but the new full time psychiatrist was going to suggest changes to the system, including having the psychiatrist complete the MOSES and DISCUS. This would resolve the delays between the examiner date and the prescriber review date. However, the Pharmacy would still need to track the completion dates to ensure the next quarterly review was within the required 90 day-time period.	
N6	Commencing within six months of	The adverse drug reaction reporting system continued to be utilized, and it was a	Substantial

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	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.	successfully implemented program. Since the Monitoring Team's last visit, there had been four adverse reactions identified. For one, a voluntary MedWatch form was completed, and the reaction was reported to the appropriate authorities due to the severity of the reaction. Adverse drug reactions were noted for Individual #469 on 10/29/10 (rash developed with Chlorpromazine), Individual #316 on 12/4/10 (low platelet count with Valproic acid), and Individual #33 on 11/14/10 (increased liver enzymes with Zyprexa). These reactions were considered known possible side effects. The pharmacy used the opportunity to utilize the adverse drug reaction system to ensure it was current and familiar to all staff. It was also an excellent method to document allergies and adverse side effects, which would have the potential to be poorly documented and/or removed from the record during thinning. These medications were listed under the allergy section of the individual's medication list/orders, and each was a permanent available record through the pharmacy system. These did not reach the threshold level of reporting to a federal authority. On 1/12/11, Individual #202 had a severe reaction to the use of Niaspan. He was found without pulse and without respirations, and was successfully resuscitated. However, a MedWatch form was completed and submitted to government authorities through the internet. These four examples indicated this system was working without problems. Staff are familiar with the process, as well as when to report an adverse effect.	Compliance
N7	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall ensure the 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.	During the last six months, a calendar was created in which drug utilization evaluations (DUEs) were scheduled every three months. For each quarter, analysis of data collected was to occur for one DUE, and, simultaneously, the next DUE would begin. In compliance with the HCG Appendix related to DUEs, four quarters of the calendar had studies and evaluations scheduled. A DUE for the administration of Zostavax was completed for the time period August to October. Analysis of results occurred in January 2011. Results indicated only a 62% compliance rate with administration of this vaccine. Informally, this reportedly had been improved, but will need to be reviewed formally through a follow-up study. For January 2011, there was a follow-up DUE from a prior DUE study for various parameters of Depakene/Depakote, including that indication was identified: seizures versus behavior, and the appropriate laboratory monitoring was to be tracked. These were excellent studies for this six-month time interval. They provided data to suggest ways to improve the health care at ABSSLC.	Noncompliance

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		However, based on the Facility's calendar, one would expect two DUEs to have been completed (one each quarter), and two follow up studies to the DUEs. Based on submitted documentation, only one DUE was completed for the six months, and one follow up study was in progress. Out of the two DUEs and two follow-up DUEs expected, only two out of four evaluations were completed, for a 50% compliance rate. From the Pharmacy and Therapeutics Committee Meeting minutes, dated 10/28/10, there was mention of a follow up study for calcium supplementation in which compliance went from 29% in the original DUE to 91%. However, this follow up study was not submitted for review. If the calendar of DUEs is implemented, this problem should be corrected.	
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.	Minutes of the Medication Error Committee were submitted for the past six months. The following summarizes some of the highlights of these minutes: ▪ The July 28, 2010 minutes indicated that errors of omission were the most common cause of medication errors. The data from May and June of 2010 had been reviewed. There were no serious category "E" or "F" errors, but there were 18 errors classified as "D" errors. Category D error were ones that reached the individual, and required monitoring to confirm that it resulted in no harm and/or required intervention to preclude harm. Category E was an error that might have contributed to or resulted in temporary harm to the individual, and required intervention. Category F was an error that may might have contributed to or resulted in temporary harm to the individual, and required initial or prolonged hospitalization. ▪ The August 25, 2010 meeting minutes again indicated that errors of omission were the dominant cause of errors. The majority of errors in July 2010 were errors of administration. There were no D category errors. ▪ The September 22, 2010 Medication Error Committee meeting minutes indicated improvement in the medication error rate for several of the residences that had previously had high numbers. Several nursing measures were put in place across the residences that assisted in reducing the medication error rate. A timeline of interventions for residence 6450 was attached to the minutes. Additional interventions were conducted in the residence over the time period from June 1st to September 3rd. A remaining area of concern was the medications left at the end of the auto fill period. These medications represented 20 of the 58 variances in August 2010. There was the possible correlation of this type of variance with residences in which individuals refused both meals and medications. There was the possibility that these medications were due to refusals that were not documented. Because of this potential cause of variances,	Noncompliance

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		the Psychology Department was to be contacted to determine whether medication refusal could be added as a target behavior. Nurses were to be provided additional in-service training on the documentation procedure for medication refusals. Specific residences were then to be monitored. ▪ The October 26, 2010 Medication Error Committee meeting minutes included a recommendation that the medication counts done between shifts be completed by two nurses. This was then assigned to a work group to develop recommendations to be brought back to the committee. Errors of omission and unreconciled doses were the main concerns. No trends were identified. It was noted that the Facility dispensed/administered 139,508 doses in October 2010 (error rate 0.0041%). There was also discussion of the data related to medication pass observations for all LVNs and RNs who were expected to administer medications. This monitoring system appeared to be newly instituted as of August 2010. Based on three months of data, no trends were reported. ▪ The 12/22/10 Medication Error Committee meeting minutes documented concern regarding whether or not all the "missed" doses were reported. The response was that spot checks would be done to determine if the drugs that were returned and the medication errors matched. ▪ The minutes of the Medication Error Committee were also reviewed for the most recent meetings of 1/26/11/and 2/16/11. These minutes indicated there was a peak of total errors in December 2010, followed by a reduction in January, which still exceeded the number of medication errors in September through November 2010. The unreconciled errors continued to constitute a large portion of the errors. A large volume of information the Medication Error Committee uses for its meetings was submitted. It reflected the different aspects of medication errors that are available for review through the data collected. This information included: a monthly tally of errors by category in a series of graph forms (minor incidents, serious errors, unknown errors, total reported, total errors) from 9/09 through 11/10, monthly errors by type summarized in graphs (extra dose, omitted dose, wrong patient, wrong time, wrong dose, wrong route, wrong drug, wrong technique) from 2/10 through 11/10, a list of all medication errors sorted by error type (1/10, through 12/10), graphs of errors sorted by node (administering, dispensing, documenting, monitoring) from 12/09 through 11/10, a list of medication errors sorted by error node (1/10 through 11/10), graphs of medication errors sorted by severity (category A through F) for 12/09 through 11/10, a list of medication errors sorted by severity (1/10 through11/10), graphs of medication errors sorted by shift from 12/09 through 11/10, a list of medication errors sorted by shift (1/10 through 11/10), graphs of medication errors sorted by unit from 12/09	

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		through 11/10, a list of medication errors sorted by unit (1/10 through 11/10), graphs for 12/09 through 11/10 sorted by residence, a list of medication errors sorted by residence (12/09 through 11/10), a list of medication errors sorted by nurse (3/10 through 11/10), and a list of medication errors sorted by individual (3/10 through 11/10), a graph of unreconciled errors fiscal year 2010/2011, a graph of total errors fiscal year 2010/2011, a graph of total/unreconciled errors fiscal year 2010/2011, a graph of unreconciled errors from 9/09 through 10/10. Additionally, there was a memorandum, dated 11/24/10, concerning the "medication observation report 8/10-10/10." There was an additional memorandum, dated 12/22/10, concerning the "medication observation report November." The data was thorough, and due to the volume of raw data available, the graphs were most apt to be of use to the various committees and staff responsible for medication error trending and reduction. From a 12/22/10 report to the Medication Error Committee summarizing the collaboration between the clinical pharmacist and the residential staff, the in-depth review to reduce medication errors was highlighted in several bullets: the medication of every individual in one residence was reviewed for sources of error, the pharmacist suggested simplification of medication regimens, there was the suggestion to increase the formulary/inventory of different strengths of medications in the pharmacy, and there was need to focus on certain drugs and dosages which caused complicated regimens. It will be important to track these specific recommendations to determine if they were completed, and, if so, the impact they have had on the various buildings' medication error rates. The unreconciled medication errors is perhaps most problematic. The suggestion offered in a Medication Error Committee meeting to focus on refusals should be implemented and tracked until the issue is resolved. Updates on medication refusals should be available in future Medication Error Committee meeting minutes. If the medication error rate remains unimproved despite the best efforts of nursing, pharmacy, and QA departments, then it is suggested that an outside consultant be considered, either from within the SSLC state system, or from a local or regional hospital, rehabilitation or other health care system to review the entire medication administration process. There were occasional medication errors that originated in the pharmacy. On 8/6/10, four individuals had either excesses or shortages of medication. On 9/10/10, there was an error in which pharmacy staff was also involved, although details of the error were not available. Additionally, a medication error report was not completed, at least not at the time of discovery, on a technician inadvertently distributing twice the dose of Ativan. There appeared not to be a system to catch this latter error. The Pharmacy Department should review the practice to identify a method of oversight or revise the system so that	

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		such an error does not occur. No information was provided regarding the overages and shortages of other medications. It suggests the need for further monitoring, such as a double or triple check system, if not already in place.	

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

1. The Facility should create a system to track that new orders are reviewed for allergies, drug interactions, need for laboratory testing, etc. (i.e., the requirements as stated in Section N.1 of the Settlement Agreement).
2. As part of the chemical restraint documentation, the clinical pharmacist should provide a historical log, perhaps as an attachment, showing the effectiveness of prior use of chemical restraints (including dosage and route of administration), as well as recommendations for alternative medications option or medication regimens based on the current drug regimen of the individual.
3. The new system of routing the chemical restraint documentation should continue to be used with a goal of decreasing the time interval between the use of the chemical restraint and the clinical pharmacist's completion of her review.
4. In the trend reports, a monthly timeline should be included that notes dates of hospitalizations for those that have needed chemical restraints. Specifically, it would be beneficial to create a graph of those requiring inpatient psychiatric admission and overlay that with chemical restraint usage.
5. If the reduction of chemical restraint use was associated with increased psychiatric hospital admissions, then involved clinical departments should meet to review programs currently in place to ensure the Facility is responding appropriately to the needs of these individuals.
6. The Pharmacy should maintain a database or log of the completion dates of the MOSES and DISCUS (based on either the rater review date, or prescriber review date) to ensure the next quarterly review is completed in a timely manner.
7. Recommendations from the clinical pharmacist to reduce medication errors in the residences should be reviewed and implemented, as appropriate. Recommendations should be followed through to closure with documentation of progress and the impact on the reduction of medication variances.
8. Medication refusals should be tracked as a separate statistic.
9. If the medication error rate remains at a plateau without further improvement, then an outside consultant either locally or through the state SSLC system should be considered to assist in further analysis.
10. A fail-safe system should be in place to eliminate pharmacy-dispensing errors.

The following are offered as additional suggestions to the State and Facility:

1. The Pharmacy and Psychiatry Departments should review the value of the "Pharmacist Review of Quarterly Psychotropic Medication Review" to determine if the same information is being reviewed in the QDRR, and if so, this process could be discontinued as a redundancy in the system.

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 Presentation Book for Section O; o The following documents: Occupational Therapy (OT)/Physical Therapy (PT)/Speech Language Pathology (SLP) Assessments, Nutrition Assessment, Nursing Care Plan, OT/PT/SLP consultations for the last year, PSP and PSP Addendums for the last year, Physical and Nutritional Management Plan (PNMP) with pictures including positioning and/or other instructions, Risk Assessment, Nutritional Management Team (NMT) Individual Record, person-specific monitoring for the past year, PNMP Clinic Notes for the past year, staff competency-based training documentation for the following 15 individuals: Individual #100, Individual #511, Individual #409, Individual #457, Individual #208, Individual #253, Individual #344, Individual #337, Individual #212, Individual #407, Individual #366, Individual #314, Individual #290, Individual #82, and Individual #435; o The following documents: Occupational Therapy/Physical Therapy/Speech Language Pathology Assessments, Nutrition Assessment, PNMT Evaluation and Action Plan including updates, Nursing Care Plan, OT/PT/SLP consultations for the last year, PSP and PSP Addendums for the last year, Physical and Nutritional Management Plan with pictures including positioning and/or other instructions, person-specific monitoring post PNMT Evaluation, PNMP Clinic Notes for the past year, competency-based training for staff post PNMT Evaluation, PNMT Integrated Progress Notes post PNMT Evaluation, Risk Assessment for the following three individuals: Individual #353, Individual #23 and Individual #433; o The following documents: Occupational Therapy Evaluation, SLP Evaluation, Nutrition Assessment, Medical Assessment, Nursing Assessment, Aspiration Pneumonia/Enteral Nutrition Assessment, PSP and PSP Addendums for the last year, Physical and Nutritional Management Plan with pictures, Dining Plan, PNMP person-specific monitoring, competency-based training for staff, Risk Assessment, Therapeutic feeding/recreation program and OT/SLP Consultations for the past year for the following 14 individuals: Individual #512, Individual #216, Individual #101, Individual #409, Individual #340, Individual #253, Individual #20, Individual #361, Individual #92, Individual #443, Individual #457, Individual #14, Individual #511, and Individual #373; o The dining plan/diet card for the following 30 individuals: Individual#353, Individual #418, Individual #103, Individual #405, Individual #364, Individual #129, Individual #206, Individual #183, Individual #163, Individual #274, Individual #285, Individual #216, Individual #204, Individual #399, Individual #201, Individual #20, Individual #525, Individual #202, Individual #138, Individual #535, Individual #312, Individual #80, Individual #337, Individual #343, Individual# 349, Individual #498, Individual #100,

	Individual #67, Individual #377, and Individual #407; o The following documents: current Medication Administration Record (MAR), PNMP, staff competency-based training for PNMPs, and person-specific monitoring for PNMPs for the following 13 individuals: Individual #250, Individual #418, Individual #311, Individual #19, Individual #362, Individual #26, Individual # 417, Individual #353, Individual #122, Individual #119, Individual #361, Individual #91, and Individual #359; o List of PNM team members and corresponding curriculum vita, various dates; o PNM Policies and Procedures, dated 11/3/10; o PNMT continuing education sessions, dated 2/08 through 2/11; o Minutes of PNMT meetings, dated 8/10 through 12/10; o PNMT Assessment Reports on Multiple Individuals, dated 11/10 and 12/10; o PNMT Evaluation (template), undated; o List of Individuals with and without PNM needs, undated; o PNMT Evaluations for Multiple Individuals, dated 9/10 through 1/11; o PNM Assessments and Updates for Multiple Individuals, dated 4/10 through 9/10; o PNMPs for Multiple Individuals, dated 12/09 through 12/10; o PNMT Action Plan (template), undated; o List of Individuals with completed PNM monitoring tools, dated 9/10 through 1/11; o PNMT Action Plan for Multiple Individuals, dated 9/10 through 1/11; o Dining Plan (template), dated 2010; o PNMP's, Dining Plans, and corresponding competency-based Training Sheets for Multiple Individuals, dated 1/10 through 12/10; o PNM Clinic Spreadsheets, dated 1/10 through 12/10; o List of individuals on modified diets/thickened liquids, undated; o List of individuals who require mealtime assistance, undated; o List of individuals who receive nutrition through non-oral methods, undated; o List of individuals whose diets have been changed to modified texture or consistency, dated 1/10 through 12/10; o List of individuals with BMI greater than or equal to (≥) 30, undated; o List of individuals with BMI less than or equal to (≤) 20; undated; o List of individuals with weight loss greater than or equal to 10%, dated 1/10 through 12/10; o List of individuals with choking incident, dated 9/10 through 11/10; o List of individuals with aspiration and/or pneumonia incident, dated 1/10 through 12/10; o List of individuals with chronic respiratory infections, dated 1/10 through 12/10; o List of individuals with injuries caused by slip/trip/fall, dated 1/10 through 1/11; o List of individuals with fractures, dated 8/10 through 12/10; o List of individuals considered to be at risk of: choking, falls, skin breakdown, fecal impaction, osteoporosis/osteopenia, aspiration, and pneumonia, dated 2/10 through 8/10; o List of individuals who are non-ambulatory or require assistance, undated; o List of individuals with poor oral hygiene and date of dental exam, dated 1/10 through

	1/11; o List of individuals who have chronic and acute pain, dated 7/09 through 11/10; o List of individuals who have received a videofluoroscopy, modified barium study, or other diagnostic swallowing evaluation, dated 1/10 through 12/10; o Meal Schedule-by residence, undated; o PNM Curricula used to train staff, undated; o Agenda and curriculum for foundational in-service trainings (templates), undated; o Competency-based Training Sessions, dated 6/10 through 12/10; o Tools and checklists used to provide competency-based training (templates), undated; o Aspiration Triggers Data Sheet (template), dated 12/10; o SSLC Risk Guidelines, undated; o SSLC Aspiration Triggers Data Sheet, dated 12/10; o Aspiration Pneumonia/Enteral Nutrition (APEN) Evaluation, dated 12/29/10; o PST Meetings focusing on risk reduction as approached as a Brainstorming Process, undated; o Integrated Risk Rating Form, dated 12/20/10; o Risk Action Plan, dated 12/20/10; o Infirmary, emergency room, hospitalization tracking sheet listed by individual, sorted by individual names and multiple dates; o List of names of At Risk PSPAs [Personal Support Plan Addendums] completed as of today since the start of the process, undated; o Presentation Handout for SA Section O for February 14, 2011 Settlement Agreement Monitoring Team Visit, undated; o Individuals at risk of aspiration pneumonia provided by State Office to ABSSLC, undated; o List of who is scheduled for next At Risk meetings and a deadline for completing initial At Risk meetings for all individuals; o ABSSLC Leadership Council/QA/QI Agenda, dated 2/14/11; o The Drive for 25 for Sections O and P, updated 1/31/11; o PNMP Coordinator Training and Instructor's Manual, undated; o PSP for Individual #417, dated 2/15/11; o An alphabetical list of all individuals served, including name of residence and day/vocational program and the date of the most recent annual PSP meeting, the date on which the PSP document was completed/filed and the date of the previous PSP meeting, undated; o A list of individuals served by residence/home, including for each residence an alphabetized list of individual served, their age (or date of birth), date of admission and legal status; o Agenda for new staff orientation, and any curricula revised since the last visit, undated; o Schedule for on-going staff training, dated 2/10 through 2/11; o The number of budgeted positions, number of staff, number of contractors, number of unfilled positions, including the number of unfilled positions for which contractors currently provide services, the current FTE [full time equivalent], and the actual staff to

	individual ratio for each position, including staff and contractors, undated; o List of individuals who have been admitted to the Facility, who have died, including the date of death, and who have transitioned to the community including the date of transition, dated 1/5/11; o Lists currently available at the Facility of each individual identified to be "at risk" utilizing the State's risk categories, including, but not limited: aspiration; aspiration pneumonia/pneumonia; chronic respiratory infections; contractures, gastroesophageal reflux, choking, dysphagia, falls, weight loss or gain, skin breakdown/decubitus ulcer, causing harm to self or others, impaction;/bowel obstruction/constipations, dehydration, Pica, metabolic syndrome, seizures, osteopenia/osteoporosis, non-ambulatory or assisted ambulation, requiring mealtime assistance, poor oral dental status, and receiving enteral feeding, by type of tube, pain (including chronic and acute) undated; o Individuals seen in emergency room, including the date seen at the emergency room and reason for visit, multiple dates; o Individuals admitted to the hospital, including date of admission, reason for admission, discharge diagnoses, and date of discharge from hospital, multiple dates; o Individuals admitted to Facility's Infirmary, including date of admission/transfer, reason for admission/transfer, and date transferred back to residential unit, multiple dates; and o Communicable Disease Report for Aspiration Pneumonia and Pneumonia, date range from 1/1/10 to 12/31/10. ▪ **Interviews with**: o Bobbie Holden, Occupational Therapist; o Karen Mayfield, PT, DPT; and o Debra Sessions, MS, CCC/SLP. ▪ **Observations of**: o Habilitation Therapies staff meeting, on 2/14/11; o PNMT Evaluation for Individual #100, on 2/16/11; o PST meeting for At Risk Assessment for Individual #100, on 2/16/11; o PST Meeting for Individual #417; o ABSSLC Leadership Council/QA/QI meeting, on 2/14/11; o Infirmary; and o Residences 6460, 6450, 5961, 5962, 6480, 6521, 6510, 5972, 5971, and 6380.
	Facility Self-Assessment: ABSSLC Plan of Improvement, updated 1/31/11, provided comments/status for Section O.1 through O.8. The Facility indicated it was in noncompliance with each of the provisions. This was consistent with the Monitoring Team's findings. This document also provided a summary of some of the action plans on which the Facility was working to achieve compliance. In addition to the POI the Facility submitted, the Habilitation Therapies Department provided additional information, including: ▪ ABSSLC Plan of Improvement, updated 1/31/11, which addressed the status of recommendations. This form addressed the status of the following recommendations: O.1, O.2, O.7, O.8, O.12, and

	O.13. ▪ ABSSLC POI, undated, offered the status of the draft Monitoring Tool for Section O. These documents should be merged to present a cohesive compliance document. In addition to providing some narrative descriptions of actions the Facility had or was taking to move towards compliance, the Facility included some data from its self-assessment reviews. This was an important step. However, it was not always clear specifically to what the data referred, making it difficult to determine if the Facility had accurately identified areas in which focused attention was needed to address the concerns that were keeping it from reaching compliance. For example, for Section O.1, which includes multiple requirements, the POI stated: "1/2011--Current monitoring results: 28% compliance from review of 87 records since 9/2010." The score appeared to be an overall score, which did not assist in providing direction for next steps, and likely could not have been calculated accurately given the monitoring tools being used. As the Facility moves forward in its self-assessment process, it will be important to ensure that data is used in meaningful ways to assist in identifying areas in which improvements are needed. Moreover, the completed monitoring review tool submitted did not indicate how compliance findings were derived. The monitoring tool did not provide a defined methodology and/or instructions for the use of the audit forms. No evidence was submitted to document that inter-rater reliability had been established with multiple reviewers completing the audit forms. Individual indicators were assigned substantial compliance without documentation to support the findings of compliance and/or non-compliance ratings for the various provisions of Section O. For example, Section O.1.A.2 stated "100% of records reviewed show that there is documentation that members of the PNM team have specialized training or experience in which they have demonstrated competency in working with individuals with complex physical and nutritional management needs." This indicator documented substantial compliance with the following comment "NMT/PNM members routinely attend continuing education opportunities provided by each state discipline as well as other outside in-service opportunities as approved by the Facility and state office." There was no data presented to validate the substantial compliance finding.
	Summary of Monitor's Assessment: Since the last review, the Facility had developed two PNMTs, which were referred to as PNMT I and PNMT II. Team members had been assigned to each. The PNMTs consisted of the membership the Settlement Agreement required. As noted with regard to Section I and Section L, given the medical complexities of the individuals the PNMT supported, it would be important for a PCP to be a regular consultant and/or member of the PNMTs. Given the numbers of individuals at ABSSLC with physical and nutritional management needs, including a large number of individuals at high risk, the slow pace of the PNMTs completion of assessments and physical and nutritional support plans was concerning. The current caseloads of the PNMT members will continue to significantly impact their ability to address adequately their responsibilities as PNMT members for individuals at the highest risk levels within the Facility, as well as provide supports to individuals on their respective caseloads.

	The importance of PNMT members' attendance at PNMT-related continuing education webinars and outside courses must be non-negotiable. The absence of attendance documentation for Core PNMT members for multiple PNMT courses was unfortunate. PNMT team members have a responsibility to participate in on-going continuing education opportunities to expand their knowledge and skills, and ensure they are knowledgeable with regard to current trends within their respective fields as well as other team members' fields of expertise. Competency-based training had been developed for PNMP Coordinators. This was an important and positive development. PNMP Coordinators played a key role in implementing PNMPs, as well as training and monitoring staff in the residences on the proper and consistent implementation of the plans. Although this was a positive development, PNMP Coordinators were not yet consistently performing their duties. This was illustrated when staff were not implementing dining plans, but PNMP Coordinators did not intervene. However, competency-based training on foundational physical and nutritional supports had not been developed, and was not being provided to staff responsible for the direct support of individuals the Facility served. Competency-based training also was not being provided on individuals' PNMPs. Given the Monitoring Team's observations that showed many errors in the implementation of PNMPs, and the risk at which this placed individuals, this was of continuing significant concern. A review of Facility reports, including those from Quality Assurance, did not illustrate that a mechanism was in place that ensured timely data was provided to the PNM Team for analysis leading to the identification of potential issues, 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, Incident Management and Risk Management systems. The Facility had begun to use a new assessment format to evaluate the ongoing need for individuals' feeding tubes, and to determine if any oral intake was appropriate. The Facility was at the very beginning stages of this process. It will be important for information gained from this assessment process to be integrated into individuals PSPs and PNMPs.

#	Provision	Assessment of Status	Compliance
O1	Commencing within six months of the Effective Date hereof and with full implementation within two	Due to the multiple requirements included in this provision of the Settlement Agreement, 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	Noncompliance

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>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, or physician's assistant. All members of the team should have specialized training or experience</td><td>summarizes the review of the requirements related to the PNMT, 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)].
Since the last review, the Facility had developed two PNMTs, which were referred to as PNMT I and PNMT II. The PNMTs consisted of the membership the Settlement Agreement required. Members of the PNMT I were: Bobbie Holden, OT; Debra Sessions, SLP; Karen Mayfield, PT; Tricia Reyes, RD; and Pat Johnson, RN. PNMT II members were: Dina Warren, OT; Melissa Fitzgerald, SLP; Lindsey Tierce, PT; Nicole Spalding, RD and Page Polston, RN. As noted with regard to Section I and Section L, given the medical complexities of the individuals the PNMT supported, it would be important for a PCP to be a regular consultant and/or member of the PNMTs.

In the section of this report that addresses Section O.2 of the Settlement Agreement, the Monitoring Team's review of the three individuals the PNMTs assessed since the last on-site compliance review (Individual #353, Individual #23, and Individual #433) is discussed. Given the numbers of individuals at ABSSLC with physical and nutritional management needs, including a large number of individuals at high risk, the slow pace of the PNMTs completion of assessments and physical and nutritional support plans was concerning.

At the time of the review, the current ABSSLC census was 447 individuals. Based on interview and document review, the following chart identifies the current caseloads and/or responsibilities of the PNMT I and PNMT II members:

<table>
<tr><th>PNMT I Members</th><th>Current Caseloads and Responsibilities</th></tr>
<tr><td>Registered Nurse (RN)</td><td>ABSSLC Staff-to-individual ratio for nursing was 1 to 2.5, but the actual caseload for this nurse was not provided</td></tr>
<tr><td>Physical Therapist (PT)</td><td>Caseload not reported per document request, but estimated to be 1:112</td></tr>
<tr><td>Occupational Therapist (OT)</td><td>Caseload not reported per document request, but estimated to be approximately 223</td></tr>
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#	Provision	Assessment of Status	Compliance
	demonstrating competence in working with individuals with complex physical and nutritional management needs.		

Dietician (RD)	One of two dieticians on campus, supporting 223 individuals
Speech Pathologist (SLP)	Supported 120 individuals

PNMT II Members	Current Caseloads and Responsibilities
Registered Nurse (RN)	ABSSLC Staff-to-individual ratio for nursing was 1 to 2.5, but the caseload for this nurse was not provided
Physical Therapist (PT)	Caseload not reported per document request, but estimated to be 1:112
Occupational Therapist (OT)	Caseload not reported per document request, but estimated to be 1:223
Dietician (RD)	One of two dieticians on campus, supporting 223 individuals
Speech Pathologist (SLP)	Supported 97 individuals

The current caseloads of the Core PNMT members will continue to significantly impact their ability to address adequately their responsibilities as Core PNMT members for individuals at the highest risk levels within the Facility, as well as provide supports to individuals on their respective caseloads. As stated with regard to Section I of the Settlement Agreement, Facility Administration, in collaboration with the PNMTs, should review the current caseloads the members of the two PNMTs to identify the changes that need to be made to enable the PNMT(s) to evaluate and provide ongoing supports to individuals at high risk within a swifter time frame.

With regard to the qualifications of the members of PNMT I, review of CVs and/or resumes submitted for the PT, OT, SLP and RD showed that each had five years of experience within their respective fields. A CV and/or resume was not submitted for the RN. CV and/or resumes of PNMT II members showed that the OT, RD, and SLP had five years of experience within their respective fields. The PT did not have five years of experience within her respective field. A CV and/or resume was not submitted for the RN.

The following table represented documentation of continuing education submitted by PNMT I and PNNT members, as well as PNMT attendance at webinars Karen Hardwick, State Coordinator for Habilitation Therapies, presented. It was difficult for the Monitoring Team to discern if webinars that were conducted on the same day were different courses and/or if participants assigned multiple titles to the same course. For example, PNMT Risk/Development Interventions III, and PNMT Clinical Assessment Technologies and Wound Investigation Process occurred on 7/30/10. It was not clear if

#	Provision	Assessment of Status	Compliance
		these were two different courses, or different names for the same course. The following chart is the Monitoring Team's best effort to document the list of continuing education webinars and courses submitted by PNMT I and PNMT II members:	

Continuing Education	PNMT I Members	PNMT II Members
Autism Extravaganza: Featuring Temple Grandin (3/9/10)	SLP, OT	PT, OT
Nutrition Practice Standards for the Bariatric Patient (4/14/10)		RD
Prevention and Treatment of Diabetes in Youth: Lessons Learned (4/14/10)		RD
Positive Behavior Support	SLP	
Fiber Basics & Beyond: There's More to Know About Fiber (5/3/10)		RD
The ABCs of Muscle: Nutrition Interventions for Aging, Bed Rest and Consequences of Disease (6/3/10)		RD
Effects of Pistachios on Cardiovascular Risk Factors and Potential Mechanism of Action (6/29/10)		RD
PNMT Seating/Positioning (7/1/10)		
Issues in Nutritional Management (7/7/10)	SLP	SLP
PNMP and Wheelchair Clinic Webinar (7/7/10)		
PNMT Risk/Development of Interventions (7/9/10)		
PNMT Risk/Development of Interventions II (7/16/10)		
PNMP and Wheelchair Clinic Webinar (7/19/10)		PT
PNMT Risk/Development Interventions III (7/23/10)		
PNMT Clinical Assessment Technologies and Wound Investigation Process (7/30/10)		
PNMT Identification of Risk and Development of Interventions (7/30/10)	SLP	
Technological Advances in the Management of Dysphagia (8/10/10)	SLP	OT
Issues in Nutritional Management Part 2 (8/13/10)		

#	Provision	Assessment of Status			Compliance
		NMT/PNMT Equipment Webinar (8/13/10)	PT, OT	PT	
		Pediatric Dysphagia-Management of the Whole Child (8/13/10)	SLP	OT	
		PNMT and Wound Care Investigation (8/13/10)			
		PNMT GI Webinar for OTs (8/17/10)			
		Fall Prevention (8/25/10)		PT	
		Seating and Positioning for Dysphagia (9/1/10)	PT, OT, RD, SLP	RD, OT, SLP	
		Managing Individuals at High Risk Webinar (9/1/10)	PT, OT	PT	
		Issues in Evaluation and Treatment of Individuals with Developmental Disabilities (9/20/10 through 9/22/10)	SLP	SLP	
		Food-Medication Interactions (9/23/10)	RD, PT, OT	RD, PT, OT	
		PNMT Core Introduction to PNMT (10/6/10)			
		Competency-Based Training (10/27/10)			
		20th Annual Habilitation Therapies Conference (9/20/10 to 9/21/10)	SLP, PT, OT	PT, OT,	
		Texas Autism Conference (10/6/10 through 10/9/10)			
		Moving Toward Standardizing Dysphagia Practice: Introducing the Modified Barium Swallow Impairment Profile (10/9 to 10/10)	SLP	SLP	
		CMS Never Events and Litigation: A Roadmap to Stopping Never Events (10/14/10)	RD		
		Teaching Children with Developmental Disabilities to Speak (10/21-22/10)		SLP	
		Vitamin D and Chronic Disease Risk (11/5/10)	RD		
		Electronic Aids for Daily Living in the Classroom (12/14/10)	SLP		
		Ethical and Effective Speech Pathology Services (12/20/10)		SLP	
		The Physical Therapist for the PNMT I documented the following continuing educational webinars in 2010 but did not document the month and day: two PNMP and Wheelchair Clinics, and two NMT/PNMP Equipment webinars. The Occupational Therapist for the PNMT II documented the following continuing educational webinars in 2010, but did not document the month and day: two PNMP and wheelchair clinics; Seating and Positioning for Eating/Management of Dysphagia, and			

#	Provision	Assessment of Status	Compliance
		PNMT Training. An additional continuing education webinar in 2011 listed Aspiration Guidelines for upcoming training. No continuing education documentation was submitted for the nurses on PNMT I or PNMT II. Review of the clinical instruction webinars completed by PNMT I and PNMT II members (PT, OT, RD and SLP) revealed the following: ▪ None of five (0%) PNMT I members, and none of five (0%) PNMT II members attended the PNMT Seating/Positioning webinar, on 7/1/10; ▪ One out of five (20%) PNMT I members, and one out of five (20%) PNMT II members attended the Issues in Nutritional Management webinar, on 7/7/10; ▪ None out of five (0%) PNMT members, and none out of five (0%) PNMT II members attended the PNMT Risk/Development of Interventions I session, on 7/9/10; ▪ None out of five (0%) PNMT I members, and none out of five (0%) PNMT II members attended the PNMT Risk/Development of Interventions II session, on 7/16/10; ▪ None out of five (0%) PNMT I members, and one out of five (20%) PNMT II members attended the PNMNP and Wheelchair Clinic webinar, on 7/19/10; ▪ None out of five (0%) PNMT I members, and none out of five (0%) PNMT II members attended the PNMT Risk/Development of Interventions III session, on 7/23/10; ▪ None out of five (0%) PNMT I members and none out of five (0%) PNMT II members attended the PNMT Clinical Assessment Technologies and Wound Investigation Process (7/23/10); ▪ None out of five (0%) PNMT I members, and none out of five (0%) PNMT II members attended the PNMT Identification of Risk and Development of Interventions, and/or PNMT Clinical Assessment Technologies and Wound Investigation Process session, on 7/30/10; ▪ None out of five (0%) PNMT I members, and none out of five (0%) PNMT II members attended Issues in Nutritional Management Part II, and/or PNMT and Wound care Investigation, on 8/13/10; ▪ Two out of five (40%) of PNMT I members, and one out of five (20%) PNMT II members attended NMT/PNMT Equipment Webinar, on 8/13/10; ▪ None out of five (0%) PNMT I members, and none out of five (0%) PNMT II members attended PNMT GI Webinar for OTs, on 8/17/10; ▪ Four out of five (80%) PNMT I members, and three out of five (60%) PNMT II members attended Seating and Positioning for Dysphagia, on 9/1/10; ▪ None out of five (0%) PNMT I members, and none out of five (0%) PNMT II members attended PNMT Core Introduction to PNMT, on 10/6/10;	

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None out of five (0%) PNMT I members, and two out of five (40%) PNMT II members attended Competency-based training, on 10/27/10; and
Three out of five (60%) PNMT I members and two out of five (40%) PNMT II members attended the 20th Annual Habilitation Therapies Conference.

The attendance of PNMT I and PNMT II members for PNMT-related continuing education webinars and outside courses must be non-negotiable. The absence of PNMT I and PNMT II members at multiple PNMT webinar courses was unfortunate. PNMT team members have a responsibility to participate in on-going continuing education opportunities to expand their knowledge and skills and ensure they are knowledgeable about current trends within their respective fields, as well as other team members' fields of expertise. Team members should be held accountable to attend continuing education courses.
<u>PNM team meets regularly to address change in status, assessments, clinical data, and monitoring results.</u>
According to the List of PNM Assessments and Updates completed in the last two quarters, since the last Monitoring Team review, the PNMT did not meet regularly, because evaluations were completed in the months of September, November and December only as documented below:
<table>
<tr><th>Individual</th><th>PNMT Meeting Dates</th><th>PST Addendum Date for PNMT Evaluation</th></tr>
<tr><td>Individual #353</td><td>September 16, 2010 and December 7, 2010 with PNMT I SLP, OT, PT, RD, and RN</td><td>October 20, 2010 PNMT Follow-up; October 27, 2010 PNMT Follow-up; and December 7, 2010</td></tr>
<tr><td>Individual #23</td><td>November 29, 2010 with PNMT II SLP, OT, PT, RD, and PNMT I RN</td><td>December 15, 2010</td></tr>
<tr><td>Individual #433</td><td>January 5, 2011 with PNMT I SLP, OT, PT, RD and RN</td><td>January 5, 2011</td></tr>
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The PNMT I completed a Physical and Nutritional Management Team Evaluation for Individual #353 and Individual #433. The PNMT II completed a PNMT Evaluation for Individual #23. As documented above, no ancillary members attended the PNMT
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#	Provision	Assessment of Status	Compliance
		meetings such as a medical provider, respiratory therapist, and/or pharmacist. Additional information on these individuals is provided below in relation to Section O.2. An individual record sample of 15 individuals was drawn from the Communicable Disease Report for Aspiration Pneumonia with the date range of 1/1/10 to 12/31/10. These included the records for Individual #100, Individual #511, Individual #409, Individual #457, Individual #208, Individual #253, Individual #344, Individual #337, Individual #212, Individual #407, Individual #366, Individual #314, Individual #290, Individual #82, and Individual #435 None of the 15 individual records reviewed (0%), documented the PNMT members had met regularly to address these individual's change in status, completion of a comprehensive evaluation, implementation of recommendations and strategies, and/or review of clinical data. Individual examples of where the PNM Team did not meet regularly to address change in status, review clinical data, develop a comprehensive assessment to identify measurable functional outcomes, provide staff competency-based training and monitor the efficacy of intervention strategy results included: ▪ During the week of the on-site review, PNMT I and PNMT II members were assessing Individual #100. On 7/21/10, Individual #100 had been hospitalized with a discharge diagnosis of acute aspiration pneumonia, and post - hospitalization was admitted to the Infirmary. He was in the Infirmary during the review recovering from a hospitalization to remove his gall bladder, as reported during a Personal Support Team meeting held to complete a Risk Assessment. During both hospitalizations, he had required the use of a respirator. Individual #100 had a feeding tube, due to recurrent silent aspiration. The PNMT did not complete a timely and proactive comprehensive assessment to address his ongoing health risks, as well as identified complex physical and nutritional support needs. As indicated with regard to Section L.1 of the Settlement Agreement, Individual #100 had not been assessed for GERD, which could have been contributing to respiratory issues. When a member of the Monitoring Team saw Individual #100 in the Infirmary, he was lying flat on his back. ▪ On 7/29/10, Individual #511 was admitted to the hospital with a diagnosis of pneumonia. On 9/29/10, he received a "planned PEG [percutaneous endoscopic gastrostomy] placement." The PNMT did not complete a timely and proactive comprehensive assessment to address his ongoing health risks, as well as identified complex physical and nutritional support needs. ▪ On 7/29/10, Individual #409 was diagnosed with aspiration pneumonia per the Communicable Disease Report. The Monitoring Team observed Individual #409	

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		alone in her bedroom receiving enteral nutrition in a poor position in her seating system. The Monitoring Team recommended that staff reposition her in her seating system. After she was repositioned, it was evident that the seating system did not provide her with optimal alignment and support. The PNMT did not complete a timely and proactive comprehensive assessment to address her ongoing health risks, as well as identified complex physical and nutritional support needs. ▪ Individual #457 was hospitalized on 8/17/10 with a discharge diagnosis of aspiration pneumonia. The Communicable Disease Report for aspiration pneumonia did not identify Individual #457. The PNMT did not complete a timely and proactive comprehensive assessment to address his ongoing health risks, as well as identified complex physical and nutritional support needs. ▪ Individual #208 was admitted multiple times to the Infirmary (i.e., 1/5/10, 6/18/10, 7/10/10, 7/12/10, 8/8/10, and 8/17/10. His discharge diagnosis for aspiration pneumonia and/or pneumonia was documented during the following Infirmary stays: 6/18/10, 7/10/10, and 7/12/10. On 8/8/10, he was admitted to the hospital with a discharge diagnosis on 8/12/10 of acute aspiration pneumonia. The PNMT did not complete a timely and proactive comprehensive assessment to address his ongoing health risks, as well as identified complex 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	<u>A process is in place that identifies individuals with PNM concerns.</u> According to one of the documents provided in relation to the POI, dated 1/21/11, " any time a person is being considered for initiation of enteral nutrition (placement of a G-tube or J-tube), the Personal Support Team (PST) should refer the person to the Physical Nutritional Management Team (PNMT) for review prior to proceeding with the procedure. This is a safe guard procedure to ensure that all avenues have been explored and enteral feeding is the least restrictive means for provision of nutrition." The following five individuals had a feeding tube placement: Individual # 92, Individual #511, Individual #373, Individual #457, and Individual #395. None of these individuals had been reviewed by the PNMT prior to tube placement. The following provides an example of an individual for whom the team believed an adequate assessment had been completed, but had not: ▪ Individual #417's PSP Addendum, dated 1/24/11, stated: "The PST met to discuss Individual #417 and PNMT referral due to necessity of her requiring a feeding tube. Per the Plan of Improvement, any time a person is being considered for initiation of enteral nutrition, the PST should refer the person to PNMT for review prior to proceeding with the procedure. PNMT members were present and in agreement in pursuing the feeding tube. Also there is a question from IRT [Incident Review Team] regarding whether [Individual #417's] history of GERD [gastroesophageal reflux disease] was addressed by the PST in regards	Noncompliance

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	management problems to identify the causes of such problems.	to her feeding tube. Team discuss (sic) that [Individual #417] does not have a formal diagnosis of GERD. She does not take medication Prilosec as a precautionary measure. She is not able to orally eat at this time and is still in need of an alternate feeding source. She has not demonstrated other symptoms of reflux." The PST Signature Sheet documented attendance by a PNMT SLP, OT, PT and RD, but a PNMT nurse was not in attendance. The PNMT did not complete a comprehensive evaluation to support the appropriateness of receiving enteral nutrition. The PSP Addendum raised questions that the PNMT should have explored during a comprehensive evaluation. As is discussed with regard to Section I, the Facility was at the beginning stages of implementing the new screening process to identify individuals at risk in various categories. As this process unfolds, it is anticipated that many individuals will be referred to the PNMT for evaluation. <u>The PNM Team provides individuals identified as being at an increased risk level with a comprehensive assessment that focuses on nutritional health status, oral care, medication administration, mealtime strategies, proper alignment, and positioning during the course of the day, and during nutritional intake.</u> Since the last compliance review, the PNMT reviewed the following three individuals: Individual #433, Individual #23 and Individual #353. A review of the PNMT evaluations for these three individuals revealed the following: ▪ In none of the three records reviewed (0%) was there documentation of risk identification levels based upon physical and nutritional history, current status, and specific criteria for guiding placement of individuals in specific risk levels. ▪ In three of the three records reviewed (100%), there was documentation of a comprehensive assessment. ▪ In none of the three records (0%) did the PNMT evaluation include an analysis to consistently provide a rationale for the development of recommendations and measurable, functional outcomes for individuals at highest risk to minimize and/or reduce the identified health risk. ▪ In none of the three records (0%) was a PSP Addendum for the PNMT meeting present that included the integration of the PNMT Action Plan. ▪ In none of the three records (0%) was there documentation of development of implementation strategies. ▪ In none of the three records (0%) was there documentation of competency-based training for individual strategies. ▪ In none of the three records (0%) was there documentation of a monitoring schedule for individuals at highest risk. ▪ In none of the three records (0%) was there documentation of a review process to determine the efficacy of individual strategies resulting in the attainment of	

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		identified outcomes. In the Monitoring Team's review of the three individuals evaluated by the PNMT I and PNMT II, the following issues were identified: ▪ The evaluations the PNMT I and PNMT II completed did not provide specific criteria for guiding the placement of individuals in specific risk levels. A Risk Assessment had not been completed for the three individuals assessed by the PNMTs. ▪ PNMT Evaluations and Action Plans should be signed and dated by PNMT members and ancillary members, but were not. ▪ On 9/16/10, the PNMT evaluated Individual #353, and multiple high-risk health concerns were identified. The following observations were made: o On 12/7/10, the PNMT completed a PNMT evaluation addendum, which did not support an aggressive approach to providing follow-up for Individual #353. o The PNMT Action Plan addressed the PNMT Recommendations, but there was no specific data presented to address the status of measurable outcomes. o A PNMT recommendation was: "to ensure nutritional stability, [Individual #353] will demonstrate stability within RWR [Recommended Weight Range] for 6 months," and the timeline was "3/21/11, changed to 180 days after reaching RWR." The PNMT should re-evaluate assigning such an extended timeline for an individual at high risk for comprised nutrition and weight. o The PNMT Action Plan did not provide a monitoring schedule to ensure recommendations were being implemented. o The PNMT Action Plan was not integrated into the PSP, nor did the PNMT include documentation in the integrated progress notes to support an integrated approach to Individual #353's complex health, physical and nutritional support needs. o The PNMT Action Plan comments sections stated: "positioning instructions revised" (11/30/10) and "PNMP positioning pictures to be placed on wall for quick reference (12/07/10)." Individual #353 was at high risk for skin integrity and had a Stage IV decubitus ulcer on her sacrum. Positioning instructions being revised almost two and a half months after she was evaluated was not an acceptable practice for the PNMT. Furthermore, the Action Plan comments section stated: "PT notified of reopened aprox. 1cm area coccyx, PT will reassess ASAP." There was no documentation of ongoing monitoring to ensure that staff were repositioning Individual #353, nor did the Action Plan state how often she was to be repositioned and monitored. No competency-based	

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		training was completed to ensure staff were competent to position Individual #353. o The PNMT Action Plan comments documented: "OT will arrange for her to be monitored at breakfasts at least 5 times a week to ensure accurate documentation until 2/18/11 in (sic) which the dietician will be contacted with recommendations if needed of increase food items." No documentation of monitoring breakfast was submitted. o There were two PNMT Evaluation Addendums, dated 12/7/10 and 2/9/11. The stated purpose of the 12/7/10 addendum was: "follow-up meeting to assess Infirmary outcomes and review documentation due to continuation of Infirmary stay greater than 60 days." The purpose of the addendum's, dated 2/9/11, was: "should [Individual #353's] stay in the Infirmary continue, follow-up meeting to assess Infirmary outcomes and review documentation will occur in 4-6 weeks." It was unclear why the PNMT was not meeting on a more frequent basis to address the status of PNMT recommendations and measurable outcomes. For example, the PNMT addendum, dated 10/27/10, listed an issue as "resume Nutritional Supplements of multivitamin with minerals and Prostat AWC [advanced wound care] in order to promote healing." The discussion and recommendation was documented as: "unknown at this time if Nutritional Supplements have been resumes (sic). Occupational Therapist and Dietician to research chart of dates nutritional supplements, resumes (sic) as well as notifying primary care provider if order needed." The same issue was raised in the 12/7/10 addendum with the same recommendation. Again, this not an acceptable practice for the PNMT. According to the PNM evaluation, Individual #353 had been identified at high risk for compromised nutrition, weight, and skin integrity, but the PNMT had not completed a screening using the Risk Guidelines. ▪ Individual #23 was evaluated by the PNMT on 11/29/10, and the PNMT "determined the following areas to be at risk: constipation, gastrointestinal, polypharmacy, urinary tract infection, aspiration and skin integrity." The following concerns were noted: o Multiple medical recommendations were made such as: "GI consultation for consideration of repeat CT Scan of abdomen/pelvis due to findings of last CT scan and UGI and gastric emptying series; urologist follow-up consultation; consideration of discontinuation of Carafate due to side effects of the medication (constipation, cramps, delayed gastric emptying, decreased renal functioning, dysphagia)," which could have been addressed if a PCP attended the PNMT evaluation. Consideration should be given to assigning a PCP to the PNM Team.	

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		o The PNMT Evaluation Addendum, dated 1/5/11, documented the following issue: "allow time out of wheelchair for at least one hour in the morning and in the afternoon." The discussion and recommendation entries were: "increase fluid per RN Case Manager; 600cc total with med pass; recommend 2500cc/day dated 12/23/10," and "8oz juice at snack with 8ox H2O; recommend increase 250ml/day; diet plan preference to dilute juice with H2O, dated 1/5/10." The recommendation was not congruent with the stated issue. o The PNMT Evaluation Addendum, dated 1/5/11, stated the issue was: "home staff and nursing to record fluid intake during all meals, snacks and medication administration times." The discussion/ recommendation was listed as: "unknown status at this time; OT/PT will consult with PNMP Coordinator." This response showed that the PNMT was not providing oversight and monitoring to ensure PNMT recommendations were being implemented to minimize Individual #23's identified risk indicators. o No additional addendums were submitted to document the status of Individual #23's recommendations and measurable outcomes. o No competency-based training was submitted to address the recommendation that stated: "home staff and nursing will be in-serviced for positioning during vomiting episodes." o No PT consultations were submitted to address recommendations to increase physical activity, consider use of ARJO walker at the residence, and re-evaluate wheelchair. It also was unclear why the PNMT members would not have evaluated Individual #23 during the assessment process to address his level of activity, use of ARJO walker, and status of his wheelchair. The PNMT has responsibility for completing a comprehensive assessment. A recommendation for a PT consultation should not be needed, but the PT on the PNMT should complete such an assessment in collaboration with Individual #23's primary PT. o The PSP Addendum, dated 12/15/10, did not incorporate the PNMT Action Plan. o Individual #23's PNMP was revised 12/15/10, and did not document his areas of high risk, including constipation, gastrointestinal, polypharmacy, urinary tract infections, aspiration, and skin integrity. His PNMP did not address positioning for bathing/showering and personal care to address his risk of aspiration. o According to the PNMT Action Plan, dated 11/29/10, on 1/10/11, the PT implemented a residential exercise program, but his PNMP and PSPA did not address this program.	

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		o His PSPA, dated 1/5/11, stated: "the time he is up after meals will be reduced to 45 minutes." This change was not reflected in his PNMP. ▪ On 1/5/11, the PNMT evaluated Individual #433. The NMT referred him to the PNMT due to recent aspiration pneumonia. A review of his records revealed the following concerns: o The PNMT Evaluation did not document aspiration pneumonia under medical problems. o The PNMT did not complete a comprehensive assessment of Individual #433. The evaluation listed medical problems, global medication side effects, physical clinical indicators, diagnostic tests, treatments since Infirmary admission on 11/30/10, routine medications held since Infirmary admission, medication history while in the Infirmary, and supportive care. The PNMT Analysis provided significant information, but the body of the assessment did not provide clinical assessment results to support information that was presented in the analysis section. PNMT recommendations stated: "remain upright for 1 hour after medication administration and elevate head of bed at all times to 15-20 degrees (although he had current orders for HOB elevation for 30 degrees, this places him at risk of skin breakdown and poor positioning due to sliding down)." These recommendations were not integrated into his PNMP, revised 12/28/10. o The PNMT Action Plan was not integrated into his PSP. o PNMT Action Plan, revised 1/17/11, stated: "OT provided competency-based training by demonstrating proper techniques and feeding strategies then PNMP Coordinators and HPT [Home Program Technician] demonstrating proper techniques and strategies back to the therapist with [Individual #433]. Then 5 of them began assisting OT feeding him 5 times daily." There were no staff competency-based training documentation records submitted. o The PNMT Action Plan, revised 1/17/11, stated: "When he returns home, residential staff and nursing will be inserviced that 3 consecutive meal refusals typically indicated that [Individual #433] is ill and should be reported immediately to nursing." Furthermore, "this process should help ensure effective communication between nursing and home staff, and will help to alleviate Urinary Tract infections that typically lead to vomiting and/or aspiration." This recommendation was not integrated into his PNMP and or health care plans. As discussed with regard to Section I, the database for the Infirmary/emergency room and hospital did not provide accurate information. The PNMT should be provided accurate and timely information related to admissions to the Infirmary, emergency room	

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		and hospital. For example, the database for Infirmary, emergency room and hospital admissions documented Individual #353 was admitted to the hospital on 10/27/10, but there were no other entries. During the week of the on-site visit, Individual #353 was in the Infirmary. To support successful implementation of the PNM process for those individuals at highest risk with complex health, physical and nutritional support needs, PNMT members should consider the following recommendations. The PNMT should: ▪ Complete a risk screening using the Risk Guidelines for individuals referred to the PNMT, if the PST has not already competed them; ▪ If the PST has completed a risk screening, review the results in comparison with the Risk Guidelines to determine if appropriate risk levels have been assigned; ▪ Complete an assessment to determine the status of safe positioning for an individual within natural environments (nighttime positioning, seating system, bathing, tooth brushing, classroom, work, leisure, medication administration, etc.) to determine the efficacy of current PNMP strategies, including staff instructions, prior to the PNMT and subsequent PST meeting; ▪ Identify individual triggers for identified risk indicators, such as aspiration pneumonia, and integrate these triggers into relevant working plans, such as the PNMP, Dining Plan, BSP, Nursing Care Plan, etc.; ▪ Ensure the assessment provides clinically justified techniques for mealtime (including individuals who were enterally nourished), oral care, bathing, dental appointments, bedtime positioning, medication administration, etc.; ▪ Provide support to individuals at highest risk on a much more frequent basis. Timeframes for review should not be extended across months, but rather days for individuals at highest risk. The PNMT, in collaboration with Facility Administration, should analyze current caseloads to determine how additional time will be made available to the PNMT to develop procedures for timely and proactive assessment, intervention, review, documentation, monitoring, and analysis to determine efficacy of supports provided at both individual-specific and systemic levels; ▪ Incorporate the Action Plan into the individual's PSP through the addendum process; ▪ Include in the analysis section of the PNM Evaluation assessment data, which provides justification and rationale for the recommendations. The analysis should provide a correlation between the identified high-risk indicators that resulted in referral to the PNMT and should summarize the assessment data, which provides justification for the recommendations and measurable outcomes; ▪ Include criteria in the recommendations and measurable outcomes to measure the efficacy of the interventions;	

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		▪ Develop implementation strategies to ensure recommendations and measureable outcomes are implemented; ▪ Ensure staff complete performance check-offs to document competency for identified skills for those individuals at highest risk; ▪ Develop a simple method to document, monitor, and track clinical objective data to support the effective implementation of recommendations; ▪ Implement a mechanism to report a change in an individual's status to the PNMT to enable the PNMT to evaluate the plan, and/or make modifications to the plan; and ▪ Develop an individual-specific monitoring plan for the PNMT to complete that is correlated to PNM recommendations and measurable outcomes enabling the Team to quickly determine the efficacy of identified implementation strategies. A review of the records of an additional 15 individuals who had been diagnosed with aspiration pneumonia (Individual #100, Individual #511, Individual #409, Individual #457, Individual #208, Individual #253, Individual #344, Individual #337, Individual #212, Individual #407, Individual #366, Individual #314, Individual #290, Individual #82, and Individual #435) revealed the following: ▪ In none of the 15 records (0%) was documentation found of PNMT review/analysis of the findings of relevant discipline-specific assessment(s), including but not limited to PNMP Clinic results, PNMP, and relevant consultation(s) leading to the development of a comprehensive summary. Such a summary should have addressed: o Physical health status; o Nutritional health status; o Oral care; o Medication administration; o Mealtime strategies; o Proper alignment; and o Positioning during the course of the day and during nutritional intake. • In none of the 15 records (0%), measurable, functional outcomes were identified. • In none of the 15 records (0%) was documentation found of PNMPs developed with input from the PNMT (NMT) for those individuals at highest risk. • In none of the 15 records (0%) was congruency found between Strategies/Interventions/Recommendations contained in the PNMP and the concerns identified in the comprehensive assessment. • In none of the 15 records (0%) were comprehensive summary results	

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		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 none of the 15 records (0%) were PNMT updates provided as needed until the individual was discharged from the PNMT. Additional individual examples are provided in the section that addresses Section O.1 of the Settlement Agreement.	
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> A review was conducted of 18 individuals identified at high risk, including: Individual #100, Individual #511, Individual #409, Individual #457, Individual #208, Individual #253, Individual #344, Individual #337, Individual #212, Individual #407, Individual #366, Individual #314, Individual #290, Individual #82, Individual #435, Individual #353, Individual #23, and Individual #433). The record review included review of the individuals' PNMPs. Although many of the components of an adequate PNMP were present for these individuals, there were a number of components missing. More specifically: ▪ In 18 of 18 records (100%), positioning instructions for wheelchair and alternate positions instructions were included. ▪ In 18 of 18 records (100%), transfer instructions were included. ▪ In 18 of 18 records (100%), the mealtime/dining plan included oral intake strategies for mealtime and snacks and/or addressed receiving nutrition through a feeding tube. ▪ In 18 of 18 records (100%) the mealtime/dining plan included food/fluid textures and/or addressed receiving nutrition through a feeding tube. ▪ In five of 18 records (27%), the time was identified that an individual needed to remain upright after eating and/or receiving enteral nutrition. ▪ In 18 of 18 records (100%), the mealtime/dining plan included behavioral concerns related to intake and/or addressed receiving nutrition through a feeding tube. ▪ In 15 of 18 records (83%), strategies for medication administration were included. ▪ In 18 of 18 records (100%), strategies for oral hygiene were included. ▪ In 18 of 18 records (100%), individual adaptive equipment was included. ▪ In none of 18 records (0%), bathing/showering positioning and related instructions were included. ▪ In none of 18 records (0%), personal care instructions were included. ▪ In 18 of 18 records (100%), communication strategies were included. Examples of where individuals were not provided with a comprehensive PNMP included:	Noncompliance

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		▪ According to the Settlement Agreement, PNMPs must incorporate strategies for medication administration, bathing/showering, and personal care for those individuals identified at risk. All of the individuals within this record sample had been diagnosed with aspiration pneumonia and were at risk. The Monitoring Team observed changing tables that were not elevated, and based on staff report, beds that were to be elevated were lowered when individuals were checked and changed. The PNMPs of individuals who received enteral nutrition, had been diagnosed with aspiration pneumonia, or were at risk of aspiration pneumonia needed to include staff instructions for checking and changing to ensure individuals were not laid flat during personal care. ▪ PNMP strategies need to be integrated within an individual's nursing care/healthcare plan to support nurses during medication administration, as well as other procedures requiring attention to positioning and presentation techniques. ▪ The PNMP should identify the amount of time that an individual should sit upright after eating and/or receiving enteral nutrition. As noted above, such strategies were not consistently included in the PNMPs reviewed. Based on interviews, Concerto bathing/showering trolleys were ordered without Habilitation Therapies being consulted. The new trolleys could not be elevated to the degree prescribed to support individuals who must be elevated at all times per physician's orders and as reflected in PNMPs. As a result, the Orthotics department had constructed wedges, which were delivered to residences during the week of the on-site review. The Monitoring Team observed multiple bathrooms on campus (i.e., Infirmary, 6480, 6450, 6460, 6480, 5961, and 5962). Some of the residences did not have a wedge for each trolley. For example, Residence 5961 had two bathing trolleys but only one wedge was available. The Infirmary had a flat stationary slab, and there was no wedge in the bathroom. PNMPs should be revised to reflect the use of wedges on bathing trolleys for those individuals who must remain elevated at all times. Furthermore, PNMPs should reflect that individuals who must remain upright at all times must be elevated when receiving personal care, such as checking and changing adult briefs. Staff in Residence 6480 reported that individuals' elevated beds were lowered, when they were checked and changed. Changing tables in bathrooms were flat and no wedges were observed on changing tables. PNMPs must reflect elevation strategies in every environment for those individuals who are at risk of aspiration pneumonia, and other related health risk indicators. <u>PNM plans were incorporated into individual's Personal Support Plans.</u> In 18 records reviewed (Individual #100, Individual #511, Individual #409, Individual #457, Individual #208, Individual #253, Individual #344, Individual #337, Individual	

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		#212, Individual #407, Individual #366, Individual #314, Individual #290, Individual #82, Individual #435, Individual #353, Individual #23, and Individual #433), none of the PNMPs (0%) were incorporated into individuals' Personal Support Plans. Information from the PNMP should be integrated within the PSP, not simply referenced and/or listed. Examples of where individual PNMPs were not incorporated in PSPs included: ▪ Individual #511's PSP Addendum, undated, stated: "Individual #511 received a PEG placement on 9/29/10. The team discussed his health risk needs related to PEG placement and gastrostomy tube feedings." There was no discussion of his PNMP to address his change in status. His PNMP, revised 12/15/10, stated "Physical Focus: To provide appropriate head/trunk support through custom seating," and the "Nutritional Focus: Ensure appropriate nutrition/hydration by monitoring G-tube tolerance." However, the physical and nutritional focuses did not address his high risk for aspiration pneumonia due to the placement of a gastrostomy tube. The PNMP did not identify individualized triggers for aspiration pneumonia, provide staff strategies for bathing/showering, personal care, and/or indicate the time to remain upright after receiving enteral nutrition. ▪ Individual #457 received a gastrostomy tube on 8/26/10. His PSP Addendum, dated 9/2/10, identified the purpose as: "The PST is meeting today to discuss level of supervision (LOS) for [Individual #457] since returning from the hospital." There was no discussion of his PNMP to address his high risk of aspiration pneumonia. His PNMP revision date was 12/10/10, approximately four months post placement of his gastrostomy tube. His PNMP did not address his individualized triggers for his high risk for aspiration pneumonia. The PNMP did not provide staff strategies for bathing/showering or personal care, and identify the amount of time to remain upright after receiving enteral nutrition. <u>PNMPs are developed with input from the PST, home staff, medical and nursing staff.</u> In 18 records reviewed (Individual #100, Individual #511, Individual #409, Individual #457, Individual #208, Individual #253, Individual #344, Individual #337, Individual #212, Individual #407, Individual #366, Individual #314, Individual #290, Individual #82, Individual #435, Individual #353, Individual #23, and Individual #433), none (0%) of the PNMPs were developed with input from the PST with an emphasis on direct support professionals, medical/nursing staff, and behavioral staff (if appropriate). Moreover, therapists needed to be, but were not available during the Personal Support Plan annual meetings to present the rationale for PNMP strategies. This is discussed in further detail with regard to Section F.1.b. Examples of where individual PNMPs were not developed with input from the IDT included: ▪ Individual #344 was diagnosed with aspiration pneumonia, according to information related to an Infirmary admission on 11/4/10. There were no PSA	

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		Addendums to address revisions to his PNMP during and/or post Infirmary admission. His PNMP, dated 7/29/10, had not been revised with input from the PST, residential staff, medical and nursing staff, or therapists to address his risk for aspiration pneumonia after his discharge diagnosis of aspiration pneumonia. ▪ The Communicable Disease Report indicated that Individual #337 was diagnosed with aspiration pneumonia on 10/4/10. There was no PSP Addendum showing that Individual #337's PST members addressed changes to his PNMP to related to his diagnosed episode of aspiration pneumonia, and ongoing high risk for aspiration pneumonia. ▪ Individual #212 was diagnosed with aspiration pneumonia on 10/14/10, per the Communicable Disease Report. There was no PSP Addendum meeting held at which Individual #337's PST members addressed changes to her PNMP related to her diagnosed episode of aspiration pneumonia and ongoing high risk for aspiration pneumonia. <u>PNMPs are reviewed annually at the PSP meetings, and updated as needed.</u> In none of 18 records reviewed (0%) were PNMPs reviewed annually at the PSP meeting, updated as needed, and integrated within the PSP. As discussed above, there was no evidence that the PNMPs were actually reviewed at the PSP meetings, particularly for those individuals for whom habilitation therapies staff were not present to meaningfully review the PNMPs. Without such review, they were not adequately integrated across disciplines, and recommendations from other assessments and/or team members were not incorporated into the plans. <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 none of 15 records reviewed (Individual #100, Individual #511, Individual #409, Individual #457, Individual #208, Individual #253, Individual #344, Individual #337, Individual #212, Individual #407, Individual #366, Individual #314, Individual #290, Individual #82, and Individual #435) (0%) were PNMPs reviewed and updated as indicated by a change in the individual's status, transition (change in setting), or as dictated by monitoring results. For example: ▪ Individual #407 was hospitalized on 11/6/10 with a discharge diagnosis of aspiration pneumonia and hypokalemia. There was no PSP Addendum to address her diagnosis of aspiration pneumonia, including the development of staff strategies to minimize her risk of aspiration pneumonia. Her PNMP, dated 9/27/10, did not address strategies for bathing/showering, personal care, and did not identify the time she should remain upright after meals. The PNMP, dated 8/4/10, was not revised to address her recent hospitalization for pneumonia. ▪ Individual #366 was diagnosed with aspiration pneumonia on 8/18/10,	

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		according to the Communicable Disease Report. Her PSP Addendum, dated 12/15/10, stated the purpose as: "to address recommended Long-Term Care Plan for Risk for Aspiration due to vomiting." The PSP Addendum did not assign a level of high risk for aspiration pneumonia. The PNMP, dated 6/1/10, was not revised to incorporate the following PSPA "parameters/Physician's orders": keep upright 30 minutes after feeding before lying down (per Physician's Order). The PNMP did not contain staff strategies for bathing/showering or personal care, nor did it prescribe a time to remain upright after meals. ▪ None of Individual #314's PSPAs addressed her diagnosis of aspiration pneumonia. Her PNMP, dated 12/10/10, did not address her high risk for aspiration pneumonia, nor were staff strategies available for bathing/showering or personal care, or a time prescribed to remain upright after meals.	
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> PNMP Coordinators played a role in ensuring that PNMP interventions were carried out. The primary duties for PNMP Coordinators were as follows: ▪ Educating new employees on the PNMPs of people in the residence assigned; ▪ Monitoring mealtime two times daily; ▪ Assisting with any needed in-services from OT/PT/SLP for the 2 p.m. to 10 p.m. shift; ▪ Being "On the floor" of the residences assigned to provide daily reminders to carefully monitor positioning (in wheelchairs and in beds), equipment, and transfers/lifts; ▪ Conducting PNMP Reviews, including as many as possible with new staff members to give them opportunities to practice; ▪ Steridient Monitoring-at least one time per month on 2 p.m. to 10 shift; ▪ Training staff on PNMP changes as they come out; ▪ Reading the communication log daily; and ▪ Monitoring all "informal" programs (walking to the dining room, transferring to a regular chair in the dining room, staff walking person one time per shift, etc.). There was no Facility policy for PNMP Coordinators, but the Habilitation Therapies Department had developed a PNMP Coordinator Training Instructor's Manual, undated, which provided comprehensive training for the PNMP Coordinators and Home Program Technicians. The PNMP Coordinator's Required Training, included the following modules with supporting training handouts documentation: ▪ PNMP-What, Where, Why, How; ▪ PNMP Monitoring; ▪ Parts and Functions for Wheelchairs; ▪ Proper Cleaning of Wheelchairs;	Noncompliance

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		▪ Steridient Protocol [for tooth brushing]; ▪ Steridient Monitoring; ▪ Adaptive Eating Equipment Identification/Function; ▪ Proper Thickening of Liquids; ▪ Food Consistencies; ▪ Mealtime Guidelines; ▪ Mealtime Monitoring; ▪ Lifting/Transferring/Repositioning; ▪ Proper In-service Technique; ▪ Communication Techniques; ▪ Proper Escort with Gait Belt; ▪ Proper Cleaning of Tightly Closed Hands; ▪ GERD-What is it-What are the precautions? ▪ Hierarchy of interventions; ▪ Promoting Independence; ▪ Safety with Walkers; and ▪ People First Language. Based on staff interview, the PNMP Coordinators were provided two full days of skills testing and re-training. In addition, for one week, each PNMP Coordinator was monitored while working with individuals on their personal caseloads. The skills testing and re-training was completed by OTs, PTs, SLPs and Dieticians as documented below: ▪ A PT trained the PNMP Coordinators on lifts (manual), lifts (procedures for use of ARJO), sling placement/removal, positioning (alternate and rationale-wheelchair), positioning (alternate and rationale-bed), and range of motion; ▪ An OT trained the PNMP Coordinators on positioning (before during, after meals) - Why and what's the difference, mealtime monitoring (compare observations and rationale for techniques), agreement regarding high risk people, hand care items (application and rationale), transfers in dining rooms, and sensory; ▪ A SLP trained the PNMP Coordinators on instructions for augmentative communication, demonstration of communication devices, how to access batteries, simple repairs of books/equipment, and who has which device and why; and ▪ The Dieticians provided training on why fluid limitations are in place and how to convert ounces to cc, rationale for diets such as 1200 kcal, low cholesterol, limited salt, limiting simple sugars, supplements, and discussion/rationale of special diets (Ketogenic, etc.). Therapists conducted the following performance check-offs to test the competency of the PNMP Coordinators. The check-offs supported achievement of staff competency within	

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		the following areas: ▪ Stand pivot/escort; ▪ Manual head/side lift; ▪ Manual side-by-side lift; ▪ Mechanical lifts/bathing equipment; ▪ Lift from floor; ▪ The Coordinators teaching each other the above steps; ▪ Expressed rationale for manual lift in lieu of ARJO for any of the above/emergency lift; ▪ Expressed rationale for three-person manual lift; ▪ Range of motion by "drawing" three movements each (assess to independent and partner communication, body mechanics, techniques); and ▪ Adaptive equipment identification, including wheelchair, eating and communication equipment and the purpose of each. The next phase of the process was for: ▪ Coordinators to train the therapist on any PNMP on their caseload; and ▪ Coordinators to train: the PT on lifts, wheelchairs, the OT on adaptive equipment, hand care, thickening liquids; the SLP on use, placement and purpose of communication equipment; the dieticians on rationale for various diets, explanations of "modified" diets on dining plans, and explanations of purpose of eating techniques, relaxation techniques, etc. The final phase of the process was for therapists to review with PNMP Coordinators the documentation expectations, including written documentation of their daily, weekly and occasional duties. Monitoring staff's implementation is another important activity to ensure that PNMPs are implemented consistently and with integrity. ABSSLC Meal/Snack/Medication/ADL [Activities of Daily Living] Observation form, undated, identified a number of important indicators, as did the ABSSLC Mealtime Observation form, undated. Based on interview, these monitoring forms had not been implemented. Training for the use of person-specific dining monitoring tool had been developed which provided instructions to the auditor on staff responsibilities in hand washing, positioning, implementation of the dining plan, texture, liquid consistency/temperature before, during and after the meal. The PNMP Training Form, dated 12/13/09, documented the following areas of competency to be reviewed with staff: ▪ Location of the PNMP; ▪ Adaptive equipment and usage of equipment (show wheelchair, walker, helmet, hand care, etc.);	

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		▪ Bed positioning instructions; ▪ Wheelchair positioning instructions/alternate positioning; ▪ Transfer status/special handling instructions; ▪ Movement section (level of assistance person needs/programming person has); ▪ Relaxation techniques; ▪ Eating equipment (show equipment, where stored in kitchen); ▪ Feeding positioning eating/feeding status; ▪ Food texture/liquid consistency; ▪ Feeding techniques; ▪ Communication equipment (where stored or kept); ▪ Location of communication dictionary; ▪ Communication instructions; and ▪ PNMP check sheet reviewed and how to document on it. There were no formal policies/procedures developed for the implementation of this training form. The PNMP Checksheet was initiated 6/2010. This form was designed to allow PNMP Coordinators to conduct monitoring of adaptive, eating, and communication equipment, and positioning. However, procedures had not been developed to support consistent implementation by PNMP Coordinators. The Monitoring Team commends the Lead Occupational Therapist and Lead Physical Therapist for their commitment to the development and implementation of training for PNMP Coordinators and Residential Program Technicians. This process should be ongoing to ensure PNMP and Residential Program Technicians demonstrate adequate competencies to perform their duties. The following policies, which were positive additions to support individual's safety, had been developed and/or updated to support staff engaging in safe practices: ▪ ABSSLC had developed a Policy for Safe Positioning During Vomiting, undated. The purpose of the policy was "to reduce the risk and/or prevent aspiration when a person is or has been vomiting." The policy identified procedures for staff to follow for an individual when in bed; in their wheelchair; and for individuals who walk about the residence. The policy further stated: "staff should remember the following during [and] immediately after vomiting episodes: o Immediately notify nurse; o Provide frequent checks on the person if they are not in the same room; and o Document the vomiting episode in the Observation Notes of the	

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		person's chart, home communication log and on the PNMP check sheet." ▪ ABSSLC Food/Drink Policy, adopted 8/2004, and revised 7/2010, stated "All Home Support Staff are directly responsible for following and providing: o Correct food and drink texture; o Dietary restrictions (ex. Food allergies, sugar restrictions, fluid restrictions, etc.); and o Prescribed food/drink adaptive equipment (ex. spout cups, youth forks, etc.) for each resident at ABSSLC. This includes mealtimes, snacks, and both on-campus and off-campus special events. If an inappropriate item is offered, it is the direct responsibility of ABSSLC staff to ensure the item (food/drink) is not served or that is it properly modified for safe intake. If a family member brings or sends food/drink items or will be taking a family member off campus, staff MUST inform the family of the prescribed texture, dietary restrictions, and adaptive equipment and encourage them to follow these guidelines. The family may choose not to do so if they are serving the item(s) themselves. However, if staff are serving the time(s), prescribed texture, dietary restrictions and adaptive equipment must be followed." ▪ The Coughing/Choking Incident Follow-Up Policy Procedure, revised 6/10, documented the following changes: o "After each episode is resolved, but before documenting, notify Coughing/Choking Hotline; o For non-serious/routine coughing/choking episodes, nursing (residential nurse or treatment room nurse) will assess person and determine need for further treatment; o For serious choking episodes where the Heimlich was used, call 4444 and the arriving RN will completed a follow-up evaluation and determine the need for further treatment; o NMT (Nutritional Management Team) will initiate follow-up of any person having a serious choking incident at the next scheduled meeting; o The policy will be presented in the Eating portion of NEPT which is conducted by a campus OT; o PNMP Coordinators will in-service Residential Support Staff twice a year on the above policy; and o PNMP Coordinators will conduct random drills at each residence regarding follow-up to a serious choking incident twice a year." Consideration should be given to revising this policy to reflect which discipline and/or the PNMT would complete an assessment for individuals experiencing a	

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		serious choking incident. Thirty-eight individual observations were completed of staff's implementation of dining plans and/or PNMPs in residences on campus. Overall, staff did not consistently implement interventions and recommendations outlined in the PNMPs and/or dining plans. This had the potential to provoke swallowing difficulties and/or increased risk of aspiration, or other risks, such as skin breakdown, etc. The following provides additional details regarding the observations: ▪ In one of 11 observations (10%), staff were following dining plans. ▪ In zero of four observations (0%), staff were following positioning instructions while individuals were receiving enteral nutrition. ▪ In zero of 14 observations (0%), staff were following wheelchair positioning instructions. ▪ In one of six observations (17%), staff were following alternate positioning instructions. ▪ In zero of one observation (0%), staff were following transfer instructions. ▪ In zero of two observations (0%), nursing staff were following the PNMP to include diet texture/fluid consistency, positioning instructions, and use of appropriate adaptive equipment for medication administration. Examples of where staff did not implement interventions and recommendations outlined in the PNMP and/or mealtime plan were as follows: ▪ Individual #103 was not in proper alignment and support in his seating system. Staff were attempting to awaken him prior to his meal, but did not reposition him prior to the meal. ▪ Individual #405's Dining Plan meal presentation instructions stated: "prompt him to take small bites and to eat SLOWLY." Individual #405 was eating a whole piece of bread rapidly without staff prompting him to slow down. ▪ Individual #129 was receiving enteral nutrition, but was not in optimal alignment and support in her seating system. The Monitoring Team requested her dining plan, but it was not submitted. ▪ Individual #206 was being transferred from a bed in his living area to his wheelchair with a mechanical lift. The staff transferring him did not set up the area prior to the transfer, which was extremely crowded with multiple wheelchairs. The transfer did not support safety for Individual #206. ▪ Individual #285 was lying in a fetal position in a recliner. He was enterally nourished, and this position placed him at risk for aspiration. ▪ The following individuals were observed during medication administration and the following issues were noted: o Individual 265's PNMP was not available in the Infirmary. His	

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		Medication Administration Record (MAR) did not incorporate information from his PNMP to support his safety during the administration of medication. o Individual #498's PNMP instructions were not integrated in his MAR to support safety during the administration of medication. Nursing staff, in collaboration with Habilitation Therapies staff, should establish a system to ensure PNMPs are integrated in medication administration records, as well as nursing care/healthcare plans to minimize identified risk factors for individuals. The Monitoring Team's observation of two PNMP Coordinators in dining rooms did not indicate that the PNMP Coordinators were competent to provide coaching, mentoring, and monitoring of the staff during mealtimes as documented in mealtime examples above. Specifically, during observations, the PNMP Coordinators did not intervene to correct position and alignment and/or model for staff the correct techniques when dining plan instructions were not being followed.	
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> Multiple staff training sheets were submitted for individual PNMPs, which documented "Staff must be able to demonstrate competency before 'passing' the in-service." The legend was T = test, V = verbalized back, and D = demonstrated. The title of the training would be identified as a person's PNMP, for example Individual #199 PNMP. However, there were no specific PNMP staff competencies identified on the training sheet to identify the content of the in-service training. A review of multiple training sheets documented staff "verbalized back," but there were multiple individual staff signatures on forms without the training level identified, according to the training legend (T, V and/or D). There appeared to be a misunderstanding of the concept of competency-based training for foundational physical and nutritional support (PNS) training, as well as the provision of person-specific PNMP training. The Facility had defined competency-based training as "passing," when staff verbalized back to the trainer what was required. Staff verbalization of a learned skill does not meet the standard of competency-based training for physical and nutritional supports. For example, the Monitoring Team observed multiple individuals who were not in optimal alignment and support in their seating systems. This led the Monitoring Team to the conclusion that staff were not competent in positioning individuals, or that they did not understand the importance of it, which should be a component of the training. To ensure staff competency in positioning and alignment, staff must demonstrate this skill. The primary characteristic of competency-based training in the area of PNS is staff should be able to demonstrate a learned skill.	Noncompliance

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		Checking off that they have received training, were able to verbalize the concept, and/or complete a written test was not adequate to ensure competency. Competency-based training should identify learning objectives/outcomes that define what a staff person must do, and provide the opportunity for staff to demonstrate the mastery of the learned skill. Review of the Facility's training curricula revealed that it did not include adequate PNM training in the following areas: ▪ Generic and individual-specific mealtime risk triggers that alert staff to problems, and what staff were to do if these triggers were observed; ▪ Techniques to promote independence and skill acquisition during mealtimes; ▪ Ensuring optimal alignment and support in seating systems and/or alternate positions for individuals receiving enteral nutrition; ▪ Presentation and position/alignment strategies to support safety during oral hygiene, bathing, personal care and medication administration; ▪ Competency-based performance check-off(s) for optimal alignment and support for individuals receiving enteral nutrition; and ▪ Competency-based performance check-off for correct food texture and consistency, oral stimulation, and safe mealtime presentation techniques for food and fluid and thickened liquids. The PNS competency-based training curriculum should identify the following: ▪ Required learner objectives and competencies for foundational skills in PNM; ▪ For each competency, there should be a list of tasks and/or activities that must be demonstrated; ▪ A description of how staff will demonstrate mastery of the skill; ▪ The best materials, and methods for training; ▪ A description of how the training will reinforce "why it is important in my job to know this information;" ▪ A training schedule that is spaced out to allow participants the opportunity to practice new skills, ask questions, and obtain a lot of feedback; and ▪ Observations of staff and/or performance check-offs in work settings with outcomes documented. The Facility training curricula did not provide foundational training in the following areas: ▪ New Employee Pre-Service Training (NEPT) Schedule, dated 11/10, for the provision of foundational skills in physical and nutritional supports identified the following topics with allotted instructional time: Physical Management (45 minutes), Nutrition/Food Textures (one hour), Physical Management (three hours). The total time to receive foundational training in physical and	

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		nutritional supports was three hours and 45 minutes. Instructional time for mealtimes was not sufficient to provide staff with foundational knowledge and to allow them to practice skills in the areas of mealtime risk indicators/triggers and problem-solving, mealtime position and alignment, presentation techniques to enhance nutritional intake and hydration, care and use of mealtime adaptive equipment, aspiration and choking precautions, understanding a swallow study, presentation and alignment strategies to support safe swallowing during oral hygiene, bathing and medication administration, and techniques to promote optimal levels of independence and skill acquisition during mealtime. ▪ There were no specific learning objectives and competencies provided within the presented training curriculum for physical and nutritional supports to support the acquisition of PNM foundational knowledge and skills. ▪ Lifting Class Procedure, undated, contained in the Presentation Book for Section O, documented physical management class would be divided into groups for individual competency-based demonstration and check-off of "3-person side by side lift; 2-person head and side lift and 2-person head and straight leg lift; stand/pivot transfers with 1- staff and 2-staff assistance; escorting with gait belt with 1-staff and 2-staff assistance; Arjo mechanical lift; Arjo bath trolley; repositioning person in wheelchair with 4 methods; discussion of the importance of repositioning and draw sheet uses for repositioning in bed and rolling side to side in bed to assist with garment changing and hygiene; 2-person assist from floor with gait belt." These procedures provided adequate performance check-offs to test staff competency. ▪ There was a NEPT lifting/transferring written assessment and Nutritional Management and Low Vision/Blindness Test submitted. <u>Competency-based training focuses on the acquisition of skills or knowledge and is represented by return demonstration of skills or by pre/post test, which may also include return demonstration as applicable.</u> As stated above, the training curriculum submitted did not include specific learning objectives and competencies to provide foundational knowledge and skills related to the appropriate implementation of physical and nutritional supports. There was a skills-based performance check-off for physical management, but there were no skills-based performance check-offs for mealtimes. <u>All foundational trainings are updated annually</u>. DADTX ABSSLC Course Participation Report, from 6/1/10 to 1/9/11, documented 366 staff had attended the physical management course, which was significantly below the identified number of current ABSSLC staff reported to be 1541. There was no documentation submitted for annual foundational PNM training.	

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		<u>Staff are provided individual-specific training on the PNMP by the appropriately trained personnel.</u> Based on a review of staff PNMP training records, competency-based individual-specific training was not documented as being provided by appropriately trained personnel. This was illustrated as follows: ▪ In zero of 15 records reviewed (0%), licensed therapists, assistants, and/or PNMP Coordinators had completed competency-based training for supervisors and/or other designated staff who would be responsible for implementation of PNMPs. ▪ In zero of 15 records reviewed (0%), licensed therapists, assistants, PNMP coordinators and/or competently trained designated supervisors/residential managers, etc. had provided instruction to direct support professionals. <u>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.</u> In zero of 15 staff training records reviewed (0%), (Individual #100, Individual #511, Individual #409, Individual #457, Individual #208, Individual #253, Individual #344, Individual #337, Individual #212, Individual #407, Individual #366, Individual #314, Individual #290, Individual #82, and Individual #435) staff who had successfully completed competency-based training provided assistance to individuals determined to be at an increased level of risk. <u>Staff are trained prior to working with individuals and retrained as changes occur with the PNMP.</u> Based on a review of staff training in 15 individual records, zero out of 15 (0%) showed that staff were re-trained using competency-based methods, when changes occurred to the PNMP. As stated above, staff verbalization of a change in a PNMP did not meet the standard of competency-based training.	
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.	<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> <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> ABSSLC did not have a policy/protocol that addressed the monitoring process for the following monitoring forms that the Facility submitted: ▪ PNMP Monitoring Form-Routine; ▪ ABSSLC Mealtime Observation; ▪ Sensory Diet Training Form; ▪ Steridient Monitoring Log;	Noncompliance

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		▪ PNMP Training Form; ▪ Wheelchair Checksheet; ▪ Adaptive Equipment Review; ▪ Water Temperature Checksheet; ▪ Sensory Activity Documentation; and ▪ Oxygen Equipment Checklist. The absence of established guidelines/protocols for monitoring forms will result in the inconsistent scoring, as well as lack of follow-up for identified issues/concerns. This was reinforced upon the review of multiple completed PNMP Monitoring Form-Routine forms that were submitted. The following were examples of forms submitted for which identified concerns/issues that were not resolved: ▪ Multiple forms identified care provider's initials were missing on the PNMP document sheet with no identified resolution; ▪ The 12/29/10 monitoring that occurred in Residence 5972 stated: "The OT is going to change his mealtime position so that he doesn't have to fight gravity as much." There was no timeline provided for the modification to his seating system. ▪ The 12/14/10 monitoring that occurred in Residence 5972 stated: Staff are concerned that we may need to go up a size for his sling;" ▪ The 12/20/10 monitoring form from Residence 6360 stated: "Individual refused supper and fluids on five occasions (11/13,14, 19, 27, and 29/10)." There was no discussion of referral to nursing and/or therapists involved with mealtimes; ▪ The 12/15/10 form from Residence 6370 stated: "Individual needs picture taken in dining chair;" ▪ It was unclear why the following entries were made on the PNMP Monitoring Form-Routine dated 12/15/10 in Residence 6370: Entries on form with multiple dates for rivet sides of both armrests of chair (11/15/10), adjusted armrest (9/22/10), replaced wheelchair (5/18/10), replaced seat guide (4/26/10), PNMP bag (1/20/10). ▪ The monitoring form of 12/9/10 for Residence 6390 stated: "Orthotics called, answer machine picked up. Message was left about left armrest broken off the frame of wheelchair. Individual was placed in recliner." The form did not address when the left armrest was replaced. Defined procedures should be developed related to the documentation of follow-up to identified concerns. Competency-based training should be provided to PNMP Coordinators upon the development of these procedures. Monitoring forms that do not provide a feedback loop for resolution do not support a proactive approach to resolution of non-compliance with monitoring indicators.	

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		As discussed in the previous compliance report, a Facility policy should be developed to ensure a system is in place to monitor staff implementation of PNMPs, including dining plans. At a minimum, such a policy should include: ▪ Definition of monitoring process to cover staff providing care in all aspects in which an individual is determined to be at risk (i.e., bathing, tooth brushing, personal care, alternate positioning, wheelchair positioning, medication administration, etc.); ▪ A requirement that all monitoring forms provide instructions for individual monitoring indicators to support consistency in monitoring and inter-rater reliability; ▪ Identification, training and validation process for monitors to achieve accurate scoring and a high level of inter-rater reliability; ▪ Formal schedule for monitoring to occur; ▪ Auditing process of completed monitoring forms to identify forms completed accurately and analysis of individual-specific concerns and systemic issues; ▪ Feedback loop identified in which deficiencies are noted and shared with appropriate supervisory staff to ameliorate deficiencies; ▪ Establish thresholds for staff re-training. <u>All members of the PNM team conduct monitoring.</u> At the time of the Monitoring Team's review, PNMT members were not conducting consistent monitoring. This is discussed with regard to Section O.2 in the examples of individuals reviewed and assessed by PNMT I and PNMT II. <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 the Quality Assurance Department, did not illustrate that a mechanism was in place to ensure timely data was provided to the PNM Team for analysis leading to the identification of potential issues, 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 should 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 Enhancement, Incident Management and Risk Management systems. <u>Immediate intervention is provided if the person is determined to be at risk of harm.</u> Examples are provided above with regard to Section I.1 and Section 0.1 of individuals who were at risk, but had not been reviewed by the PNMT and/or had timely intervention completed by the PNMT.	

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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> For none of the 15 individual records reviewed (Individual #100, Individual #511, Individual #409, Individual #457, Individual #208, Individual #253, Individual #344, Individual #337, Individual #212, Individual #407, Individual #366, Individual #314, Individual #290, Individual #82, and Individual #435) (0%), had the PNMTs completed a comprehensive assessment leading to the development of strategies. As a result, the PNMTs did not document progress of individual strategies on a monthly basis to ensure the efficacy of those strategies in minimizing and/or reducing PNM risk indicators. In none of the 15 records was documentation found to support if strategies were not effective, these strategies and the PNMP were revised. The PNMTs did complete a comprehensive assessment for three individuals reviewed (Individual #353, Individual #23, and Individual #433), but the PNMT did not consistently implement necessary components of the PNM process as discussed with regard in Section O.2 above. <u>Person-specific monitoring is conducted that focuses on plan effectiveness and how the plan addresses and minimizes PNM risk indicators.</u> Based on review, in none of the 15 individual records (0%) did the PNMT evaluate these individuals at high risk for aspiration pneumonia, and as a result did not develop an individualized action plan, document the efficacy of the individual plans, conduct person-specific monitoring to ensure the implementation of the plan, and/or revise the plan if identified strategies to minimize and/or reduce PNM risk indicators were not effective.	Noncompliance
O8	Commencing within six months of the Effective Date hereof and with full implementation within 18 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.	<u>All individuals receiving enteral nutrition receive annual assessments that address the medical necessity of the tube and potential pathways to PO status.</u> Per State policy, all individuals who received enteral nutrition would receive an annual Aspiration Pneumonia/Enteral Nutrition (APEN) Evaluation. The evaluation format was labeled draft. Assessment information was to be obtained from the PCP, RN, Habilitation Therapies, Dietary, and PST members. The Nurse Case Manager would compile the APEN evaluation document. The major elements of the APEN Nutrition Evaluation were: ▪ History to be completed by Primary PCP and RN, including diagnosis, comorbidities, history of aspiration pneumonia, other respiratory infections/conditions, hospitalizations for aspiration pneumonia/respiratory conditions, tracheostomy, reflux, emesis, and dental/oral heath issues (to be completed by dentist);	Noncompliance

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		▪ Risk Level-Health Status to be completed by Team (risk level and rationale); ▪ Method of eating to be completed by PCP and Dietician (nasogastric tube, gastrostomy tube, jejunostomy tube, type of enteral feeding and oral eating); ▪ Reason/rationale for enteral eating to be completed by PCP, RN and Habilitation Therapies; ▪ Diagnostic tests performed to be completed by PCP, RN, and Habilitation Therapies; ▪ Attempts to return to oral or least restrictive method of eating to be completed by Habilitation Therapies; ▪ Current treatment; ▪ Analysis of findings to be completed by team; ▪ Recommendations; ▪ Measurable outcomes; and ▪ Action plan. The draft evaluation format stated: "not all sections will be applicable to every individual." An APEN Evaluation for Individual #213, dated 1/25/11, stated: "recreational eating began 1/17/11. He is offered a pureed dessert and beverage at morning and afternoon snack. If these feedings go well, OT will reassess his feeding times and look at increasing volume of these snacks and possibly including a meal." The evaluation did not include an analysis of findings, recommendations, and/or measurable outcomes. The assessment stated an action plan was not needed at this time, and "will continue current treatment and care plans." The APEN for Individual #213 was not a comprehensive assessment, and there were no team member signatures and dates. The incomplete APEN evaluation for Individual #213 would support the need for PST members to receive consultation and/or for the development and implementation of an APEN evaluation and subsequent action plan. ABSSLC NMT Proposal for Annual Enteral Feeding Review, dated 8-10, stated: "The following annual assessment will include a statement regarding enteral feeding status and reasons continuation is needed: ▪ Annual physical examination; ▪ Annual nursing assessment; ▪ Annual nutrition assessment." This proposal did not require the completion of the APEN Evaluation. Based on the review of 14 individual records (Individual #512, Individual #216,	

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		Individual #101, Individual #409, Individual #340, Individual #253, Individual #20, Individual #361, Individual #92, Individual #443, Individual #457, Individual #14, Individual #511 and Individual #373) who were enterally nourished and/or received supplemental tube feedings, none (0%) of these individuals had received an annual APEN evaluation that addressed the medical necessity of the tube and potential pathways to PO (by mouth) status. A document request was made for APEN evaluations, but none were provided for this group. Examples of individuals who received enteral nutrition and did not receive an annual assessment included: ▪ Individual #512's OT/SLP Eating Evaluation/Nutritional Management Plan Addendum, dated 10/28/10, revealed: "[Individual #512] currently receives all his nutrition via G-tube. A surgical gastrostomy placement was performed on 3/22/2001 due to recurrent anorexia with increased difficulty swallowing and several choking episodes resulting in an inability to maintain proper nutrition. He began recreational drinking and oral/gustatory stimulation 4/02. Staff report he continues to enjoy recreational drinking." There was no evidence of an annual assessment to address the medical necessity of the tube. ▪ Individual #216's OT/PT Update, dated 7/21/10, stated "[Individual #216's] nutritional needs are currently being maintained through the use of his G-tube and this continues to remain appropriate." There was no evidence of an annual assessment to address the medical necessity of the tube. ▪ Individual #101's OT/SLP Eating Evaluation/Nutritional Management Plan Addendum, dated 12/29/06 documented: "[Individual #101] receives her nutrition via G-tube but does engage in recreating eating (mostly snacks)." There was no evidence of an annual assessment to address the medical necessity of the tube. As is noted above with regard to Section I, an additional sample was requested of several examples of completed "Aspiration pneumonia/enteral nutrition evaluation" forms. All of the examples provided (Individual #378, Individual #515, Individual #314, Individual #520, Individual #480, Individual #373, and Individual #33 were extensive and detailed. It should be noted that Individual #373 was included in each sample, but a completed APEN was provided in one sample, but not the other. The reason for this was unclear. Additionally, it was not clear who completed these forms, although it appeared it was the PNMT. The concern was that this form, with extremely valuable information and well reviewed medical history, risk levels, method of eating, and completed diagnostic tests, was a separate document that, given the degree of detail provided, might be difficult to incorporate as part of the Risk Action Plan. However, to ensure good communication and consistency of information, it would be important for the "method of eating" section to be	

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		incorporated into the Risk Action Plan. The information from the "Aspiration pneumonia/enteral nutrition evaluation" should be an integral part of the Risk Action Plan for the PNMP to be successful. <u>People who receive enteral nutrition and/or therapeutic/pleasure feedings are provided with PNMPs that include the components listed above.</u> Based on a review of 14 records, individuals were provided with a PNMP that: ▪ In 14 of 14 records (100%), positioning instructions for wheelchair and alternate positions instructions were included. ▪ In 14 of 14 records (100%), transfer instructions were included. ▪ In none of 14 records (0%), staff instructions were provided to identify the prescribed time an individual was to remain upright after receiving enteral nutrition. ▪ In nine of 14 records (64%), strategies for medication administration were included. Individual #340, Individual #361, Individual #92, Individual #443, and Individual #14 did not have strategies for medication administration. ▪ In 10 of 14 records (71%), strategies for oral hygiene were included. For Individual #340, Individual #361, Individual #443, and Individual #14, no positioning instructions were provided when oral care was administered. ▪ In 14 of 14 records (100%), individual adaptive equipment was included. ▪ In none of 14 records reviewed (0%), bathing/showering positioning and instructions were included. ▪ In none of 14 records (0%), personal care instructions were included. ▪ In 14 of 14 records reviewed (100%), communication strategies were included. A review of individual PNMPs identified the following concerns: ▪ Individual #340's PNMP, dated 10/28/09, did not provide positioning elevation instructions for staff for bathing/showering, personal care for checking/changing, medication administration, oral care, and the prescribed time to remain upright after receiving enteral nutrition. The absence of these strategies had the potential to place Individual #340 at risk for aspiration. ▪ Individual 409#'s PNMP, dated 11/3/10, did not provide positioning elevation instructions for staff for bathing/showering, personal care for checking/changing and the prescribed time to remain upright after receiving enteral nutrition. The absence of these strategies had the potential to place her at risk for aspiration. ▪ Individual #92's PNMP, dated 5/4/10, had not been updated to address the placement of a feeding tube on 10/27/10. <u>The need for continued enteral nutrition is integrated into the PSP.</u>	

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		Based on a review of 14 individuals' PSPs who received enteral nutrition, none (0%) of the individuals' PSPs documented the rationale for the continued need for enteral nutrition and/or attempts to return the individual to oral intake, or the least restrictive method of receiving nutrition. <u>A policy exists that clearly defines the frequency and depth of evaluations (Nursing, MD, SLP or OT).</u> The At-Risk Individuals policy (Policy Number 006, dated 11/02/10) stated: "a regular risk assessment and management system will be used to identify persons at risk of illness and injury." A component of the At-Risk Individuals policy required "a comprehensive integrated assessment performed at least annually and as indicated for individuals who have a long history of/or recent hospitalization for aspiration pneumonia and for individuals who receive enteral nutrition. The assessment is designed to reduce the incidence of aspiration pneumonia and its complications and to assess continued need for enteral eating." All individuals who were enterally nourished were to be evaluated using the evaluation format. According to the documentation provided, none of the 14 individuals within this sample had received an annual APEN evaluation. As is noted above, it was not clear why an APEN for Individual #373 was submitted in response to one document request, but not the other. <u>Individuals who are at an increased PNM risk are provided with interventions to promote continued oral intake.</u> Reportedly, Individual #512, Individual #216 and Individual #101 received therapeutic feeding. None of these three individuals reviewed (0%) had a formal therapeutic feeding program with therapy documentation to support the efficacy of the program. The following concerns were noted: ▪ Individual #512's OT/SLP Eating Evaluation/Nutritional Management Plan Addendum, dated 1/22/03, documented "[Individual #512] currently receives all his nutrition via G-tube… He began receiving recreational drinking and oral/gustatory stimulation 4/02." His current PNMP, dated 1/20/11, provided staff instructions for recreational drinking/oral gustatory stimulation: "warm liquids thickened to pudding consistency; unmoistened bubblegum flavored toothettes." The most current OT/SLP Eating Evaluation/Nutritional Management Plan Addendum stated: "Inconsistency among staff during preparation of the milkshake consistency liquids had led to liquids being served anywhere in the range from honey to pudding consistency over the past few years. Since repeated teaching sessions, inservicing of staff, and monitoring has not solved the problem, therapists are discontinuing the milkshake consistency. Further, it is vitally important that staff consistently provide people with swallowing dysfunction (dysphagia) the correct consistency of liquids, the	

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		campus is transitioning to pre-thickened liquids and thickening recipes are only available in nectar, honey and pudding consistencies. Therefore, [Individual #512's] coffee will now be thickened to pudding consistency." Individual #512 had been receiving recreational feeding for over eight years, but there was no documentation of attempts to return to oral intake and/or an exploration of the least restrictive method of receiving enteral nutrition. • Individual #216's OT/SLP Eating Evaluation/Nutritional Management Plan Addendum, dated 10/28/10, summary stated: "[Individual #216] is returning to oral eating after being fed by gastrostomy tube for the last four years. He received a vagal nerve stimulator in June of this year and has reportedly had a significant seizure reduction since that time. A repeat Modified Barium Swallow was completed on October 18, 2010. At that time he ate pureed food and drank liquids without significant problems." There was no documentation of an APEN evaluation, OT/SLP consultations, and/or progress notes to address the efficacy of his recreational eating. PSPAs documented ongoing success with his return to oral eating, but a comprehensive APEN Evaluation had not been completed to provide clinical justification for a return to oral eating.	

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

1. PNMT members should be required to attend all state-sponsored PNMT-related continuing education courses.
2. As recommended with regard to Section G, a full-time equivalent PNMT is needed to assist in addressing the needs of individuals with aspiration pneumonias, dysphagia, GERD, skin breakdown, etc. Facility Administration, in collaboration with PNMT members, should complete an analysis of the current caseloads of the PNMT members to determine how to realign therapy, dietician, and nursing caseloads to enable the PNMT to complete a timely and proactive PNMT evaluation(s), develop and implement interventions, complete ongoing review and monitoring, and analyze the efficacy of supports provided to individuals with complex health, physical and nutritional supports needs.
3. Consideration should be given to eliminating the current caseload assigned to the nurse on the PNMT. The nurse's caseload would consist of individual's evaluated and followed by the PNMT. This would enable the PNMT nurse to provide support and leadership to PNMT.
4. As recommended with regard to Section G, the PNMT should have a physician liaison to the Medical Department.
5. To support successful implementation of the PNM process for those individuals at highest risk with complex health, physical and nutritional support needs, the PNMT should:
    a. Complete a risk screening using the Risk Guidelines for individuals referred to the PNMT, if the PST has not already competed them;
    b. If the PST has completed a risk screening, review the results in comparison with the Risk Guidelines to determine if appropriate risk levels have been assigned;
    c. Complete an assessment to determine the status of safe positioning for an individual within natural environments (nighttime positioning, seating system, bathing, tooth brushing, classroom, work, leisure, medication administration, etc.) to determine the efficacy of current PNMP strategies, including staff instructions, prior to the PNMT and subsequent PST meeting;
    d. Identify individual triggers for identified risk indicators, such as aspiration pneumonia, and integrate these triggers into relevant working plans, such as the PNMP, Dining Plan, BSP, Nursing Care Plan, etc.;
    e. Ensure the assessment provides clinically justified techniques for mealtime (including individuals who were enterally nourished), oral

care, bathing, dental appointments, bedtime positioning, medication administration, etc.;

f. Provide support to individuals at highest risk on a much more frequent basis. Timeframes for review should not be extended across months, but rather days for individuals at highest risk. The PNMT, in collaboration with Facility Administration, should analyze current caseloads to determine how additional time will be made available to the PNMT to develop procedures for timely and proactive assessment, intervention, review, documentation, monitoring, and analysis to determine efficacy of supports provided at both individual-specific and systemic levels;
g. Incorporate the Action Plan into the individual's PSP through the addendum process;
h. Include in the analysis section of the PNM Evaluation assessment data, which provides justification and rationale for the recommendations. The analysis should provide a correlation between the identified high-risk indicators that resulted in referral to the PNMT and should summarize the assessment data, which provides justification for the recommendations and measurable outcomes;
i. Include criteria in the recommendations and measurable outcomes to measure the efficacy of the interventions;
j. Develop implementation strategies to ensure recommendations and measureable outcomes are implemented;
k. Ensure staff complete performance check-offs to document competency for identified skills for those individuals at highest risk;
l. Develop a simple method to document, monitor, and track clinical objective data to support the effective implementation of recommendations;
m. Implement a mechanism to report a change in an individual's status to the PNMT to enable the PNMT to evaluate the plan, and/or make modifications to the plan; and
n. Develop an individual-specific monitoring plan for the PNMT to complete that is correlated to PNM recommendations and measurable outcomes enabling the Team to quickly determine the efficacy of identified implementation strategies.

6. The PNMT should identify individuals with complex health, physical and nutritional support needs and provide a timely, proactive comprehensive assessment; develop and implement a comprehensive action plan(s) to include strategies to implement measurable outcomes including an appropriate PNMP; initiate regular review; provide competency-based training; ensure integrated documentation, initiate monitoring to ensure recommendations are being implemented by competent staff, and complete an analysis to determine the efficacy of the supports provided, and develop modifications to plans, as necessary.
7. PNMPs should be revised to reflect the use of wedges on bathing trolleys for those individuals who must remain elevated at all times. In addition, PNMPs should reflect that individuals who must remain upright at all times must be elevated when receiving personal care such as checking and changing adult briefs. PNMPs should reflect elevation strategies in every environment for those individuals who are at risk of aspiration pneumonia and other related health risk indicators.
8. The PNS competency-based training curriculum should identify the following:
    a. Required learner objectives and competencies for foundational skills in PNM;
    b. For each competency, there should be a list of tasks and/or activities that must be demonstrated;
    c. A description of how staff will demonstrate mastery of the skill;
    d. The best materials, and methods for training;
    e. A description of how the training will reinforce "why it is important in my job to know this information;"
    f. A training schedule that is spaced out to allow participants the opportunity to practice new skills, ask questions, and obtain a lot of feedback; and
    g. Observations of staff and/or performance check-offs in work settings with outcomes documented.
9. A Facility policy should be developed to ensure a system is in place to monitor staff implementation of PNMPs, including dining plans. At a minimum, such a policy should include:
    a. Definition of monitoring process to cover staff providing care in all aspects in which an individual is determined to be at risk (i.e., bathing, tooth brushing, personal care, alternate positioning, wheelchair positioning, medication administration, etc.);
    b. Requires all monitoring forms to provide instructions for individual monitoring indicators to support consistency and support inter-

rater reliability;

c. Identification, training, and validation process for monitors to achieve accurate scoring and a high level of inter-rater reliability;
d. Formal schedule for monitoring to occur;
e. Auditing process of completed monitoring forms to identify forms completed accurately and analysis of individual-specific concerns and systemic issues;
f. Feedback loop identified in which deficiencies are noted and shared with appropriate supervisory staff to ameliorate deficiencies; and
g. Establish thresholds for staff re-training.

10. 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.
11. A comprehensive APEN 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 a person to oral intake, if appropriate. As necessary and appropriate, teams should be provided training and/or consultation to ensure APEN evaluations are completed to support compliance with Section O.8.
12. Information gained from the APEN evaluations should be integrated, as appropriate, into individuals PSPs and PNMPs.

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 Presentation Book for Section P; o The following documents: Occupational Therapy (OT) and Physical Therapy (PT) Assessments and Updates, Wheelchair assessment, monthly OT/PT Programs progress notes, OT/PT/SLP consultations for the last year, OT/PT Programs, PSP and PSP Addendums for the last year, Physical and Nutritional Management Plan (PNMP) with pictures (including positioning instructions), PNMP person-specific monitoring, PNMP Clinic Notes for the past year, competency-based training for PNMP Coordinators, HT Techs and staff, OT/PT PSP monthly progress note and dining plan/diet card, daily schedule, and Modified Barium Swallow Study (MBSS) for the following 16 individuals: Individual #231, Individual #500, Individual #349, Individual #82, Individual #323, Individual #201, Individual #396, Individual #124, Individual #213, Individual #77, Individual #377, Individual #296, Individual #232, Individual #223, Individual #277, and Individual #12; o The following documents: OT Evaluation, PT Evaluation, PSP, and PNMP with pictures for the following seven individuals: Individual #390, Individual #318, Individual #495, Individual #450, Individual #37, Individual #261, and Individual #143; o List of Therapists, undated; o Continuing Education and Curriculum Vitae for therapists, undated; o List of Individuals with Case number, and Residence number, undated; o Monthly Health Monitoring Report-Decubitus Report, from 6/10 through 12/10; o List of Individuals with Injuries caused by Slip/Trip/Fall, from 1/10 through 1/11; o PNM Maintenance Log Utilized by the Facility to track Modifications made to Individual's Adaptive/Assistive Equipment, 2009 and 2010; o OT/PT Assessments (template), revised 2/10; o Five (5) most current OT/PT Assessments conducted by each Therapist and corresponding PSPs, 1/10 through 12/10; o PNMP Tracking Log, 9/10 through 1/11; o PNMP Clinic Notes, Seating System Assessment, and PNMPs (templates), undated; o Seating System Assessments and PNMP Clinic Assessments for Multiple Individuals, from 3/10 through 12/10; o OT/PT Related Spreadsheets, from 2/10 through 1/11; o PNMP Monitoring Forms and Mealtime Observations for Multiple Individuals, for 12/10; o List of Individuals receiving Direct OT and/or PT Services and Focus of Intervention, undated; o PT Program Review-Objective Data Sheet (blank), undated; o Steridient Monitoring Log (blank), revised 10/18/06; o Sensory Diet Training Form (blank), dated 2/9/10;

	○ Positioning Instructions (blank), undated; ○ PNMP Training Form (blank), dated 12/13/09; ○ ABSSLC Mealtime Observation (blank), undated; ○ PNMP Monitoring Form-Routine (blank), undated; ○ Wheelchair Check Sheet (blank), undated; ○ Habilitation Therapy Wheelchair/Equipment Log (blank), dated 3/04; ○ Adaptive Equipment Review (blank), revised 5/13/10 ○ Water Temperature Cheek Sheet (blank), undated; ○ Proposed Agenda for Habilitation Therapies Key Staff Meeting, dated 1/10/11; ○ Priority As Soon As Possible (ASAP) Work Orders (blank), 1/12/11; ○ Annual Program Review for December 2010 (blank); ○ Orthotics Work Order (blank), undated; ○ Sensory Activity Documentation (blank), for January 2011; ○ Oxygen Equipment Checklist (blank), undated; ○ Proposed Agenda Habilitation Therapies Key Staff Meeting, dated 2/14/11; ○ Presentation Section P for February 14, 2011 Settlement Agreement Monitoring Team Visit; ○ Wheelchair frames, as of 2/11/11; ○ Priority ASAP Work Orders, dated 2/14/11; and ○ Shift Report, dated 2/16/11. ▪ **Interviews with**: ○ Bobbie Holden, Lead Occupational Therapist; and ○ Karen Mayfield, Lead Physical Therapist. ▪ **Observations of**: ○ Activity Center 6340; ○ Vocational Services 680, and 662; ○ Residences 6460, 6450, 5961, 5962, 6480, 6521, 6510, 5972, 5971, and 6380.
	Facility Self-Assessment: ABSSLC Plan of Improvement, updated 1/31/11, provided comments/status for Section P. Compliance for each of these sections was documented as non-compliance. This was consistent with the Monitoring Team's findings. This document also provided a summary of some of the action plans on which the Facility was working to achieve compliance. In addition to the POI the Facility submitted, the Habilitation Therapies Department provided additional information, including: ▪ ABSSLC Plan of Improvement, updated 1/31/11, which addressed the status of recommendations. This form addressed the status of the following recommendations: P2, and P3. ▪ ABSSLC POI, undated, offered the status of the draft Monitoring Tool for Section P. These documents should be merged to present a cohesive compliance document. In addition to providing some narrative descriptions of actions the Facility had or was taking to move

	towards compliance, the Facility included some data from its self-assessment reviews. This was an important step. However, it was not always clear specifically to what the data referred, making it difficult to determine if the Facility had accurately identified areas in which focused attention was needed to address the concerns that were keeping it from reaching compliance. For example, Section P.2 includes multiple requirements related to the development and integration of OT/PT plans into individuals' PSPs, the content of the plans, and the implementation of the plans. However, the POI stated: "1/2011--Current monitoring results: 73% compliance from review of 85 records since 9/2010." The score appeared to be an overall score, which did not assist in providing direction for next steps, and likely could not have been calculated accurately given the monitoring tools being used. As the Facility moves forward in its self-assessment process, it will be important to ensure that data is used in meaningful ways to assist in identifying areas in which improvements are needed. Moreover, the completed monitoring review tool submitted did not indicate how compliance findings were derived. The monitoring tool did not provide a defined methodology and/or instructions for the use of the audit forms. No evidence was submitted to document that inter-rater reliability had been established with multiple reviewers completing the audit forms. Individual indicators were assigned substantial compliance without documentation to support the findings of compliance and/or non-compliance ratings for the various provisions of Section P. For example, Section P.1.A.4 stated: "100% of records reviewed show that all individuals receive a comprehensive integrated Occupational Therapy/Physical Therapy Assessment upon admission." This indicator documented substantial compliance with no comment.
	Summary of Monitor's Assessment: There were six budgeted positions for Occupational Therapy. The Facility had three full-time Occupational Therapists. Based on staff report, three contract Occupational Therapists, providing 20 to 30 hours per week, had been hired to provide support in the interim until additional full-time occupational therapists were hired. Efforts to recruit occupational therapists should continue. ABSSLC had six budgeted positions for physical therapy. At the time of the review, there were five full-time Physical Therapists, including the Habilitation Therapies Director. The Facility continued to recruit a Physical Therapist. The current staff to individual ratio, undated, indicated the ABSSLC average ratio for OTs was 1:223, and PTs was 1:118. As a result, therapists were not active members of the PSTs, as evidenced by, but not limited to, their absence in annual PSP meetings, insufficient time to provide direct therapy, completion of comprehensive OT/PT Evaluations per established guidelines, development and integration of therapy recommendations into formal skill acquisition programs, development of instructional programs for PNMP Coordinators and/or staff, and the development of informal strategies to reinforce assessment recommendations.

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P1	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 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.	<u>The Facility provides an adequate number of physical and occupational therapists, mobility specialists, or other professionals with specialized training or experience.</u> According to the current census provided to the Monitoring Team, there were 447 individuals living at ABSSLC. A list of therapy staff with titles, current caseloads, and license numbers was requested, but OT and PT therapy caseloads were not submitted. There were six budgeted positions for Occupational Therapy. The Facility had three full- time Occupational Therapists. Per staff report, three contract Occupational Therapists, providing 20 to 30 hours per week, had been hired to provide support in the interim until additional full-time occupational therapists were hired. Efforts to recruit occupational therapists should continue. ABSSLC had six budgeted positions for physical therapy. At the time of the review, there were five full-time Physical Therapists, including the Habilitation Therapies Director. The Facility continued to recruit a Physical Therapist. The current staff to individual ratio, undated, indicated the ABSSLC average ratio for OTs was 1:223, and PTs was 1:118. The psychology staff-to-individual ratio required by the Settlement Agreement was 1:30. OTs and PTs had similar duties with regard to assessment, planning, monitoring, and provision of direct supports and/or oversight. As a result, therapists were not active members of the PSTs, as evidenced by, but not limited to, their absence in annual PSP meetings, insufficient time to provide direct therapy, completion of comprehensive OT/PT Evaluations per established guidelines, development and integration of therapy recommendations into formal skill acquisition programs, development of instructional programs for PNMP Coordinators and/or staff, and the development of informal strategies to reinforce assessment recommendations. The three full-time Occupational Therapists and two contract Occupational Therapist licenses were current. The license status of the one additional contract Occupational Therapist was not provided. The five full-time Physical Therapists licenses were current. Since the last monitoring visit, two new fabricators/mobility specialists (Orthotics technicians) were hired. No continuing education courses were submitted by the Habilitation Therapies Director, one full-time OT, and three contract OTs. Continuing education documentation for two OTs including the Lead OT, and four PTs, including the Lead PT, documented attendance at the following continuing education courses and/or conferences:	Noncompliance

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		Continuing Education	**OT**	**PT**	
		Family Caregivers-Doing Double Duty (2/16/10)		1 PT	
		Understanding Distal Radius Fractures (2/16/10)		1 PT	
		ABCs of Physical Therapy Wound Management (2/16/10)		1 PT	
		The Management of Knee Osteoarthritis (3/4/10)		1 PT	
		Improving Your Ability to Think Critically (3/4/10)		1 PT	
		Functional Knee Bracing for Sports (3/4/10)		1 PT	
		Fall Prevention Among the Elderly (3/4/10)		1 PT	
		Autism Extravaganza: Featuring Temple Grandin (3/9/10)	2 OTs	1 PT	
		PNMP and Wheelchair Clinic Webinar (7/19/10)		2 PTs	
		Technological Advances in the Management of Dysphagia (8/10/10)	1 OT		
		NMT/PNMT Equipment Webinar (8/13/10)	1 OT	2 PTs	
		Pediatric Dysphagia-Management of the Whole Child (8/13/10)	1 OT		
		Fall Prevention (8/25/10)		1 PT	
		Seating and Positioning for Dysphagia (9/1/10)	1 OT	3 PTs	
		Managing Individuals at High Risk Webinar (9/1/10)	1 OT	2 PTs	
		Issues in Evaluation and Treatment of Individuals with Developmental Disabilities (9/20/10 through 9/22/10)		2 PTs	
		Food-Medication Interactions (9/23/10)	2 OTs	3 PTs	
		PNMP and Wheelchair Clinic Teleconference (9/30/10)		1 PT	
		PNMP and Wheelchair Clinic Teleconference (10/12/10)		1 PT	
		20th Annual Habilitation Therapies Conference (9/20/10 to 9/21/10)	2 PTs	3 PTs	
		PNMP and Wheelchair Clinic Teleconference (10/21/10)		1 PT	
		PNMP and Wheelchair Clinic Teleconference		1 PT	

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(10/28/10)		
PNMP and Wheelchair Clinic Teleconference (11/18/10)		1 PT
PNMP and Wheelchair Clinic Teleconference (11/30/10)		1 PT

The Lead Physical Therapist documented the following continuing education courses, but did not provide the dates of the courses: PNMP and Wheelchair Clinic Teleconferences, Considerations for Safe and Effective Weight Lifting in Athletes, and the Role of Manual Therapy in Pediatric Orthopedics.

The Lead Occupational Therapist documented the following continuing education courses, but did not provide the dates of the courses: 5 Keys to Being Proactive with Hearing Loss, Gravity and Movement Challenged: The Sensory Motor Vestibular Triad, and Aspiration Webinar.

An additional OT documented the following continuing education courses, but did not provided the dates of the courses: Root Cause Analysis, Executive Dysfunction: This Disorganized, Defiant, and Chaotic Child and Adolescent, and PNMP and Wheelchair Clinics, PNMT Training, and Aspiration Guidelines.

The OT/PTs attended a wide variety of continuing education courses and conferences. The Facility should continue to support therapists' attendance at a variety of annual continuing education courses to bring diversity of knowledge and skills to the provision of therapy supports for individuals living at CCSSLC.

Sixteen (16) records were reviewed, including those for: Individual #231, Individual #500, Individual #349, Individual #82, Individual #323, Individual #201, Individual #396, Individual #124, Individual #213, Individual #77, Individual #377, Individual #296, Individual #232, Individual #223, Individual #277, and Individual #12. These 16 individuals had identified needs related to, but not limited to movement, mobility, range of motion, independence, regression of functional skills, a change in status, and/or community transition.

<u>All individuals have received an OT/PT screening. If newly admitted, this occurred within 30 days of admission.</u>
There were nine new admissions to ABSSLC since the last review. A sample of seven individuals was selected. Seven of seven individuals (100%) (Individual #390, Individual #318, Individual #495, Individual #450, Individual #37, Individual #261, and Individual #143) received an OT/PT evaluation within 30 days of admission. The respective Occupational Therapist and/or Physical Therapist had not signed and dated

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		the admission evaluations. <u>All people identified with therapy needs have received a comprehensive OT and PT assessment within 30 days of identification.</u> The OT/PT Annual Evaluation template had been updated to incorporate health risk indicators, as well as strategies to minimize or reduce the effects of those identified risks. Consideration should be given to incorporating the following guidance into the OT/PT Evaluation template: ▪ Assessment process should be sufficiently discreet to identity an individual's functional skills, interests, and preferences via observation and clinical assessment; ▪ Assessment data should be analyzed to identify an individual's strengths, abilities, and potentials for skill acquisition; and ▪ Analysis of findings to provide a rationale for functional recommendations and intervention strategies. ▪ Recommendations should be integrated into an individual's PSP; ▪ Documentation should be present to justify initiation, continuation, or discontinuation of direct and/or indirect therapy supports; and ▪ A process should be delineated for implementing change in an individual's supports when progress is made or a lack of progress. The lack of progress would identify a re-evaluation timeframe. The OT/PT Evaluation template included the following sections: ▪ General Information o Active problems; o Fracture/surgical history; o Medications; o Health risk indicators; o Communication; and o Behavioral considerations. ▪ Assessments o Range of motion; o Upper extremities/fine motor; o Lower extremities; o Foot assessment; o Posture; o Abnormal Reflexes; o Transfers/handling; o Mobility; o Gait Analysis; o Review of falls;	

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		o Sensory motor functioning; o Activities of daily living; o Skin integrity/wound care; and o Wheelchair. ▪ Physical/Nutritional Management Plan (PNMP) ▪ Nutritional Management Information ▪ Assistive/Supportive Devices ▪ Recommendations Consideration should be given to a discussion/summary of OT/PT consultations completed. <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, none of the eight individuals who had received direct therapy and/or experienced a change in status (Individual #231, Individual #500, Individual #82, Individual #323, Individual #201, Individual #396, Individual #77, and Individual #27) (0%) had received an evaluation within the past three years, and/or timely interim update. Changes in status included events such as, but not limited to, becoming at risk for weight, a fracture, serious choking incidents, unplanned weight loss, and/or community transition. The following individual concerns were identified: ▪ Individual #231 had a Body Mass Index (BMI) of 56.7. The BMI ranges are based on the relationship between body weight, disease and death. Overweight and obese individuals are at increased risk for many diseases and health conditions, including the following: hypertension, dyslipidemia, type 2 diabetes, coronary heart disease, stroke, gallbladder disease, osteoarthritis, sleep apnea, respiratory problems and some cancers (endometrial, breast, and colon) (http://www.cdc.gov/healthyweight/assessing/bmi/adult_bmi/index.html). The OT/PT Annual Evaluation, dated 5/4/10, documented her recommended weight range of 104 to 126 pounds, and her current weight was 344 pounds. She exceeded her recommended weight by 218 pounds. She had a weight gain of 44 pounds since her last OT/PT evaluation. Individual #231 current weight placed her at high risk according to the Risk Guidelines. The evaluation recommended: "encourage [Individual #231] to exercise and/or participate in physical activities to promote weight loss and improve her strength/endurance." No direct therapy was recommended to address her significant health concerns related to her status of morbid obesity. ▪ Individual #500's BMI was 16.8, placing her in the underweight range. Her most current OT/PT Evaluation was dated 6/29/05, and the OT/SLP Eating Evaluation/Nutritional Management Plan was dated 1/10/08. Individual #50	

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		had not received an update to address her underweight status. The Monitoring Team requested her Personal Support Plan, but it was not submitted. ▪ Individual #82's OT/SLP Eating Evaluation/Nutritional Management Plan, dated 10/12/10, documented a serious choking incident that occurred on the morning of 9/29/10 after taking his morning medications. The evaluation recommended suggested eating techniques, but did not discuss strategies for medication administration. The Personal Support Plan Addendum, dated 10/6/10, stated: "The Occupational Therapists suggested that the nurses crush [Individual #82's] medications when he is postictal [altered state of consciousness that a person enters after experiencing a seizure] or lethargic." This recommendation was not present in the Eating Evaluation. ▪ Individual #323's experienced a serious choking incident on 11/18/10, but a OT/SLP Eating Evaluation/Nutritional Management Plan, dated 12/22/10, was not completed until a month after the choking incident. This was not an acceptable time frame following a serious choking incident. ▪ Individual #201's PSP, dated 9/2/10, identified protective/supportive devices for padded bedrails, ear molds, and gel mattress, but these devices were not documented in his PNMP, or discussed in his OT/PT Annual Evaluation, dated 8/17/10. ▪ The list of Individuals with Fractures Since Last Site Visit, undated, documented Individual #396 sustained a left fibular diaphyseal fracture with slight angulation on 11/15/10. The PT Update, dated 1/11/10, documented "[Individual #396] sustained a left tibial fracture on 8.24.09 and has since progressed to a rolling walker and a walking boot. She currently required one-person assist, a gait belt, helmet, rolling walker and a walking boot for all ambulation and transfers. She only uses her standard wheelchair for off home long distances." Her PNMP, revised 11/23/10, had not been revised to address these changes. The Monitoring Team observed Individual #396 in her residence and in the workshop, and she was in her wheelchair, which did not support strategies identified on her PNMP. The PNMP stated: "wheelchair should not be used as seating when at home" and "should sit in a chair with arms when at work for her safety due to seizures." Individual #396 had not received a PT update to address her fracture, which occurred on 11/15/10. ▪ According to the list Individuals with Fractures Since Last Site Visit, undated, on 12/9/10, Individual #124 sustained a medial malleolus fracture to her left ankle. Her Physical Therapy Update, dated 12/22/10, stated: "PT met with [Individual #124's] PST again today to discuss issues encountered since her return home from the Infirmary. [Individual #124] is refusing to walk and will stand but is having difficulty with stand-pivot transfers." The PT made multiple recommendations and the PT was to revise the PNMP to reflect these recommendations. Individual #124's PNMP, revised 2/1/11, did not integrate	

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		the following recommendations from the PT Update: o "Use two staff assistance (using a gait belt) for all standing, ambulation and transfers. Staff must hold on to the gait belt at all times unless she is seated or in bed. May use staff as needed to bring the chair or wheelchair behind her if she refuses to take steps. o May use a home wheelchair as needed up to two hours at a time. o Use two-person assist from floor method to get her up from floor mat. Use third staff to place the chair under her once standing. Use fourth staff if needed to block her feet. o Place in bed for dressing and hygiene. Do not require her to stand for extended periods of time." Individual #124 was experiencing physical regression. Direct physical therapy was not recommended, even though she was "refusing to walk and will stand but is having difficulty with stand-pivot transfers" and "for dressing and changing, PT instructed staff to place [Individual #124] in bed and roll her from side to side due to her inability or refusal to stand for long enough to complete this task." ▪ According to the document entitled Community Placement Since Last On-Site Visit, dated 1/5/11, Individual #277 transitioned to the community on 10/18/10. Her OT/PT Annual Evaluation, dated 9/2/10, did not address her upcoming community placement, and/or provide recommendations to her community provider. ▪ Individual #77 participated in a PT program to "improve ambulation." Her OT/PT Evaluation, dated 1/28/05, recommended: "PT recommends implementing a formal ambulation program at the OT/PT center to encourage increased activity and weight bearing, to improve ambulation skills. Program to be written and implemented upon PST approval." Individual #77 was receiving direct therapy, but had not received an OT/PT evaluation within the past three years. ▪ Individual #296 participated in a PT program "to promote joint movement of upper and lower extremities." The OT/PT Evaluation, dated 4/15/02, stated: "[Individual #296] currently participates in a formal physical therapy program for range of motion to help prevent further contractures. It is recommended that she continue to receive services for range of motion at the OT/PT Center twice a week." Individual #296 received direct therapy, but had not benefited from an OT/PT evaluation within the past three years. <u>Medical issues and health risk indicators are included in the assessment process with appropriate analysis to establish rationale for recommendations/therapeutic interventions.</u> Nine of the 16 (56%) evaluations reviewed (Individual #349, Individual #323,	

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		Individual #201, Individual #213, Individual #377, Individual #232, Individual #223, Individual #277, and Individual #12) addressed medical issues and health risk indicators that would have an impact on the analysis utilized to establish rationale for recommendations/therapeutic interventions. The following concerns were noted: ▪ Individual #201's Health Risk Indicators section stated: "[Individual #201's] Health Screening Team most recently met on 3/18/10 to discuss health risk factors. During that meeting, polypharmacy was identified at a medium risk by the team." Active problems documented "recent bouts of pneumonia and/or bronchitis related to probable aspiration on 12/5/08, 3/26/09, and 4/13/09. Individual #201 was prescribed thickened liquids. These criteria would place Individual #201 in the medium risk range for aspiration, which also would impact strategies on his PNMP, but this was not reflected in the risk indicator section. ▪ On 2/14/10, Individual #377's was admitted to the emergency room with an admission diagnosis of aspiration pneumonia, which would place her at high risk per the Risk Guidelines. In her OT/PT Annual Evaluation, dated 7/15/10, the Health Risk Indicator section did not discuss her high risk for aspiration pneumonia, which would have a significant impact on the development of PNMP strategies. <u>Evidence of communication and or collaboration is present in the OT/PT assessments.</u> Based on record review, four of the 16 OT/PT Evaluation (25%) included signatures and date by 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	<u>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.</u> Based on a review of six individuals (Individual #213, Individual #77, Individual #377, Individual #296, Individual #232, and Individual #223), who were selected from the submitted list of individuals receiving direct/indirect OT/PT services, none of the six (0%) therapy programs was integrated in the individual's PSP. The following individual examples document the absence of a plan and/or integration into the PSP: ▪ The stated objective of Individual #213's PT Service Plan, dated 8/16/10 and effective date of 9/15/10, was: "[Individual #213] will be provided with a general range of motion exercise program with the application of a left wrist/hand air splint. This program is offered to help increase his comfort and tolerance of passive movement during daily activities (dressing, bathing, grooming, etc.) and to minimize further regression." Individual #213 also received Sensory Programming for "diet and brushing done every 2 hours to decrease agitation." There was no formal OT Program submitted. Individual #213's PSP, dated 9/30/09, stated: "continue participation in formal PT Service Plan for range of motion," but the PT Service Plan was not integrated in the PSP	Noncompliance

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	outcomes; positioning devices and/or other adaptive equipment; and, for individuals who have regressed, interventions to minimize further regression.	Action Plans. The PSP did not include functional, measurable outcomes associated with the PT Service Plan. ▪ Individual #77 participated in a PT program at the OT/PT center to "improve ambulation," as documented on the list of individuals receiving direct OT and/or PT services and focus of intervention, undated. Individual #77's PSP, dated 1/18/11, stated: "Physical Therapist recommended discontinuing [Individual #77's] formal ambulation and activity program due to her regression. This recommendation was discussed during [Individual #77's] PSP and the team agreed it would be discontinued with informal opportunities to walk inside and outside of the home continued to be offered as available. [Individual #77] enjoys these walks and they should be continued for that reason and in order to maintain the strength and dexterity that she still has in her lower extremities." The PSP had a service objective "walk with staff (indoors and outdoors)." It was unclear if Individual #77 was showing regression, why the program was discontinued, but a recommendation was made for her to walk "informally." The formal PT program should have been modified to reverse the regression, as well as to integrate multiple opportunities for her to walk formally and informally throughout the 24-hour day to minimize her regression. ▪ The objective in Individual #377's PT Service Plan, dated 8/4/10 and effective date of 8/9/10, stated: "[Individual #377] will be provided with ambulation activities in the ARJO walker with the assistance of one person in order to increase weight bearing activities throughout her day. This will aid in slowing progression of osteoporosis as well as maintain cardiovascular and respiratory function." Her PSP, dated 8/9/10, did not integrate her formal PT program into an action plan training objective. The PSP stated: "[Individual #377] attends the OT/PT department twice a week for a formal training sessions of her ambulating, [Individual #377] is non-ambulatory except when at the OT/PT gym in her training session. [Individual #377] is a stand/pivot due to the fact of her ability to keep some of the strength in her legs (due to OT/PT training). This is considered a special need for [Individual #377] to continue so that she will not loose that ability. The Home Support Staff (HSS) that was present at [Individual #377's] meeting mentioned that she has a tendency to buckle her knees when HSS attempt to stand/pivot [Individual #377]. The PST team stated that [Individual #377] has been approved to receive a new bed that will be a regular height off the ground instead like (sic) her present bed (very close to the ground). The PST team is hoping that a bed regular height off the ground will make [Individual #377] not buckle her knees as often. The bed is hopefully being purchased soon." Individual #377 was not being provided with opportunities to "increase weight bearing activities throughout the day," because she only had the opportunity to practice this skill in the OT/PT	

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		department on "Tuesdays and Thursdays, excluding scheduled holidays," according the PT Service Plan. The PT Service Plan was not integrated into PSP through formal training objectives and/or informal service objectives. ▪ The objective in Individual #296's PT Service Plan, effective date 8/3/10, stated: "[Individual #296] will be provided with a general range of motion exercise program." The PSP, dated 5/11/10, did not integrate this program into formal training objectives and/or informal service objectives. ▪ The objective in Individual #232's PT Service Plan, effective date 7/28/10, stated: "[Individual #232] will be provided with a range of motion exercise program to promote joint movement and to increase his ability to be assisted during daily activities." A Habilitation Technician offered this program twice a week at the OT/PT Center. His PSP, dated 7/28/10, did not integrate this program into formal training objectives and/or informal service objectives. ▪ The objective in Individual #223's PT Service Plan, effective date 12/8/10, stated: "[Individual #223] will be provided with ambulation activities in the Arjo walker two days a week to promote functional ability. Range of motion exercises also will be performed three times a week (twice with use of left hand/wrist air splint and one in the whirlpool) to minimize loss of movement and to improve his willingness to participate in daily activities." His PSP, dated 12/08/10, did not integrate this program into formal training objectives and/or informal service objectives. <u>Within 30 days of development of the plan, it is implemented.</u> As stated above, there were plans developed and implemented within the OT/PT Center for five individuals (Individual #213, Individual #377, Individual #296, Individual #232, and Individual #223), but none of these five (0%) individuals' formal PT Programs or one formal OT program were integrated into formal and/or informal PSP Action Plan objectives. <u>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.</u> None of the six individuals (Individual #213, Individual #77, Individual #377, Individual #296, Individual #232, and Individual #223) (0%) with direct and/or indirect OT/PT services had the plans integrated into the PSP. <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> When individuals' status changed, there was not consistent review and/or modifications to plans. This is discussed above, and examples provided with regard to	

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		Section P.1 of the Settlement Agreement. Based on review of OT/PT documentation for six individuals in the sample (Individual #213, Individual #77, Individual #377, Individual #296, Individual #232, and Individual #223), there was evidence in none (0%) of the records that each individual was reviewed at least monthly for OT/PT status. For example: ▪ There were no monthly progress notes submitted by therapist(s) to document justification for the initiation, continuation or discontinuation of OT and/or PT programs. When progress is being made or a lack of progress is noted, therapy progress notes also should discuss the process for implementing change in a person's programs, and a timeframe for re-evaluation should be noted. ▪ Individual #213's PT Program Review Objective Data Sheet(s) were submitted for multiple reporting periods, which documented the areas addressed, sessions documented, tolerance, and behavior. There was a comment section, which documented the reason for a missed therapy session. There were no therapy updates to address progress and/or lack of progress during the reporting period.	
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> Examples are provided above in with regard to Section O.4 of the Settlement Agreement with regard to staff not following PNMPs, which OTs and PTs had recommended. <u>Staff successfully complete general and person-specific competency-based training related to the implementation of OT/PT recommendations.</u> Based on review of individual records, direct support professionals were identified as competent to implement OT/PT interventions and supports as outlined in the PNMPs and other activity plans for none of 16 individuals reviewed (0%). Discussion with regard to Section O.5 provides further information related to the lack of competency-based training.	Noncompliance
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	<u>System exists to routinely evaluate: fit; availability; function; condition and effectiveness of all adaptive equipment/assistive technology.</u> None of the 15 individual records reviewed (Individual #231, Individual #500, Individual #349, Individual #82, Individual #323, Individual #201, Individual #396, Individual #124, Individual #213, Individual #77, Individual #377, Individual #296, Individual #232, Individual #223, and Individual #277) (0%) had an annual comprehensive evaluation/review during the PNMP Clinic to evaluate the fit, availability, function, condition, and effectiveness of all prescribed PNMP adaptive/assistive equipment. The following issues were noted: ▪ Multiple individual PNMP Clinics (for example, Individual #349, Individual #500, Individual #201, and Individual #396) documented the attendance of	Noncompliance

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	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.	four physical therapists. This was not an efficient utilization of therapists' time. Staff in attendance were listed in the attendance column, but there were no signatures to document staff attendance. ▪ Individual #231's OT/PT Evaluation, dated 5/4/10, documented "wedge used to elevate her head/upper body when in bed due to diagnosis of reflux." Individual #231 did not have her assistive equipment reviewed during a PNMP Clinic. ▪ Individual #500's PNMP Clinic, dated 4/9/10, did not address the fit, availability, function, condition, and effectiveness of her eating equipment, modified positioning blankets, and communication dictionary. ▪ Individual #349's PNMP Clinic, dated 10/8/10, did not address the fit, availability, function, condition, and effectiveness of his gait belt, multiple eating utensils/equipment, communication book, environmental control unit, adaptive TV remove, and communication dictionary. The communication equipment status section stated: "clean and functional," but did not identify the status of his multiple communication devices. ▪ Individual #82's PNMP Clinic, dated 7/16/10, did not address the fit, availability, function, condition, and effectiveness of his gait belt, wedge for bed, helmet, eating utensils/equipment, modified communication booklet for input, and communication dictionary. ▪ Individual #323's OT/PT Annual Evaluation, dated 8/11/10, documented the following assistive equipment: plate/bowl guard-to reduce spillage and promote an upright position; custom insert-for dining chair to promote upright posture when lethargic; and plastic handle infant fork and spoon-to limit bite size to reduce the risk of choking. Individual #323 did not have his assistive equipment reviewed in a PNMP Clinic to address the fit, availability, function, condition, and effectiveness of his eating equipment. It was unclear why Individual #323 was prescribed an infant fork and spoon, because he was an adult. Consideration should be given to his therapists working with a psychologist to develop and implement a formal program to slow his eating pace. The provision of an infant fork and spoon was not an age-appropriate solution to "reduce risk of choking." ▪ Individual #396's PNMP Clinic, dated 2/11/11, did not address the fit, availability, function, condition, and effectiveness of her orthotic shoes, custom orthopedic shoe inserts, Danmar hard shell helmet, gait belt, wheelchair gloves, wedge, and communication dictionary. ▪ Individual #124's PNMP, revised dated 2/1/11, prescribed a custom chair with padded pelvic positioning belt for grooming, Danmar soft shell helmets, gait belt, multiple eating utensils/equipment, and communication dictionary. There was no PNMP Clinic to address the fit, availability, function, condition, and effectiveness of her prescribed equipment.	

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		An Adaptive Equipment Review form, revised 5/13/10, identified the following fields: ▪ Reporting period; ▪ Equipment; ▪ Usage (not used, used part time, used appropriately, used inappropriately); ▪ Condition (in need of repair, good); ▪ Fit (fits properly, does not fit properly, and not applicable); ▪ Function (working well, problems noted-notify OT/PT, not working properly-notify OT or PT); and ▪ Skin condition (no problem, red area, open area, reported, and not applicable). The content of the Adaptive Equipment Review form should be considered for use in the PNMP Clinic. Procedures for Delivery of Sensory Equipment at ABSSLC, undated, documented the following: ▪ After completing an evaluation or OT update, the OT must hand deliver all new sensory equipment to either the Home Program Tech or the PNMP Coordinator. ▪ If the OT is unable to accomplish #1 above, then she must deliver the equipment to the residence personally. ▪ At the time the new sensory equipment is delivered to the residential support staff, a notation shall be made in the residence's communication log. ▪ After making a note in the residence's communication log, the OT, Home Program Tech, or PNMP Coordinator shall immediately initiate an in-service with the staff working with that individual and any other staff in the residence at the time. ▪ Before the residential support staff sign the in-service sheet, they will have verbalized or demonstrated understanding and/or competency with equipment and sensory program. ▪ The in-service should continue until all staff at the residence are competent with the equipment and the sensory program. ▪ When all staff have signed the in-service sheet, the in-service sheet shall be turned in to the OT/PT Administrative Assistant who will file the documents for future reference. The Monitoring Team supports the development of the preceding procedures, but these procedures did not outline the process for ongoing monitoring to ensure ongoing staff competency in the implementation of an individual's sensory program and related equipment. A tracking system for adaptive equipment was submitted that contained a number of important fields. However, the following issues were noted:	

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		▪ There were no policies/procedures developed for the adaptive equipment tracking system. ▪ There were 13 individuals (Individual #387, Individual #213, Individual #163, Individual #65, Individual #438, Individual #227, Individual #81, Individual #455, Individual #337, Individual #168, Individual #140 Individual #189, and Individual #132) identified as receiving sensory programs. For four of the 13 individuals (31%) the rationale for the program was identified in the database. However, based on a list submitted in response to a document request, the number of individuals who received a formal sensory program was only two (Individual #213 and Individual #120). This brought into question the ability of Habilitation Therapies to provide accurate information for supports being provided to individuals. The accuracy of the data tracking system(s) is critical. A tracking system was developed to track the status of work orders for seating systems and adaptive equipment. Although this database included some relevant fields, consideration should be given to contacting CCSSLC Habilitation Therapies to review their more comprehensive database. The following concerns were noted: ▪ The Communicable Disease Report identified Individual #86 as having been diagnosed with pneumonia on 4/15/10. On 9/15/10, Individual #86 was recommended for a new wheelchair with the assignment of Priority 2. At the time of the Monitoring Team's review, the work order remained open. It was unclear why Individual #86 was designated as a Priority 2. ▪ Individual #368 was recommended for padded arm supports on 9/17/10. The priority was ASAP, but the work order remained open. ▪ The tracking system identified multiple work orders as "completed," but the date column was blank. It was unclear how the work order was designated as complete without a definitive delivery date. ▪ On 9/30/10, Individual #1 had an ASAP work order for a lap tray and headrest, which remained open. Individual #1 received enteral nutrition, which placed her at risk of aspiration. It was unclear why an ASAP work order had not been completed in a timely manner. ▪ Individual #33 had an ASAP work order for a wheelchair, dated 10/6/10, which remained open. Individual #33 was enterally nourished which placed her at risk of aspiration. The tracking system did not provide a status update on her new seating system. ▪ Individual #275 had a Priority 2 work order for a new custom wheelchair. She received enteral nutrition and was as risk for aspiration. It was unclear why a Priority 2 was assigned for Individual #275. ▪ Individual #214 had a Priority 3 work order to modify his seating system. Individual #214 received enteral nutrition, and it was unclear why he was assigned a Priority 3 for modification of his seating system.	

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		▪ A document entitled Outstanding ASAP Work Orders, undated, was submitted. This document was not congruent with the Work Order Log submitted based on another document request. For example, Individual #275 had an ASAP work order dated 1/16/09 to modify her wheelchair. The Work Order Log, undated, documented the date of the work order as 11/2/10. Both of these tracking systems identified the work order status as open. As a result, the Monitoring Team did not have confidence in the validity and/or accuracy of the tracking system(s) for seating systems and adaptive equipment. Procedures should be developed for tracking the delivery of wheelchairs and adaptive equipment to address the following: ▪ Re-evaluation of the identification of priority levels for individuals; ▪ Completion of an audit to determine compliance with established timelines; and ▪ Provision for the resolution and/or adequate justification for timelines that were exceeded. <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> Systemic issues related to monitoring are discussed above with regard to Section O.6 of the Settlement Agreement. <u>On a regular basis, all staff are monitored for their continued competence in implementing the OT/PT programs.</u> Systemic issues related to monitoring are discussed above with regard to Section O.6 of the Settlement Agreement. <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 (as discussed further with regard to Section O.5 of the SA)</u>. Systemic and individual-specific issues related to training staff are discussed above with regard to Section O.5 of the Settlement Agreement. <u>Responses to monitoring findings are clearly documented from identification to resolution of any issues identified (as discussed further with regard to Section O.4 of the SA).</u> Systemic and individual-specific issues related to monitoring are discussed above with regard to Section O.6 of the Settlement Agreement <u>Safeguards are provided to ensure each individual has appropriate adaptive equipment</u>	

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		and assistive technology supports immediately available. As discussed above, adequate safeguards were not in place to ensure each individual had appropriate adaptive and assistive technology supports. Person-specific monitoring is conducted that focuses on plan effectiveness and how the plan addresses the identified needs (as discussed further with regard to Section O.5 of the SA). As is discussed above with regard to Section O.5 of the Settlement Agreement, adequate training and monitoring of staff on person-specific plans was not being completed. Data collection method is validated by the program's author(s). For none of the five individuals (0%) did the PT Program Review Objective Data Sheet(s) have the data collection method validated by the program's author (Physical Therapist).	

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

1. Facility Administration, in collaboration with the Habilitation Therapies Department, should complete an analysis of OT and PT caseloads to ensure therapists become active participants of individuals' PSTs. As appropriate, based on information gained from the analysis, realignment of positions should be considered to support reasonable OT/PT staff-to-individual(s) caseloads.
2. The following guidance should be integrated into the OT/PT Evaluation template:
    a. Assessment process should be sufficiently discreet to identity an individual's functional skills, interests, and preferences via observation and clinical assessment;
    b. Assessment data should be analyzed to identify an individual's strengths, abilities, and potentials for skill acquisition; and
    c. Analysis of findings to provide a rationale for functional recommendations and intervention strategies.
    d. Recommendations should be integrated into an individual's PSP;
    e. Documentation should be present to justify initiation, continuation, or discontinuation of direct and/or indirect therapy supports; and
    f. A process should be delineated for implementing change in an individual's supports when progress is made or a lack of progress. The lack of progress would identify a re-evaluation timeframe.
3. The Facility should develop and implement audit protocols to ensure OT/PT Evaluations follow established guidelines as outlined in the OT/PT evaluation template.
4. Procedures should be developed and implemented to define the update process to be followed when an individual experiences a change in status.
5. The content of the Adaptive Equipment Review form should be considered for use in the PNMP Clinic.
6. Procedures should be developed for tracking the delivery of wheelchairs and adaptive equipment to address the following:
    a. Re-evaluation of the identification of priority levels for individuals;
    b. Completion of an audit to determine compliance with established timelines; and
    c. Provision for the resolution and/or adequate justification for timelines that were exceeded.
7. Guidelines for the PNMP Clinic should be developed and implemented to ensure at least the following:
    a. Therapist's signatures document their PNMP Clinic attendance;

b. All PNMP prescribed assistive equipment will be assessed on an annual basis for fit, availability, function, condition and effectiveness;
c. A documentation process is established for resolution of problems with fit, availability, function, and condition of prescribed equipment; and
d. Criteria are identified to determine assignment of the priority levels with which wheelchair mat assessments are completed.

The following are offered as additional suggestions to the State and Facility:

1. With regard to the OT/PT Evaluation template, consideration should be given to a discussion/summary of OT/PT consultations completed.
2. Although ABSSLC's equipment and work order database included some relevant fields, consideration should be given to contacting CCSSLC Habilitation Therapies to review their more comprehensive database.

SECTION Q: Dental Services	
	Steps Taken to Assess Compliance: The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o ABSSLC Dental office staff listing; o ABSSLC Abbreviations for Dental use, undated (TX-AB-1102-XIV.6); o SSLC Policy: Dental Services Policy Number 015, dated 8/17/10; o ABSSLC Dental Policy and Procedures, dated 1/5/11 (TX-AB-1102-XIV.1); o For the past six months, minutes from the dental peer review committee (TX-AB-1102-XIV.2); o ABSSLC Admission tracking Worksheet Dental (TX-AB-1102-XIV.3a); o For those completing annual exams in the last six months, oral hygiene rating in each exam listed per individual and date of exam (TX-AB-1102-XIV.31a); o The most recent /current Facility oral hygiene data (Percent Good, Fair, Poor Ratings), 2010 (TX-AB-1102-XIV.37); o Not seen in one year and reasons why with days over and within exam month (TX-AB-1102-XIV.10); o List of annual assessments completed in last six months, and the date of previous annual assessment (TX-AB-1102-XIV.35); o Copy of annual dental assessments completed in last 30 days and for the prior year of these same individuals (TX-AB-1102-XIV.34); o Copy of annual dental summary provided for the PSP, most recent summaries for 10% of individuals (TX-AB-1102-XIV.36); o ABSSLC X-rays needed and scheduled (2011): List of those who have outstanding need for dental x-rays according to the current professional standards and type of x-ray that is needed to fulfill requirements/recommendations (TX-AB-1102-XIV.11); o Sterident List, generated 1/13/11; o People recommended to use the Sterident system with Plav-Vac toothbrush, revised 1/4/11 (TX-AB-1102-XIV.32); o For emergency exams, integrated progress notes from start of emergency to closure, and copy of Dental Department evaluation and treatment (TX-AB-1102-XIV.17) for the following: Individual #12, Individual #478, Individual #442, Individual #310, Individual #476, Individual #243, Individual #530, Individual #504, Individual #409, Individual #153, Individual #159, and Individual #149; o For any extraction in past six months, copy of initial evaluation for this, second opinion, and subsequent documentation until closure on following: Individual #12, Individual #6, Individual #15, Individual #471, Individual #319, Individual #241, Individual #424, Individual #310, Individual #159, Individual #476, Individual #504, Individual #387, Individual #282, Individual #136, and Individual #526; o List of individuals who for the last six months have been seen for dental emergencies (TX-AB-1102-XIV.3e); o ABSSLC Extractions July through December 2010 (TX-AB-1101-XIV.3d);

	o ABSSLC Restorations July through December 2010 (TX-AB-1102-XIV.3g); o ABSSLC Annual Exams for past six months (TX-AB-1102-XIV.3h); o Appointment schedule for those undergoing general anesthesia/conscious sedation (TX-AB-1102-XIV.18); o ABSSLC per month percentage of general anesthesia for dental visits 2010 (TX-AB-1102-XIV.27); o For six individuals undergoing general anesthesia/conscious sedation, complete copy of dental record from start of concern to closure, including copy of any operative reports, copy of any monitoring tapes, consents, second opinions, consultation reports, pre-operative checklist or evaluation, and post-operative checklist or monitoring forms, etc. for: Individual #526, Individual #168, Individual #276, Individual #387, Individual #178, and Individual #451 (TX-AB-XIV.19); o Most recent twenty dental pre-treatment assessments, or 10% of individuals, whichever is greater for the following: Individual #427 on 11/19/10, Individual #242 on 10/29/10, Individual #140 on 8/31/10, Individual #307 on 9/13/10, Individual #303 on 1/13/11, Individual #303 on 1/4/11, Individual #387 on 1/6/11, Individual #440 on 8/24/10, Individual #318 on 10/19/10, Individual #318 on 11/15/10, Individual #198 on 8/23/10, Individual #469 on 8/23/10, Individual #469 on 9/15/10. Individual #469 on 9/24/10, Individual #271 on 8/23/10, Individual #527 on 11/2/10, Individual #276 on 12/2/10, Individual #363 on 11/10/10, Individual #104 on 11/3/10, Individual #69 on 9/10/10, Individual #69 on 12/30/10, Individual #455 on 1/11/11, and Individual #178 on 12/31/10 (TX-AB-1102-XIV.23); o For 10 individuals given pre treatment sedation, copies of progress notes from record and dental office from start of sedation to release from monitoring (include pre-treatment sedation sheets) for following: Individual #303 on 1/13/11, Individual #303 on 1/4/11, Individual #274 on 7/22/10, Individual #387 on 1/6/11 to 1/7/11, Individual #455 on 1/11/11, Individual #486 on 1/14/11, Individual #69 on 12/30/10, dental notes 2/2010 through 9/10/10, Individual #168 on 12/3/10, Individual #178 on 12/31/10, Individual #276 on 12/2/10, and Individual #198 on 8/23/10 (TX-AB-1102-XIV.24); o Copy of any oral surgery consultations and progress notes for the past six months for following: Individual #451, Individual #12, Individual #15, Individual #136, Individual #471, Individual #526, Individual #504, Individual #387, Individual #476, Individual #159, Individual #282, Individual #319, Individual #139, Individual #424, Individual #310, Individual #241, and Individual #6 (TX-AB-1102-XIV.5); o List of individuals who within the last six months have had preventive dental care: ABSSLC Preventative Care July to December 2010 unduplicated, and July to December 2010 duplicated (TX-AB-1102-XIV.3f); o For each individual undergoing preventive/prophylactic exams not categorized elsewhere as part of annual or other routine exam (no duplicates), indicate if prophylactic visit (cleaning) and annual were done at same time, or if there was more than one reason for any visit (TX-AB-1102-XIV.20); o Most recent comprehensive exams for 10 individuals: copy of dental record of visit and

	copy of record of same visit (TX-AB-1102-XIV.4); o List of no shows/missed appointments per building per month for the last six months, July to December 2010 (TX-AB-1102-XIV.13); o List of individuals who have refused dental services within past six months (TX-AB-1102-XIV.3b); o List of individuals who have missed dental appointments within past six months: ABSSLC Attendance Tracking Worksheet July 2010 to December 2010 (TX-AB-1101-XIV.3c); o List of refusals per building per month for the last six months, July 2010 to December 2010 (TX-AB-1102-XIV.14); o List of refusals for past six months per date of refusal (TX-AB-1102-XIV.9); o List of other reasons for missed appointment by date for six months July to December 2010 (TX-AB-1102-XIV.12); o List of interventions per individual for missed appointments (follow up appointment scheduled, whether follow up completed, any correspondence to QMRP, residence manager, team, etc.): "Missed Dental Appointment" Forms, PSP Addendums for Individual #26, Individual #122, Individual #424, email correspondence from Dental Department, memos concerning missed appointments for individuals sent to supervisors, dated 12/3/10, completed Missed Dental Appointment forms, dated 8/10/10 to 12/27/10 (TX-AB-1102-XIV.15); o QMRP, IDT minutes that review, assess, develop and implement strategies for dental visit refusals, and no shows last six months for following: Individual #267, including 10/19/10 PSP addendum; Individual #451, including 12/17/10 PSP addendum; Individual #390, including 12/7/10 Review of Rights Restrictions; Individual #307, including 10/21/10 PSP addendum; and Individual #509, including 10/21/10 PSP addendum (TX-AB-1102-XIV.16); o For the past six months, any data summaries used by the Facility related to dental services, and/or quality assurance/enhancements reports, including subsequent corrective action plans: Dental Daily Log July 1, 2010 through 12/31/10, tracking of restorations and extractions 2010 graph, percent missed dental appointments 2010 graph, missed dental appointments by type 2010 (refusals/non-refusals), dental restraint by residence 2010, dental areas of interest 2010 by residence (desensitization plan, updated Oral Health training plans, vacuum tooth brushing, general anesthesia), missed dental appointments by residence 2010 (TX-AB-102-XIV.7); o ABSSLC per month percentage of sedation for dental visits 2010 (TX-AB-1102-XIV.28); o Current list of HRC approved dental medical restraint with sedation for referrals reviewed by HRC from 6/1/10 through 12/28/10 (TX-AB-1102-XIV.25); o Current list of HRC approved dental medical restraint with sedation: Restraint and sedation tracking list July 2010 through December 2010 (TX-AB-1102-XIV.26); o For the past six months, copies of any correspondence concerning restraint and sedation use for office visit to QMRP, Team, Psychologist, etc. (TX-AB-1101-XIV.21); o ABSSLC per month percentage of mechanical restraints for dental visits 2010 (TX-AB-1102-XIV.29); and

	○ Dental Desensitization Plans: summary table, and plans for: Individual #104, Individual #307 (TX-AB-1102-XIV.33). ▪ **Interviews with**: ○ Dr. Jerry Griffin, DDS, Dental Director; and ○ Dr. Walter Clendenen, DDS, Staff Dentist.
	Facility Self-Assessment: Section Q of the Settlement Agreement has two components, each with a significant number of independent requirements. The Facility determined that it was not in compliance with Section Q.1, and that is was in compliance with Section Q.2. For both sections, the Dental Director indicated the monitoring tools needed revision. For Section Q.2, the Monitoring Team disagreed with the Facility's compliance rating, because the number of refusals for appointments, although improved from past months, was still an area in need of improvement. The categories of reasons for missed appointments was expanded and entered into the database, and there was increased cooperation in determining the cause of a missed appointment from staff in the residences. This information will be of great value in improving the rate of successful visits. Desensitization remained in its early stages of development, although there was some progress. The Dental Department policy had been revamped to accommodate the changes from the DADS State Office.
	Summary of Monitor's Assessment: The Dental Department now had a full complement of staff. There was a continuing focus on oral hygiene in the residences. Review of several emergency visits indicated a need for the Dental Director to determine ways to hasten closure of acute painful problems. In addition, the Dental Peer Review Committee should develop outcome measures that provide a reasonable estimate of time for closure of various acute dental problems, such as the time from finding a painful carious tooth to restoration with a permanent filling, etc. The Dental Department could use these as quality assurance indicators. Such indicators could be stated as a range, with the parameters/variables affecting the length of time. Considerable effort and creativity had resulted in the development of an intricate and detailed system to identify causes of missed appointments. The refusal rate has dropped by approximately 50%, which is significant, but there was continuing need to improve. Sedation and mechanical restraint use remained a challenge. Ten individuals were selected for the development of desensitization programs, and were in various stages of completion of the development and implementation process. The Dental Department was attending PSTs for individuals with chronic refusals, or needing desensitization plans or other strategies to reduce the need for sedation. Database management remained a challenge. Reduction in the error rate during data entry will be imperative in order to provide accurate data for interpretation of trends. There was the continuing challenge to make the dental forms in the medical record easy to read and interpret.

	There was much challenge ahead in attaining compliance with the Settlement Agreement. However, there had been major steps forward in approaching the goal.

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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, 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.	Since the last Monitoring Team visit, a new full-time dentist had been hired. There were two dental hygienists, two dental assistants, and a clerk. The dental hygienists had alternating schedules in which one was assigned to work in the residences, while the other was in the office setting. Each of the dental hygienists worked approximately half time in the residences. The radiology technician who was very experienced in obtaining quality dental x-rays retired in 2010, and, recently, a replacement had been hired. Before the full-time dentist was hired, there were four months during which temporary dentists were utilized. Subsequently, it was learned the temporary dentists would write orders or requests in the record, but this was not communicated to the clerk or other personnel. The Dental Director had had to review copies of each of these reports or entries to ensure all orders were carried out. The new radiology technician had had to match up x-ray orders with readings that were done, to ensure all orders were carried out. At this point in time, these issues appeared to have been resolved. There was a QA review in which it was stated there was 71% compliance with Section Q.1. However, the Dental Director believed the monitoring tool was flawed, and the tools needed fine tuning to be more accurate in their reflection of actual dental care. Individuals who were newly admitted had had their admission dental evaluations completed. To accomplish this, the Dental Department started scheduling the individuals earlier, beginning approximately three to five days following the date of admission, with several more days to reschedule if there were conflicts in the schedule. The result was full compliance with this aspect of dental care. From 8/10/10 through 12/30/10, there were nine admissions, and all (100%) had completion of an admission dental exam within 30 days. As the Dental Department attempted to demonstrate compliance with the Settlement Agreement, it had developed additional ability to generate data. The hurdle currently was achieving quality data input. The number of errors in data input that had been identified, and the enormous amount of data that was generated were two areas needing attention and assistance from administration. However, much information had been generated that could serve as a baseline for the Dental Department, and from which one could determine progress.	Noncompliance

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		A list of those individual completing an annual exam from 7/1/10 to 1/7/11 (six months plus one week) was submitted, including the date of the dental exam. During this time, 269 individuals completed an annual dental exam. That represented 269 out of 447 individuals, or 60% of the population. Additionally, a document was submitted listing annual assessments completed in the prior six months, as well as the date of the previous annual assessment. This listed 270 annual examinations completed during this time. The date of the prior annual examination was reviewed to ensure the time interval to the current exam did not exceed 365 days. It was determined that 22% were out of compliance with this definition of timely completion. Oral hygiene was measured and recorded yearly at ABSSLC. Oral hygiene scores were submitted for the last annual exams completed during 2010. The levels were recorded for 448 individuals. It was not clear how the oral hygiene rating was determined for those individuals the Dental Department had not seen in over a year. A total of 71.6% were rated as having good oral hygiene. Another 19% were rated as fair, and 9.4% were rated as poor. Data from prior years were not submitted to determine improvement. However, the scores reflected the impact of the dental hygienists focusing on oral hygiene across campus. When dental peer review occurs, it is recommended that the visiting dentist sample the oral health of individuals and compare their ratings with those on record to determine inter-rater reliability and validity of the rating system at ABSSLC. It also would benefit the entire state system if the Dental Peer Review Committee chose the oral hygiene index to be used. In a separate listing, oral hygiene scores were submitted for those who had annual exams during the last six months. There were 270 individuals listed. Of these 69.6% had good oral hygiene, 18.5% had fair oral hygiene, and 11.9% had poor oral hygiene. This showed similar results to the annual information. However, it represented more recent evaluations. The values were too close to determine whether or not there was any statistical difference, or if the slight decreased scores had any clinical importance. It is recommended that oral hygiene scores be determined quarterly and entered into a database, or that the six-month rating system be maintained. The Dental Peer Review Committee should determine the frequency of oral hygiene rating scores. Oral hygiene continued to be a focus of the Dental Department. One dental hygienist was assigned to the residences daily providing teaching and guidance to the direct support professionals in tooth brushing of the individuals. For individuals requiring assistance with tooth brushing, the direct support professionals had responsibility for tooth brushing, and to document any reason for not being able to brush the individual's teeth.	

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		When the Dental Department recorded an oral hygiene score of 0, this indicated that tooth brushing was not being completed. The Dental Department then reviewed the record to determine if the lack of tooth brushing was being recorded, along with the reason. This has led to direct support professionals increasing their documentation of when tooth brushing was not done, along with QMRP review, and contact with the Dental Department. It has led to increased dental office visits, as well as an increased presence of the dental hygienist in the residences in which there had been difficulty with completing tooth brushing. In the document entitled "List of those who have not seen a dentist in one year and reason," there were 21 individuals listed. This was a 95% completion rate. Of these, two individuals were overdue by at least a month. Both delays were recorded as due to sickness. As a different measure of completeness of care, of the 447 individuals, 168 were edentulous. For the 279 individuals with teeth, 40 had not had a dental x-ray completed. Compliance was 239 out of 279 (86%). From July through December 2010, 48 individuals underwent restorative care. From July through December 2010, 285 individuals completed preventive dental care. Of these, many had more than one preventive visit. During this time, these 285 individuals completed 852 preventive dental care visits. From July through December 2010, there were 26 individuals needing emergency care visits. In this same time period there were 21 individuals who underwent an extraction. In comparing the list submitted of extractions with other information submitted, there were some irregularities noted. Individual #159 had an extraction on 10/6/10, but the list recorded it as 10/11/10. Individual #149 had an extraction on 8/25/10, but was not listed. Individual #476 first presented with concerns on 7/13/10 and again on 7/20/10, not 8/10/10. There was variation between the onset of acute symptoms necessitating a first dental visit, and the date of extraction. The range was less than 30 days for 12 out of 21 individuals. For four individuals, the time was 30 to 60 days. For three individuals, the time range was 60 to 90 days, and for two individual, it took over 90 days to complete the extraction. There were many variables, including the number of teeth to be extracted, the type of anesthesia, the consent process, etc. However, if there was significant tooth pain, the Dental Department should provide evidence of expeditious resolution, when at all possible. The Dental Director should review the length of time from date of first symptom to extraction to ensure timely treatment and resolution of the problem. In the document "ABSSLC X-rays Needed and Scheduled," 62 individuals were listed as needing x-rays, including left and right oblique x-rays as a substitute for bitewing x-rays. These were all currently scheduled according to this list, but there was no information as	

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		to whether they had been completed. This represented 62 out of 447 individuals, which was 14% of the population. A number of individuals were identified by the PNMT as at risk for aspiration. Other individuals were identified using additional criteria, including those individuals that could not manage thin liquids, those individuals that could not spit, and those individuals that were unable to brush independently. The resulting roster represented those individuals who required the Sterident system with Plak-Vac toothbrush for safe dental hygiene. The Facility submitted two lists. A 1/4/11 list totaled 135 individuals needing this system of tooth brushing. A list dated 1/13/11 totaled 132 individuals. This represented an aggressive and important step in preventing aspiration during tooth brushing, and required the cooperation of the Dental Department and the PNMT. A number of documents were submitted reflecting emergency dental care. These were reviewed for documentation, timeliness and availability of the Dental Department, and attention to pain and discomfort. The following summarizes these reviews: ▪ On 2/9/10, the dental office saw Individual #12, at which time tooth #3 was noted to have a temporary filling. Due to challenging behavior, he was to be scheduled for general anesthesia for restoration. On 6/9/10, he was seen for an initial evaluation of a dental complaint. There was no direct statement as to the chief complaint, but it could be inferred it was a toothache from the findings on dental exam. Tooth #3 was examined. The temporary filling was removed, and a diagnosis of periapical abscess was made, indicating a need for an extraction. Pain medication was ordered as well as antibiotic. On 7/19/10, he again was seen and x-rays were completed/reviewed. He completed oral surgery on 7/27/10, during which a tooth was extracted. The dentist entered a postoperative note later in the day on 7/27/10. On 7/29/10, the nurse provided documentation about pain control. In summary, on 2/9/10, he was noted to have a temporary filling, and there was the comment that he needed restorative care under general anesthesia. However, there was no documentation to suggest an appointment was made for this. Four months later, he developed an abscess and the tooth was subsequently extracted. No information was provided concerning the delay in obtaining a permanent filling. Once dental pain developed, the Dental Department was responsive, including pain management, control of infection, and subsequent scheduling for extraction. ▪ Individual #12 saw the dentist on 8/6/10 for a painful draining tooth (#30), x-rays were obtained, and referrals were made for endodontic treatment and restorative treatment of tooth #30. On 9/22/10, the next note indicated there was a chronic abscess of tooth #30, and the recommendation was made for extraction. On 12/3/10, an attempt at extraction in the office could not be completed due to the individual's behavior. He underwent oral surgery on	

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		12/7/10, and there was both an operative and a postoperative note documenting recovery from the anesthesia and surgery. On 12/15/10, there was a postoperative note indicating normal healing and no complications. After the visit of 8/6/10, there was no information submitted that indicated the referrals for endodontic treatment and restorative treatment under general anesthesia actually occurred. Although it was recommended he be referred on 8/6/10 for restorative treatment, he later required an extraction in 12/10. Whether or not more timely treatment could have prevented an extraction cannot not be determined. However, it took four months from the finding of his painful tooth to extraction and resolution of the pain. The Dental Department should review the length of time it takes for treatment to be provided to individuals with painful symptoms, and identify system approaches to reducing the time it takes for treatment to be provided. ▪ Individual #478 was sent to the dental office and on examination found to have a dry socket, which was promptly treated. The progress notes did not indicate any prior signs or symptoms. ▪ Individual #442 presented with ulcers to the lower lip, and medication was ordered. No information was submitted reflecting when the symptoms first appeared. ▪ On 7/13/10, Individual #310 was found to have a food impaction causing cratering between tooth #28 and #29. To resolve this, dental work was completed on 7/16/10. However, on 8/16/10, during a prophylactic exam, it was discovered there was something wedged between tooth #28 and #29. The dentist then examined him, and described an "extra dense object may be a rock wedged between teeth." He was to be rescheduled for foreign body removal after the gingiva repaired. The next dental notes did not indicate whether or not this occurred, although he was seen several times. It is not known if the foreign body spontaneously became dislodged, and, if so, if he swallowed it. However, it would have been important to document closure of this problem. ▪ On 7/13/10, Individual #476 was seen for pain in his right ear, and found to have impacted molars with possible infection. It was recommended he have four teeth extracted under general anesthesia. He was prescribed pain medication and an antibiotic. On 7/20/10, he was seen for follow-up, with no discomfort noted. On 8/6/10, he was prescribed further pain medication, because he was agitated that day and would not allow the dentist to examine his teeth. Also, on 8/6/10, there was documentation of contact with a brother for consent. On 8/10/10, a second opinion was documented, which agreed with the recommendation for extraction. On 9/28/10, he underwent surgery under general anesthesia with extraction of four teeth. An operative note was written at that time. There was a post anesthesia post surgery recovery dental note later that day. On 10/1/10, further pain management occurred. For this case, clear	

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		documentation was provided of the chief complaint, findings, pain management, progress in obtaining consent, the second opinion, operative and postoperative care, and pain management. From the initial complaint of pain to extraction, 2.5 months elapsed. Again, the Dental Department should review each of these cases, especially involving toothache, to determine if the time to final treatment could be reduced. This could present challenges given the need for consents, second opinions, and scheduling for general anesthesia, but it is important that it be evaluated and action taken, as appropriate. ▪ Individual #243 had tooth #25 fracture at the gum line with a crown destroyed. A dental evaluation consultation for implant, and crown was recommended. On 10/7/09, there was another entry for the oral surgeon to evaluate the individual for a single tooth implant. There was documentation that a written oral surgery consultation had been completed that day, but none was submitted. In a dental note completed 10/8/09, the process was begun for consent for the procedure and for general anesthesia. There were dental notes on 10/8/09 (a brief entry about "increased coil"), and 11/11/09 (study models taken). There was another consultation note several months later on 7/8/10, indicating some space had been lost for implant restoration #25. On 7/15/10, a dental hygiene note indicated the goal to improve gingival health prior to the next dental procedure. He was seen in the dental clinic on 7/21/10, with complaints of a loose wire, but the exam was normal and wax was recommended to cover the area of concern. It was not clear from the submitted information that the dental implant had occurred. If there was an operative report, it was not included. He was not listed on the operative report roster from August 2010 through January 2011 (July 2010 was not submitted). ▪ On 7/20/10 at 5:30 p.m., Individual #530 complained of tooth pain, and was given pain medication. He was seen in the dental clinic the next morning at 9:30 a.m., and after examination was scheduled the next day for restorative work, which was completed 7/22/10. He again was seen on 7/23/10, with a new complaint of pain in another tooth, but there were no findings. He was to return for x-rays. No further information was submitted. ▪ On 8/5/10, Individual #159 developed a toothache, and the Dental Department saw him. An abscess and fistula had formed on tooth #14. Extraction was recommended and antibiotic was prescribed. On 9/14/10, she again was seen, had dental pain, and x-rays were obtained. A second fistula in the mid palate had developed and was draining. On 10/6/10, she underwent extraction of tooth #14. This was accomplished with local anesthesia. She was given pain medication for three days. One-week post op, a note indicated the site was healing well. The reason for the eight-week delay was not recorded, considering the dental pain that occurred. If there were consents that were pending, then there should have been an entry regarding when the consent was mailed and	

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		obtained, or verbally obtained. These several emergency visits indicated a need for the Dental Director to determine ways to hasten closure of acute painful problems. If there are delays in consent process, or obtaining second opinions, or scheduling for general anesthesia, the reasons for the delays should be identified. If there are systems issues needing correction, then actions should be taken to reduce the time individuals wait for needed treatment. The Dental Peer Review Committee should develop outcome measures that provide a reasonable estimate of time for closure of various acute dental problems, such as the time from finding a painful carious tooth to restoration with a permanent filling, etc. The Dental Department could use these as quality assurance indicators. Such indicators could be stated as a range, with the parameters/variables affecting the length of time. According to the Dental Director, there had been increased monitoring instituted when pre-treatment sedation was administered in the residence. This occurred through a policy change in the nursing department, and was followed by in-service training to nurses. Compliance was easy to determine, because the restraint checklist indicated the number of vital signs that were recorded, and this restraint checklist was brought to the Dental Department. However, the new Dental Department policy did not address the pre-office sedation monitoring. It only mentioned that the nurse was to obtain an initial set of vital signs, and initiate the restraint checklist. If the Dental Department intended to increase surveillance to every 15 minutes until the individual was seen in the dental office, then this was not clarified in the dental policy. A number of dental records were submitted that included the nursing notes when the medication was administered for sedation, the completion of the restraint form, and a copy of the anesthesia and clinical record during dental treatment. The following summarizes review of these records: ▪ On 1/13/11, Individual #303 was administered Chloral hydrate, Ativan, and Benadryl, followed by vital signs every 15 minutes for an hour, and then every half hour until the appointment. Unfortunately, despite the sedation, he refused to come to the dental office. It was not clear if he was monitored further in the residence, because he still would require observation until he had recovered from the sedation. ▪ On 1/14/11, Individual #486 received Valium. Vital signs from the residence were not submitted. In the dental office, vital signs were recorded on the monitoring tape. The monitoring tape was a log of blood pressure, pulse and pulse oximetry readings recorded at frequent intervals (often at one-minute intervals, but at times at longer intervals at the discretion of the dentist. ▪ On 7/22/10, Individual #274, age 10, had chloral hydrate at 7:15 a.m. There were no other vital signs submitted until a set of vital signs was taken in the	

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		dental office at 9:00 a.m. It was not clear from the note if the sedation was given by the treatment room nurse or in the residence. The Dental Department could not obtain a monitoring tape, because the medication was not effective. ▪ On 1/7/11, Individual #387, age 14, received Ativan in the dental office. No vital signs were submitted from the residence as a baseline. In the dental office, a serial taping of vital signs was recorded every 30 to 60 seconds. ▪ On 1/11/11, Individual #455, age 13, was administered Halcion in the dental office. Vital signs were taken in the office, followed by monitoring tape recording of vital signs at frequent intervals. Per policy, sedation of minors was to be administered in the dental office, not the residence. It appeared that for two of the three cases reviewed, this policy was followed. However, the administration site of the sedation for Individual #274 was not clear. Sedation in minors should be followed by documentation of whether it was given in the residence, in the treatment room, in the dental office, or other site in order to ensure compliance with the policy. For the sampling of other cases, it was difficult to determine the amount and frequency of monitoring. The submitted documents did not necessarily reflect a set of vital signs at initial administration of the medication, although this appeared to be standard practice. At the other end of the spectrum, on occasion, the recording of frequent vital sign readings followed sedation administered in the residence. All individuals had monitoring tapes in the dental office or attempts at monitoring tapes. For those individuals to whom a sedative was given, but they refused treatment and remained in the residence, there should be close follow-up and vital sign monitoring until the sedative effect resolves. This should be recorded in the IPN section. The dental records of those individuals undergoing oral surgery during the past six months were reviewed. There were a total of 17 individuals' names submitted, including Individual #451, Individual #12, Individual #15, Individual #136, Individual #471, Individual #526, Individual #504, Individual #387, Individual #476, Individual #159, Individual #282, Individual #319, Individual #139, Individual #424, Individual #310, Individual #241, and Individual #6. Individual #12, Individual #451, Individual #310, Individual #424, Individual #159,s and Individual #136 had more than one oral surgery appointment completed. There were two cases in which the surgery occurred at the regional hospital. In one of these cases, involving Individual #15, the surgery occurred on 8/9/10, but from the Dental Department notes, there was no operative report received until 9/15/10. Included in the packet was a pre-operative hospital report, a pre-anesthetic summary, an intraoperative anesthesia record, an intraoperative report, a routine post-anesthesia	

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		care orders sheet, a multiple dental restorations and extractions order sheet, anesthesia pre-operative orders for adult patients over 18 years old having surgery, a post procedure recovery sheet, post anesthesia care recovery day surgery sheet and signed consent. There was no readmission summary of dental care from the Dental Department. The first follow up dental note was 10/13/10. The other case had an operative note and a postoperative Infirmary note. There were 12 cases in which general anesthesia was given at ABSSLC in the Facility's operating room. All had an operative note. In one of these cases, no postoperative Infirmary note/summary was submitted (Individual #282). Expected documentation was present in 11 out of 12, or 92% of the total cases in which general anesthesia was given on campus. Additionally, nine individuals only required local anesthesia as an outpatient in the dental office. Most, if not all, of the operative cases involved dental extractions. It was not clear in all cases, especially those done under local anesthesia as an outpatient, if second opinions were documented. Out of the nine cases requiring local anesthesia for extractions, a second opinion was readily identified in five cases. There should be a simple routine entry for the name and second opinion of the second dentist. This would be automatic for those cases requiring an oral surgeon (the referring dentist and oral surgeon are the two opinions), but it would improve the record of justification for extractions done in the regular dental office.	
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;	On 1/5/11, the Dental Department's Policy and Procedure Manual was revised with the goal of meeting the requirements, focus, and vision of the new DADS State Office dental policy. There was much more focus on integration of dental services into the total care of and other services provided to the individual. It included sections entitled "Dental Professionals Participation in the PST Process," and "Personal Support Plan Attendance." It also reflected the requirement that all original dental records be kept in the individual's file in the residence. Copies of this information were to be kept in the dental office. Also, under the "Quality Assurance" section of the policy, there was a protocol for follow-up on missed appointments, including contacting the residence supervisors for written information with a timeline of expected response. To review compliance with the dental policy that "all original records are kept in a folder on the resident's home" (Quality Assurance Section 9.0 of Dental Policies and Procedures), the most recent comprehensive exams for 10 individuals were submitted, including both copies of the dental records and the copies of the dental reports in the record. In nine of these cases, it directly referred in the record to form #8509 (the dental examination record completed annually or on admission) in the dental record. The 10th	Noncompliance

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	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.	record referenced the annual dental exam, but not where it was located. It was inferred, but did not clearly state that form #8509 was located after the dental tab in the record, and not only available in the dental office. The submitted documents indicated that the annual dental examination record was available for the PSP meeting, suggesting availability in the record. However copies of the contents of information under the dental tab were not submitted for verification that all original records (including form 8509) were in this section. The brief entry in the progress note only made reference to the dental record, and not the dental section of the medical record in the home. When completing form 8509, the dentist should provide more information as to the location in the medical record where it can be found. If it can only be found in the Dental Department, it should state this fact. Further, the annual dental exam was a two-page document designed to minimize handwriting. It required check marks in boxes. The intended audience was those with dental health backgrounds. It is recommended that a one-page summary be placed in the record, which provides in lay terms the important dental findings, as well as dental recommendations (e.g., need for desensitization, review of chronic refusal pattern, etc.). This would allow all PST members to interpret the information and apply it to the PSP. It is also important to ensure that all abbreviations on the Dental Examination Record are defined in a key somewhere on the page, and on any other summary form the Dental Department creates. Additionally, a copy of the dental progress note for dental procedures/periodic routine exams was also available to the PST. The dental hygienist note in the integrated progress notes was changed to a large stamp that only required the completion of details. This made the report legible and required less time to complete. There was much progress in determining the causes of missed appointments. There were 18 categories of reasons for missed appointments identified, and this information was entered into the database. When there was a missed appointment, a written form was sent to the residential supervisors for investigation of the cause. The supervisor was to provide the information with the supervisor's signature to the Dental Department. Compliance with this request improved over time. The Dental Department kept a list of outstanding request forms, and there were a few supervisors who were responsible for the bulk of the unreturned forms. However, there has been significant improvement and cooperation over the past several months. Administration had sent out a notice indicating the Dental Department needed this information. The supervisors also realized that if they responded immediately, the information was easier to provide. The Dental Director should work with his counterpart in residential services or communicate with administration regarding any ongoing unresolved concerns, such as delays or lack of	

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		cooperation. To help with reducing the occurrence of missed appointments, the Dental Department also had begun to remind staff of the appointments. They started calling (or texting) the staff to check the calendar three days ahead of time. Additionally, the Dental Department had begun to attend PSP meetings for individuals with chronic refusal patterns. According to the Dental Director, these efforts had decreased the missed appointment rate from approximately 20%, down to seven or eight percent. The "Attendance Tracking Sheet for Dental Appointments for the past 6 months" was submitted. It documented in detail the information collected for missed dental appointments. Based on their description, many of the causes could then be immediately identified for corrective action. The categories of reasons for missed appointments included: SH- stayed on residence/resident refused dental appointment; RO – resident refused dental appointment at dental office, NOC- not on appointment calendar on residence/clerk did not add dental appointment to calendar, IS –insufficient staff to bring resident to dental appointment, DAC – appointment conflict/clerk failed to notify dental office about conflict, F – furlough off campus/ appointment not rescheduled when dental schedule received, SK – sick, BSSH - at Big Spring State Hospital (temporary placement), FG – forgot appointment, HR - residence on restrictions, PST - appointment cancelled by dental office to attend PST meeting, SCH – in school during appointment time, PSTH – resident to attend PST meeting, SE – staff error/staff stated resident had already been seen that day, DC – appointment cancelled by dental office, AC – appointment conflict, and FNR - missed appointment form not returned. As the months of information were accumulated, additional categories for a missed appointment were created: FL – staff still feeding lunch, SO – staff oversight, AF – at the fair, SC&A –soiled clothing and agitated, WS – came without staff and no records, TP – track practice, SV – stayed on the van /refused to get off, NC – no wheelchair (at orthotics being fixed), FB – fed breakfast (needed to be NPO), and SI – sick in the Infirmary. This "Attendance Tracking Sheet" indicated that the dental schedules were distributed to four residential personnel, including the residence clerk, supervisor, QMRP, and RN. It also indicated that the Dental Department expected any rescheduling to occur the day the schedule was sent out. That there were still missed appointments due to confusion regarding the date or time of an appointment suggested a lack of communication among the four personnel positions in the residence. If this remains a significant issue in any one residence, the next level of residential management should monitor and correct the situation. A folder of documents was submitted reflecting that the Dental Department did	

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		communicate with members of the PSTs for individuals that refused appointments. These documents included memos to the responsible team member requesting a PST meeting be scheduled to include the Dental Department. Additionally, copies of several completed "Missed Dental Appointment" forms were reviewed, spanning the time period between 8/10 to 12/10. The residential supervisors provided a written reason for the missed appointment. This information was then entered into the Dental Department database for further trend analysis. Some data was available for the months provided: July data indicated there were 287 total appointments, of which 43 were missed appointments. This was a missed appointment rate of 15%. In August 2010, there were 266 total appointments, of which 31 were missed. This was a 12% missed appointment rate. In September 2010 there were 287 total appointments, of which 62 were missed appointments. This was a 22% missed appointment rate. In October 2010, there were 259 total appointments, but there were 58 (57 in some listings) missed appointments. This was a missed appointment rate of 22%. In November 2010, there were 254 total appointments, and the tracking form indicated there were 28 missed appointments (there were only 26 missed appointments listed). This was an 11% missed appointment rate. In December 2010, there were 213 total appointments, of which 15 were missed. This was a seven percent missed appointment rate. It was not clear if there was a sustainable trend downward, as January data was not available at the time of the onsite review, but the last two months were showing significant improvement. Separately, data was collected on the number of those appointments considered refusals. In July 2010, there were 18 refusals out of 287 scheduled appointments (refusals = 6%.) In August 2010, there were 19 refusals out of 266 total scheduled appointments (refusals = 7%.). In September 2010, there were 30 refusals out of 287 total appointments (refusals = 10%). In October 2010, there were 40 refusals out of 259 total appointments (refusals = 15%). In November 2010, there were 15 refusals out of 254 total appointments (refusals = 6%). In December 2010, there were eight refusals out of 213 total appointments (refusals = 4%). For those missed appointments that were determined to be refusals, the trend in the last two months of 2010 was promising. Whether this trend will continue will be evaluated with the data collected in the next six months. The percentage of missed appointments due to refusals appeared to vary over time. In July 2010, there were 18 refusals, and 25 (58%) missed appointments for other reasons. In August 2010, there were 19 refusals and 13 (41%) missed appointments for other reasons. For September 2010, there were 30 refusals and 31 (51%) missed	

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		appointments for other reasons. For October 2010, there were 40 refusals and 19 (32%) missed appointments for other reasons. In November 2010, there were 15 refusals and 11 (42%) missed appointments for other reasons. In December 2010, there were eight refusals and seven (47%) missed appointments for other reasons. The refusals were a major contributor to the missed appointments, but tracking the reason for the other missed appointments will also have considerable impact on the potential resolution of 32 to 58% of missed appointments. From "List of refusals for past 6 months per date of refusal," there appeared to be a few individuals who had a pattern of chronic refusal. These included: Individual #539 (refused dental appointments on 6/7/10, 6/9/10, 7/9/10, and 9/21/10), Individual #267 (refused dental appointments on 7/16/10, 7/20/10, 7/22/10, 8/2/10, 8/6/10, 8/20/10, 8/24/10, 9/13/10, 9/21/10, 10/26/10, and 11/10/10), Individual #324 (refused dental appointments on 6/23/10, 8/24/10, 9/27/10, 10/26/10, and 11/1/10), Individual #26 (refused dental appointments on 7/22/10, 8/18/10, 10/26/10, 11/1/10, 12/1/10, and 12/13/10), and Individual #4 (refused dental appointments on 8/18/10, 9/29/10, 10/21/10, and 10/25/10). There were many others with chronic refusal patterns. In some instances, considerable time had passed before the appointment was kept. For example, Individual #324 for whom refusals stretched from 8/24/10 to 11/1/10, presumably keeping an appointment on 11/2/10. This represented delays in needed care, and also caused inefficiencies in the schedule of the dental clinic. For individuals with chronic refusal patterns due to behavioral issues or tactile defensiveness, they should be prioritized for desensitization program assessment, development, and implementation. In response to the information about those individuals with frequent refusal patterns, information was submitted reflecting the QMRP and PST action steps for some of these individuals. For example: ▪ At a PSP addendum meeting on 10/19/10, it was documented that Individual #267 requested a female dentist. There was a decision made to complete her dental work at the regional hospital. The dentist also discussed the need for a desensitization program. ▪ At a PSP Addendum meeting on 12/17/10, the dentist and PST agreed that Individual #451 should be placed on a waiting list as priority for dental desensitization. A further meeting was to be held including the guardian for further decision making on dental treatment. ▪ At a meeting on 12/7/10, for Review of Rights Restrictions for Individual #390, who had three unsuccessful sessions for dental hygiene, the PST decided to use chloral hydrate, to send familiar staff, and to have the psychologist begin to observe residential dental hygiene activities to determine if a desensitization	

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		plan would be beneficial. ▪ At a PSP addendum meeting on 10/21/10 for Individual #307, the PST agreed a desensitization plan should be implemented. It was also determined that this individual did better with morning appointments and with sedation. ▪ At a PSP addendum meeting on 10/21/10 for Individual #509, who required restraints at her last dental visit (the use of restraints was atypical with this individual), the team discussed the need to schedule her early in the morning, and to ensure a quiet environment with only a few people in the area (she did not like music or crowds). With the data collected, the Dental Department was able to determine which buildings had the most refusals, and begin to work with the building staff to reduce these rates, a different and potentially highly effective approach. A list of missed appointments per building was also available. Increased cooperation amongst the Dental and Nursing departments was in part responsible for the improvement in Individual #505's behavior. Although the psychologist often addressed behavioral challenges, the nurse in the residence referred this individual to the dental office to rule out a dental cause for his behavior. When he finally got to the dental clinic, he was given antibiotic for a dental infection, and, eventually, was treated with aggressive restorative care. Since that time he was reported to have reduced behaviors. There was continued use of restraints, sedation, and general anesthesia in the Dental Department. The rate was estimated to be less than three percent of the total population per month, but this translated to approximately 80 individuals on campus. A "Current List of HRC Approved Dental Medical Restraint with Sedation" was submitted. From this list, the following rates and types of restraints were documented for dental procedures: ▪ In July 2010, nine individuals needed restraints. Three chemical/sedation, and two of these may have needed mechanical restraints as well. Six individuals needed mechanical restraints exclusively. ▪ In August 2010, 10 individuals needed restraints. Eight chemical/sedation, and one may have required mechanical restraints as well. Two required mechanical restraints exclusively. ▪ In September 2010, there were 10 individuals that had restraint for dental procedures. Four required sedation, and six required mechanical restraints exclusively. ▪ In October 2010, four individuals had restraint use for dental procedures. Two	

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		required sedation (one with mechanical restraint use also). Two individuals required mechanical restraints exclusively. ▪ In November 2010, there were 16 individuals requiring restraints. This included five requiring sedation (two with additional mechanical restraints), and 11 required mechanical restraints exclusively. ▪ In December 2010, nine individuals required restraints. Five required sedation (three of which required additional mechanical restraints), and four required mechanical restraints exclusively. Of importance, this list tracked whether a sedation plan was in place, the reason for the restraint, the drug and dosage used, the effectiveness of the medication, and the type of dental procedure for which it was ordered. It also indicated in each month's list that the Dental Director reviewed this list. A separate list of those using "mechanical restraints for dental visits" provided different numbers than listed above: July 2010 - three mechanical restraints, August 2010 - two mechanical restraints, September 2010 – one mechanical restraint, October 2010 - one mechanical restraint, November 2010 - one mechanical restraint, and December 2010 - three mechanical restraints. The reasons for the difference in the two lists are not known, but it suggests the need to review the database. A second submitted list "Past 6 months per month percentage of individuals utilizing oral sedation for dental visits" confirmed the oral sedation numbers on the prior list. The percentages provided were based on a denominator of the total population at ABSSLC that month. However, a better estimate of sedation use would be to calculate the number of appointments kept (total appointments minus missed appointments) as the denominator, and it is recommended that future statistics include this percentage. For the total dental appointments kept in August 2010, the denominator would be 266 -31 = 235. The percentage of sedation use in dental appointments for August 2010 was 8/235 = 3.4%. In September 2010, this was 4/225 = 1.8%. October had no total appointment number submitted. In November, the sedation use in dental appointments was 5/226 = 2.2%. In December 2010, the sedation use in dental appointments was 5/198 = 2.5%. However, this second list confirmed that sedation only referred to oral medications received prior to the dental visit. It did not include individuals receiving general anesthesia or IV sedation. A list was submitted entitled "ABSSLC per month percentage of general anesthesia for dental visits, and a footnote indicated that the number provided included both on campus and off campus general anesthesia per month for inhalation general anesthesia only, no IV sedation or Total Intravenous Anesthesia (TIVA). It appeared no IV sedation was given on or off campus, although off campus information	

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		was not available to confirm this for cases referred elsewhere. For the month of August 2010, one individual required general anesthesia. For September 2010, three individuals underwent general anesthesia. In October 2010, three individuals underwent general anesthesia. For November 2010, one individual required general anesthesia. In December 2010, four individuals required general anesthesia. When adding these numbers to those who had oral sedation, more complete percentages of dental visits requiring sedation were tabulated. For these calculations, it was assumed the general anesthesia appointments were included in the total dental appointments kept category, as there was no footnote to indicate general anesthesia appointments were totaled separately. For August 2010, the revised sedation use rate in dental appointments was 9/235 = 3.8%. For September 2010, this sedation rate was revised to 3.1%. From a different roster, it was determined that in October, there were 259 total appointments, of which 19 were missed appointments. For the October 2010 sedation rate, the calculation was 5/240 (for oral sedation + general anesthesia) = 2.1%. For November 2010, this sedation rate was revised to 2.7%, and the December 2010 sedation rate was revised to 4.5%. This information suggested there was no improvement in chemical sedation use for dental procedures during this time period. However, the accurate and complete tracking log for chemical sedation use, including the reason, the dental procedure, and the effectiveness of the sedation, is commendable and should be continued. It should be shared with the PST in determining any reduction in dosage. Further, there might have been reductions in the dosages of some of the oral sedations provided, but these would not be reflected in the data. The data only confirmed whether sedation was provided or not, not potential reductions in dosages administered prior to the dental office visit. It also was not clear if any of the individuals undergoing general anesthesia also required a preoperative oral sedative for that visit, which would again change the statistics slightly. The Dental Department should review all of these considerations. It is recommended that a statistic be calculated each month that includes and corrects for these issues. A separate statistic should be kept for any reduction in dosage of sedation from a prior visit. Additionally, a list of HRC referrals for rights restrictions including sedation plans was submitted for meetings of the HRC from 6/1/10 through 12/28/10. Based on these lists, 11 individuals were approved for dental sedation plans. It was difficult to match these 11 individuals to the completed dental sedation plans listed above. Presumably, the majority of the chemical and mechanical restraints were approved prior to 6/1/10. The Dental Department sent the psychology department a list of 30 individuals needing desensitization programming. Of these, the psychologist chose 10 for a desensitization	

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		program. A list of 11 individuals was submitted, indicating they were in various stages of desensitization plan development. A PST meeting was held for each of these individuals, with dates ranging from 10/21/10 to 1/11/11. One, Individual #312, had no PST meeting date entered. All but one, Individual #455, had had an assessment date listed. One other was in process, but two assessment dates were listed. The plan was completed for one, Individual #307, on 11/14/10. A plan was submitted for Individual #104, but the date begun was listed as "to be determined." It was comprehensive and detailed. There was a "training documentation report" also created for the support staff to document the objective, and success of the training session. Individual #307 had a desensitization program written and implemented on 11/14/10. Many detailed steps were outlined. A copy of the training record was not submitted, if it was developed. Currently, five to six of these had been implemented, a couple of them were in draft stage, and some were currently being assessed through observation in the dental clinic office setting. This was an initiative in the initial stages of development and implementation.	

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

1. The Dental Department should be provided administrative support staff skilled in data entry to minimize data entry errors in the database management system.
2. When dental peer review occurs, the visiting dentist should sample the oral health of individuals and compare their ratings with those on record to determine inter-rater reliability and validity of the rating system at ABSSLC.
3. If this has not already occurred, the State Dental Peer Review Committee should choose one oral hygiene index to be used by all SSLCs. The Dental Peer Review Committee should determine the frequency of oral hygiene rating scores, with consideration being given to either quarterly or semi-annual scoring.
4. The Dental Department should review the length of time from when an individual presents with painful symptoms to the resolution of the pain and/or completion of appropriate dental treatment. As appropriate actions should be taken on both on an individual, as well as systemic level, to minimize the time between the recommendation for treatment to be completed, and the completion of the treatment.
5. A database be developed to track the type of pain medication provided, the number of days the pain medication was prescribed or required by the individual, the number of dental visits until resolution of the cause of the pain, and whether there was a closure exam or closure note indicating the pain had resolved.
6. The Dental Peer Review Committee should develop outcome measures that provide a reasonable estimate of time for closure of various acute dental problems, such as the time from finding a painful carious tooth to restoration with a permanent filling, etc. The Dental Department could use these as quality assurance indicators. Such indicators could be stated as a range, with the parameters/variables affecting the length of time.
7. A more detailed history should be obtained for emergency visits, such as signs and symptoms, and length of time the concern was present.
8. If an individual is seen for a problem, a note indicating resolution of the problem should be entered into the IPN, even if the presenting problem resolved without further follow up in the dental office. When there is no further follow up in the dental office, a mechanism should be in place to verify resolution of the problem. In all cases, there should be a note of closure.
9. If a procedure is recommended and preparations have begun, a closure note should be entered if the treatment is completed, a progress note should be entered if plans change, and periodic notes should be maintained during ongoing treatment over a prolonged time period, as well as to document reasons for delay in finalizing the treatment.

10. For those individuals scheduled for follow up dental exams, x-rays, etc., for a dental problem or to rule out a dental problem, who do not show up for the appointment, there should be a closure note describing the status of the dental problem or potential dental problem. This might require a telephone call or other communication to the residence, if the individual refuses to have the appointment rescheduled.
11. The consent process should be tracked to completion (with each step of the process tracked) for each consent. Delays can then be analyzed to determine to systems improvement approaches for obtaining timely consent completion.
12. If there are delays in care (from refusal patterns or other causes), the reason should be documented in the individual's record.
13. The dental policy should include a statement requiring 15-minute monitoring checks once sedation has been administered, until the individual is seen in the dental office.
14. Sedation in minors should be followed by documentation of whether it was given in the residence, in the treatment room, in the dental office, or other site in order to ensure compliance with the policy.
15. For those individuals to whom a sedative was given, but they refused treatment and remained in the residence, there should be close follow-up and vital sign monitoring until the sedative effect resolves. This should be recorded in the IPN section.
16. The Dental Director should develop a QI tool to measure the completeness of the documentation found in the medical record that reflects care before, during, and after a dental operative procedure.
17. For extractions, second opinions should be obtained that can be easily identified on the record.
18. The Dental Department is encouraged to develop a one-page dental summary written in lay terms, which includes important dental findings and dental recommendations for the PST to act upon (e.g., need for desensitization, review of chronic refusal pattern, etc.).
19. All abbreviations on the Dental Examination Record (and any future form developed) should be defined in a key on that same page.
20. The Dental Department is encouraged to continue to track the reason for all missed appointments.
21. Individuals with chronic refusal patterns due to behavioral issues or tactile defensiveness should be prioritized for desensitization program assessment, development, and implementation.
22. The Dental Department should review the use of restraints, sedation, and general anesthesia in the individuals residing at ABSSLC, and develop and implement a reduction plan for each of these categories.
23. The database for mechanical and chemical restraints for dental care should be reviewed to ensure consistency across the many reports generated.
24. For computing use of oral sedation, the denominator should not be total appointments, but total appointments kept.
25. A statistic should be calculated each month that includes and corrects for a variety of issues surrounding chemical sedation (i.e., general anesthesia, pre-treatment sedation, off campus sedation should be included in the sedation totals; the denominator should be completed visits, etc.).

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 Presentation Book for Section R; o The following documents were requested: SLP Assessment, SLP Progress notes, SLP communication program, communication device instructions, PSP and PSP Addendums, Behavior Support Plan, SLP consultations for the last year, SLP documentation for the last year, and communication dictionary for the following 14 individuals: Individual #280, Individual #92, Individual #455, Individual #274, Individual #160, Individual #63, Individual #83, Individual #409, Individual #377, Individual #284, Individual #185, Individual #287, Individual #510, and Individual #228; o The following documents: SLP Evaluation, PSP, and PNMP with pictures for the following seven individuals: Individual #390, Individual #318, Individual #495, Individual #450, Individual #37, Individual #261, and Individual #143; o Continuing Education completed by SLPs since last visit, undated; o List of current SLP and Audiology Staff, undated; o List of Individuals with Alternative and Augmentative Communication (AAC) and Environmental Control Unit (ECU) Equipment, Spreadsheets, and Monitoring List, dated 1/11; o Communication Master Plan, undated; o AAC Evaluation and Speech-Language Assessment (template), undated; o Five (5) most current AAC and SLP Assessments conducted by each Therapist and corresponding PSPs, 1/10 through 1/11; o Completed Speech Evaluations, dated 1/7/11; o Speech AAC's and ECU's Spreadsheet and Monitoring list (blank), dated 1/11; o Speech AAC's and ECU's Spreadsheet and Monitoring list for Multiple Individuals, dated 12/10 and 1/11; o Analysis of Monitoring of Speech (AAC) Equipment, dated 7/25/10; o List of Individuals receiving Direct Speech Therapy and Service Plans for Speech-Language Pathology, dated 12/09 through 12/10; o List of Individuals with Behavioral Issues and Co-Existing Severe Language Deficits, undated; o List of Individuals with PBSP's with Replacement Behaviors related to Communication, undated; o Speech-Language Pathology-revised policy, undated; o Communication-Master Plan, undated; o Communication Equipment Usage, dated 7/10 through 12/10; o Questionnaire in attempt to remove barriers to equipment usage, dated 9/10 and 10/10; o List of individuals involved in Psychology Integration, dated 1/7/11; and o Registration form for SLP attending Teaching Communication Skills to Children with Autism and other Developmental Disabilities, presented by Vincent J. Carbone, Ed.D.,

	Board Certified Behavior Analysis, February 23 to 25, 2011. ▪ **Interviews with**: o Glen Funkey, PT, Director of Habilitation Therapies; o Cheryl Balanay, Lead Speech Language Pathologist, MA, CCC/SLP; o David Feemster, MA, CCC/SLP; and o Debbie Sessions, MS, CCC/SLP. ▪ **Observations of**: o Individual #280, Individual #92, Individual #274, Individual #63, Individual #409, Individual #377, Individual #185, and Individual #287; o Activity Center 6340; o Vocational Services 680 and 662; and o Residences 6460, 6450, 5961, 5962, 6480, 6521, 6510, 5972, 5971, and 6380.
	Facility Self-Assessment: ABSSLC Plan of Improvement, updated 1/31/11, provided comments/status for Section R. Compliance for each of these sections was documented as noncompliance. This was consistent with the Monitoring Team's findings. This document also provided a summary of some of the action plans on which the Facility was working to achieve compliance. In addition to the POI the Facility submitted, the Habilitation Therapies Department provided additional information, including: ▪ ABSSLC Plan of Improvement, updated 1/31/11, which addressed the status of recommendations. This form addressed the status of the following recommendations: R.2, R.3, R.4, R.6, and R.7. ▪ ABSSLC POI, undated, offered the status of the draft Monitoring Tool for Section R. These documents should be merged to present a cohesive compliance document. In addition to providing some narrative descriptions of actions the Facility had or was taking to move towards compliance, the Facility included some data from its self-assessment reviews. This was an important step. However, it was not always clear specifically to what the data referred, making it difficult to determine if the Facility had accurately identified areas in which focused attention was needed to address the concerns that were keeping it from reaching compliance. For example, Section R.3 includes multiple requirements related to the development of speech/communication plans into individuals' PSPs, and the implementation of the plans. However, the POI stated: "1/2011--Current monitoring results: 77% compliance from 86 reviews since 9/2010." The score appeared to be an overall score, which did not assist in providing direction for next steps, and likely could not have been calculated accurately given the monitoring tools being used. As the Facility moves forward in its self-assessment process, it will be important to ensure that data is used in meaningful ways to assist in identifying areas in which improvements are needed. Moreover, the completed monitoring review tool submitted did not indicate how compliance findings were derived. The monitoring tool did not provide a defined methodology and/or instructions for the use of the audit forms. No evidence was submitted to document that inter-rater reliability had been established with

	multiple reviewers completing the audit forms. Individual indicators were assigned substantial compliance without documentation to support the findings of compliance and/or non-compliance ratings for the various provisions of Section P. For example, Section P.1.A.4 stated: "100% of records reviewed show that all individuals receive a comprehensive integrated Occupational Therapy/Physical Therapy Assessment upon admission." This indicator documented substantial compliance with no comment.
	Summary of Monitor's Assessment: ABSSLC had made progress in increasing the number of full-time Speech Language Pathologists positions to five. A sixth SLP was slated to begin employment in June 2011, upon completion of his Master's degree. Based on the Monitoring Team's review, the current staffing ratio of approximately one SLP for 89 individuals was not sufficient to allow compliance with the Settlement Agreement. SLP staff had completed an analysis of the staffing needs of the department. The Facility is encouraged to address the results of this analysis. SLPs were completing evaluations that did not recommend direct and/or indirect therapy for individuals who presented with the strengths, potentials, and abilities for functional communication. There were insufficient SLP resources present during the past six months to provide direct and/or indirect speech therapy supports for individuals with an identified need. The goal for an individual with an augmentative/alternative device should be to provide the supports necessary for multiple, intense opportunities for learning (formal and informal) to successfully utilize the device in a variety of natural environments. The integration of functional communication recommendations on a formal and/or informal basis within an individual's PSP and multiple environments is necessary to ensure a device becomes an integral part of how an individual communicates on a daily basis. This was not occurring at ABSSLC. The Monitoring Team commends the Speech Language Department for the revision and ongoing implementation of monitoring individual communication equipment, but the percentage of usage of individual communication devices continued to be disappointing. Working in conjunction with the Quality Assurance Department, the Speech Language Department had developed an action plan to further analyze the barriers to individuals' regular use of communication devices, and to begin to overcome some of these issues. Facility Administration, in collaboration with the SLPs, should continue to problem-solve and identify solutions to significantly increase staff compliance with utilization of individual communication systems.

#	Provision	Assessment of Status	Compliance
R1	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	<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> ABSSLC had made progress in increasing the number of full-time Speech Language Pathologists (SLPs) positions to five. A sixth SLP was slated to begin employment in June 2011, upon completion of his Master's degree. There were seven budgeted SLP positions.	Noncompliance

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>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>The staff-to-individual ratio document revealed that seven SLPs were employed, which was not congruent with the documentation submitted from Speech and Language Department or the Monitoring Team's observations. If the Speech Language Assistant (SLA) was included in this ratio, it would not be accurate, because a Speech Language Assistant is not licensed to perform speech language evaluations. This position should not be reflected in the ratio. The following chart shows the status and caseloads of the SLPs, Speech Language Assistant, and a contract with an Audiologist:

<table>
<tr><th>Current SLPs and SLA</th><th>Current Caseloads and Other Responsibilities</th></tr>
<tr><td>SLP #1</td><td>SLP/Audiology Department Head, Supported 48 individuals</td></tr>
<tr><td>SLP #2</td><td>Responsible for Engagement/Integration Project, Supported 100 individuals</td></tr>
<tr><td>SLP #3</td><td>PNMT I Member, Supported 120 individuals</td></tr>
<tr><td>SLP #4</td><td>PNMT II Member, Supported 97 individuals</td></tr>
<tr><td>SLP #5</td><td>Hired on 11/16/10, Supported 88 individuals</td></tr>
<tr><td>SLA #1</td><td>Did not have an assigned caseload</td></tr>
<tr><td colspan="2">Audiologist</td></tr>
<tr><td>Audiologist</td><td>One Audiologist on contract providing 18 to 30 hours per month</td></tr>
</table>

Reportedly, recruitment strategies for an Audiologist had continued from 8/08 to the present without success in hiring and retaining a full-time Audiologist. Multiple audiologists have applied, but had turned down the position primarily related to the low salary.

The licenses of the five full-time SLPs were current for practice in the state of Texas.

The current staff-to-individual ratio list, undated, indicated the ABSSLC ratio for SLPs was 1:74, which did not appear to be accurate. The current staff-to-individual ratio with five SLPs on staff would 1:89. The psychology staff-to-individual ratio required by the Settlement Agreement was 1:30. SLPs had similar duties with regard to assessment, planning, monitoring, and provision of direct supports and/or oversight, but their caseloads were significantly higher which was impacting their ability to comply with Section R.

The Lead SLP and staff had continued the process of analyzing the current staffing needs of SLPs through the identification of required work tasks and the correspondent time needed to complete these tasks. The Analysis of SLP Staffing Needs at ABSSLC, dated</td><td></td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		1/10/11, identified multiple tasks to be completed, number of individuals living at ABSSLC, number of residences, number of hours, weeks/times done per year and total hours to complete identified tasks. This analysis calculated the number of SLPs needed as 10 SLPs with full caseloads, not including department head, licensed speech language assistant, and dedicated PNMT member. This was a positive initiative and should lead to the development of a realistic caseload for speech language pathologists to support compliance with the Settlement Agreement. Although related to schools, the following statement from American Speech and Hearing Association (ASHA) recommended that SLP caseloads not exceed 40 individuals to enable SLPs to provide appropriate services: "...in order to provide balance between the amount of time available for appropriate services and the amount of time needed to complete other required responsibilities, it is recommended that the maximum caseload size should not exceed 40 students, regardless of the type or number of service delivery models selected. Special populations and circumstances will dictate even fewer students on the caseload, since certain types of services and students are more time-intensive than others." (From ASHA's "Guidelines for Caseload Size and Speech-Language Service Delivery in the Schools") The following chart documents SLP and SLA attendance for continuing education courses:	

Continuing Education	SLP	SLA
Becoming a Love and Logic Parent (1/23/10)	1 SLP	
Texas Speech Hearing Association Annual Conference (3/10)	1 SLP	
Autism Extravaganza: Featuring Temple Grandin (3/9/10)	4 SLPs	1 SLA
Issues in Nutritional Management (7/7/10)	1 SLP	1 SLA
PNMP and Wheelchair Clinic Webinar (7/7/10)	1 SLP	
PNMT Risk/Development of Interventions (7/9/10)		
VitalStim Therapy Provider-Pediatric Focus	1 SLP	
Pediatric Dysphagia-Management of the Whole Child (8/13/10)	2 SLPs	
Issues in Evaluation and Treatment of Individuals with Developmental Disabilities (9/20/10 through 9/22/10)	3 SLPs	
Food-Medication Interactions (9/23/10)	1 SLP	
MBS: The Clear Picture-Pediatric (9/30/10)	1 SLP	
20th Annual Habilitation Therapies Conference (9/20/10 to 9/21/10)	2 SLPs	1 SLA
Moving Toward Standardizing Dysphagia Practice: Introducing the Modified Barium Swallow Impairment Profile (10/9/10 to 10/10/10)	5 SLPs	
Teaching Children with Developmental Disabilities to Speak (10/21/10 to 10/22/10)	1 SLP	
Issues in Nutritional Managements Part 3 (11/10/10)	2 SLPs	

#	Provision	Assessment of Status	Compliance

Electronic Aids for Daily Living in the Classroom (12/14/10)	1 SLP	1 SLA
Ethical and Effective Speech Pathology Services (12/20/10)	1 SLP	

Five SLPs had been approved to attend "Teaching Communication Skills to Children with Autism and other Developmental Disabilities: 3-day Introduction to Verbal Behavior," presented by Vincent J. Carbone, Ed.D., Board Certified Behavior Analyst, on February 23 through 25, 2011.

The Monitoring Team continues to encourage SLPs having additional opportunities to attend continuing education courses related to augmentative/alternative. The majority of continuing education the Facility's SLPs completed was not in reference to augmentative/alternative communication.

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.

Fourteen individual records were reviewed, including: Individual #280, Individual #92, Individual #455, Individual #274, Individual #160, Individual #63, Individual #83, Individual #409, Individual #377, Individual #284, Individual #185, Individual #287, Individual #510, and Individual #228. Eight individuals in the sample were reported to be receiving direct speech therapy (Individual #280, Individual #92, Individual #455, Individual #274, Individual #160, Individual #63, Individual #83, and Individual #409), and the remaining six individuals were not reported to be receiving direct speech therapy services.

None of the six individuals reported not to be receiving direct speech therapy (Individual #377, Individual #284, Individual #185, Individual #287, Individual #510, and Individual #228) were receiving direct and/or indirect services, but they all were in need of functional communication supports as documented below:

- Individual #284's BSP stated: "If [Individual #284] can learn to tell us when she needs to stop a task, and to express some her wants and needs, this will reduce potential frustration leading to the displace (sic) of her target behaviors." Individual #284's SL Evaluation/Update, dated 1/6/03, stated: "In view of the above clinical impressions, Speech-Language therapy is not indicated as her needs can best be addressed in the context of daily living activities." Individual #284 needed the support of a SLP to assist her in learning effective ways to communicate.
- A recommendation in Individual #185's Speech Language Evaluation Update/Discharge Summary, dated 2/19/10, stated: "In view of the above

#	Provision	Assessment of Status	Compliance
		Clinical Impressions, diagnostic Speech-Language therapy is not longer indicated to introduce and program a more sophisticated computerized speech device." This recommendation was include despite documentation in the discharge summary of additional areas that Individual #185 would benefit from speech services. There was not a clear rationale for the discontinuation of "diagnostic Speech-Language therapy." ▪ Individual #287's BSP identified one of her replacement behaviors as appropriate communication using signs, gestures, or a communication book to communicate her wants or needs with staff. Her SL Evaluation Addendum, dated 1/7/04, stated: "In view of the above clinical impressions, Speech-Language therapy is not indicated as her needs can best be addressed in the context of daily living activities." Individual #287 was in need of functional communication supports, but she had not been evaluated by a SLP in over five years. ▪ Individual #228's SL Evaluation, dated 1/4/11, stated: "[Individual #228] typically communicates through a combination of a few words (cursing when mad), vocalizations, and facial expressions and will propel his wheelchair to person or object." One recommendation was: "In view of above Clinical Impressions, Speech-Language therapy is not indicated as his needs can best be addressed in the context of daily living activities." As documented above, this recommendation consistently appeared in SL evaluations, even though individuals were in need of an individualized functional communication system. Individual #228 had a BSP with the target behaviors of aggressions, self-injurious behavior and sleep disturbance, but did not have an effective way to communicate. ▪ A recommendation in Individual #377's SL Evaluation, dated 8/24/00, was: "In view of above Clinical Impressions, Speech-Language therapy is not indicated as her needs can best be addressed in the context of daily living activities" although she used a Cheap Talk 4 for clarification/requesting leisure activities and her 4"X4" communication book. Eight of 447 individuals living at ABSSLC (1.8%) were receiving direct speech therapy. Eight of the fourteen individual records reviewed (Individual #280, Individual #92, Individual #455, Individual #274, Individual #160, Individual #63, Individual #83, and Individual #409) were reported to be receiving direct speech therapy. The SLP service plans for none of the eight individuals' records reviewed (0%) provided measurable functional outcomes. The SLP evaluations did not include an analysis of findings to provide a rationale for individuals receiving direct speech therapy, and/or justification for individual recommendation(s). In addition, quarterly documentation submitted did not justify the initiation, continuation or discontinuation of speech therapy supports; when progress was not made, recommendations and/or objectives were not revised; and	

#	Provision	Assessment of Status	Compliance
		there was no analysis to determine the efficacy of the direct therapy supports provided. The following issues were noted: ▪ Individual #280 had two SL Evaluations, dated 1/26/11 and 1/27/11 respectively. It was unclear why two SL evaluations had been completed. The SL Evaluation, dated 1/27/11, had the following recommendation: "In view of the above clinical impressions, continued speech language therapy is indicated to maximize and continue to develop use of his communication book and hand held commuter voice device." The SLP Service Plan Revision, dated 2/1/11, stated: "[Individual #280] will receive direct and indirect speech-language activities to improve and maintain his communication system," but the revision did not document the purpose of the revision. The revision strategy stated: "[Individual #280] will continue to receive ongoing speech-language consulting at least once per week to help him to acquire and maintain skills in use of his hand held computerized Say-It-Sam communication devices and his picture communication system during daily activities. In addition, the therapist will be working with other department to script his use of the new Say-It-Sam handheld device in certain situations. These activities will allow him to communicate basic information to others. Practice will help him become skilled at accessing increasing vocabulary appropriately." The recommendation and SLP service plan was not supported by a measurable, functional outcome. Progress notes were submitted for the following time periods: 11/09 to 2/10, 2/10/ to 5/10, 5/10 to 8/10, and 8/10 to 11/10. The progress notes, primarily consisting of check boxes, documented attendance and participation, benefit, and continue plan, discharge and/or other, but did not provide clinical data to support individual progress and/or lack of progress with direct therapy. The progress notes provided updates such as: "We continue to add items to his hand held Say-It-Sam device. He is not very motivated to communicate. Most of the time he is cooperative although he does become aggressive periodically." However, these quarterly progress notes did not provide justification for continuation and/or discontinuation of his program. In addition, in the absence of a measurable, functional outcome, the progress notes did not provide objective data to support progress and/or lack of progress. The Monitoring Team observed Individual #280 in the workshop, and he was not able to communicate with his device. His staff reported that they felt the device was too complex for him. ▪ Individual #92's SLP Service Plan, dated 5/4/10, stated [Individual #92] will receive speech-language activities once a week for 30-60 minutes to refine her skills in accessing her augmentative communication systems, increasing vocabulary and usage. This is in addition to her have (sic) her equipment at her home." This did not reflect a measurable, functional outcome. Quarterly progress notes were submitted for the following time periods: 11/12/09 to 2/11/10; 2/12/10 to 5/3/10; 5/4/10 to 8/3/10; 8/4/10 to 11/3/10; and	

#	Provision	Assessment of Status	Compliance
		11/4/10 to 2/3/11. Generally accepted clinical practice, at a minimum, supports monthly progress notes to justify the initiation, continuation and/or discontinuation of direct SLP therapy. These progress notes documented attendance as "good," but did not identify how many "speech-language activities" were completed during the quarter. ▪ Individual #455's SLP Service Plan, dated 5/7/10, stated: [Individual #455] will receive speech-language activities once or twice a week to facilitate the development of an augmentative communication system for him to use throughout his daily schedule." Progress notes were submitted for the following time periods: 5/13/10 to 7/26/10; 5/13/10 to 7/26/10; and 10/27/10 to 1/26/11. A consistent comment on all progress notes was: "[Individual #455] usually enjoys coming to the sensory gym and working with the SLP and PT. His use of the PECS to request items is sporadic and some days are better than others." The progress notes did not provide objective data to support progress and/or lack of progress. ▪ Individual #160's SLP Service Plan, dated 3/3/10, service objective stated: "[Individual #160] 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 also focus on [Individual #160] following directions." The service objectives did not support a measurable, functional outcome. It was unclear why speech-language activities did not provide for a formal schedule versus "once or twice a week." ▪ Individual #63's SLP's Service Plan, dated 6/15/10, stated: [Individual #63 will receive speech-language activities at least once a week to refine her skills in accessing her augmentative communication system, increasing vocabulary and usage. This is in addition to her having her equipment at her home." The service plan did not support a measurable, functional outcome. It was unclear why speech-language activities did not provide for a formal schedule versus "once or twice a week."	
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	<u>All individuals in need of AAC are identified as being in need of AAC.</u> None of the six records reviewed (Individual #377, Individual #284, Individual #185, Individual #287, Individual #510, and Individual #228) (0%) indicated individuals identified with severe expressive/receptive language deficits had AAC options investigated, assessed, and if identified as being in need of AAC systems, were provided ongoing support by an SLP to facilitate functional communication. Examples of concerns are provided with regard to Section R.1 of the Settlement Agreement. A Communication Evaluation Master Plan had been developed and prioritized individuals for evaluation as follows:	Noncompliance

#	Provision	Assessment of Status	Compliance
	involving behavioral supports or interventions.	▪ Priority 1 (Evaluate within 30 days) o New admissions; and o Consultations. ▪ Priority 2 (Evaluate yearly) o Individuals who have expressive communication devices as a primary need; o BSP high flyers (individuals who do not communicate verbally, with BSP for aggression/SIB or have low frequency/low severity behaviors may be placed as Priority 3); o School age individuals; and o Individuals in therapy. ▪ Priority 3 (Evaluate every three years) o Individuals who have input communication device; o Individuals who have clarification AAC who are functionally verbal; o Individuals who have environmental control switches/equipment only; and o Individuals with BSP who have limited verbal skills. ▪ Priority 4 o Everyone else will be re-evaluated as indicated by change or referral. The prioritization categories and timelines included in the Master Communication Plan should be re-evaluated. For example: ▪ Type of SLP consultations should be prioritized, and not all consultations should be assigned a Priority 1. The completion of multiple consultations could entail significant time and negatively impact SLPs ability to address individuals with significant functional communication needs. ▪ Priority 1 should include individuals with a BSP who do not communicate verbally. ▪ Priority 2 should include individuals with a BSP who communicate verbally, but have difficulty in being understood. Priority 3 identified "individuals with a BSP who have limited verbal skills," but these individuals have a significant need for a functional communication system and should be evaluated sooner, not later. ▪ The timelines assigned to the priority levels should be reconsidered. They did not present an aggressive schedule for the completion of individual evaluations, followed by the development and implementation of a functional communication system. The following fields were on the Communication Master Plan SLP Evaluation Tracking: name, case number, residence, date of birth, admissions date, priority number, PSP date, last full evaluation, due again, and therapist. The tracking form did not identify a proposed evaluation date according to the new prioritization levels. The Speech Language/Audiology Department should determine each individual's due date, and	

#	Provision	Assessment of Status	Compliance
		analyze them to ensure completion of evaluations do not exceed the Settlement Agreement requirement that all individuals are assessed within three years of the Settlement Agreement Effective Date. The Facility Speech-Language Pathology policy was revised to include the following: ▪ An additional Screening Process for individuals who have a BSP was added. Each person with a BSP will be reviewed yearly for integration of identified SLP information and associated communication needs via their Behavior Support Committee (BSC) meeting. The SLP will collaborate with the psychologist to integrate communication supports. ▪ Every individual on campus had a Communication Dictionary (CD). Their BSP and SLP evaluations were reviewed and the CD was updated by the SLP prior to their PSP. Additionally, team members reviewed the CD at the time of the PSP for make further additions/changes. Updates to the CD could be made by the SLP in the interim. The SLP printed and distributed the CD. Updates could also be added during the year. ▪ Based on recommendations from a licensed SLP, an individual could undergo a diagnostic period for AAC or other speech-language diagnostics for four to 10 sessions. This period could be extended. At the end of the diagnostic training period, the SLP and the PST would determine if further services were warranted. If continued services were indicated, the individual would be admitted to formal training, and an objective or Service Plan would be written. If training was not indicated, the individual would be discharged, and a SL evaluation or addendum would be submitted. Consideration should be given to integrating the following information/guidelines in the Facility Speech Language policy: ▪ The policy should define how the SLP should document collaboration with the Psychologist on individuals' BSPs. ▪ The policy should define how the therapist should document the diagnostic period, including, at a minimum, the following: speech language evaluation should provide an analysis of team's findings, including a rationale for diagnostic period; development of a measurable, functional outcome to be achieved during the diagnostic training period; and documentation providing objective data to justify continuation and/or discontinuation of diagnostic training period, and/or a recommendation for continuation of services. <u>All people have received a communication screening or assessment within 30 days of admission, readmission or change in status.</u> Since the previous review, there were nine new admissions to ABSSLC. Records for seven of these individuals were requested, including Individual #390, Individual #318,	

#	Provision	Assessment of Status	Compliance
		Individual #495, Individual #450, Individual #37, Individual #261, and Individual #143. Seven of seven individuals (100%) received a SL evaluation within 30 days of admission. The admission evaluations were not signed and dated by respective Speech Language Pathologist. Based on staff report, four SL evaluation formats had been merged into two evaluation formats. One comprehensive format was developed for individuals "unable to express well enough for verbal testing," and the second comprehensive format for individuals who are "higher functioning." A review of these evaluation formats did not show significant differences from one evaluation format to the other. The SL evaluation was to be considered a "living document," which means: ▪ Using the new format, therapists would continue to add changes and updated testing information as time passed; ▪ The new format was a simpler way for QMRPs to retrieve important information, rather than garnering information from four different types of formats; and ▪ Information would show what was found last time compared to current changes or "no changes." The Facility's Speech Department Comprehensive Evaluation Format for individuals unable to express well enough for verbal testing and individuals with higher functioning, undated, included the following: ▪ Reason for referral; ▪ Significant information; ▪ Reports from significant others; ▪ Observation; ▪ Receptive/expressive language; ▪ Augmentative communication; ▪ Articulation, voice, and fluency; ▪ Oral mechanism; ▪ Hearing and vision; ▪ Clinical impressions; ▪ Recommendations; ▪ Communication equipment; ▪ Adapted environmental control equipment; ▪ Language/modality preference; and ▪ Communication/active treatment instructions. The following domains and/or guidance should be incorporated into the SL Evaluation template: ▪ Description of significant health care issues and risk indicators, including	

#	Provision	Assessment of Status	Compliance
		discussion of the impact of health care issues and risk indicators on performance, and current and/or future therapeutic intervention; ▪ Behavioral considerations; ▪ Functional reading skills and literacy; ▪ Assessment process should be sufficiently discreet to identity an individual's functional skills, interest and preferences via observation and clinical assessment; ▪ Assessment data should be analyzed to identify an individual's strengths, abilities, and potentials for skill acquisition; and ▪ Analysis of findings to provide a rationale for functional recommendations and intervention strategies. Additional guidelines to ensure: ▪ Integration of recommendations into an individual's PSP; ▪ Documentation to justify initiation, continuation or discontinuation of direct and/or indirect therapy supports; ▪ Process for implementing change in an individual's supports when progress is made or there is a lack of progress. The lack of progress should identify a re-evaluation timeframe. To ensure SLPs use a consistent approach during the evaluation process, additional guidelines should be developed to supplement the format. Also, to ensure SL Evaluations follow established guidelines, the Facility should develop and implement an audit protocol. In addition, the development of procedures defining the SL update process when an individual experienced a change in status would be beneficial. <u>Programs, goals and objectives related to the acquisition or improvement of speech or language are written by the SLP.</u> In none of eight records reviewed (Individual #280, Individual #92, Individual #455, Individual #274, Individual #160, Individual #63, Individual #83, and Individual #409) (0%), for individuals reported to be receiving direct speech therapy services, were measurable, functional outcomes developed and documented on a monthly basis. Individual examples are provided with regard to Section R.1. Examples of individuals diagnosed with severe language difficulties where AAC was assessed or investigated, but SLP supports were not recommended to provide direct guidance to the PST to integrate an AAC device across all natural environments for the individual also were provided above with regard to Section R.1 of the Settlement Agreement. Individual examples provided regarding Section R.1 illustrated the impact of not having	

#	Provision	Assessment of Status	Compliance
		an adequate number of SLPs to address the functional communication needs of the individuals residing at ABSSLC. SLPs were completing evaluations that did not recommend direct and/or indirect therapy for individuals who presented with the strengths, potentials, and abilities for functional communication. There were insufficient SLP resources present during the past six months to provide direct and/or indirect speech therapy supports for individuals with an identified need. The goal for an individual with an augmentative/alternative device should be to provide the supports necessary for multiple, intense opportunities for learning (formal and informal) to successfully utilize the device in a variety of natural environments. The integration of functional communication recommendations on a formal and/or informal basis within an individual's PSP and multiple environments is necessary to ensure a device becomes an integral part of how an individual communicates on a daily basis. <u>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.</u> None of the eight records reviewed of individuals with BSPs (Individual #280, Individual #455, Individual #274, Individual #160, Individual #510, Individual #228, Individual #287, and Individual #284) (0%) documented collaboration with the psychologist and SLP in the development of the Behavior Support Plans. A document entitled Psychology Integration, updated 2/9/11 documented that a SLP had attended the Behavior Support Committee (BSC) meeting for the following individuals: Individual #280, Individual #274, Individual #160, Individual 510 (added additional signs to BSP), and Individual #287 (met with 6340 Activities Center staff and Psychology to integrate replacement behaviors). However, the individuals' BSPs did not document collaboration with the SLP. <u>Policy exits that outlines assessment schedule and staff responsibilities.</u> The Facility had a policy, but as is recommended in throughout this section, consideration should be given to modifying some of the aspects of this policy. This policy defined the priority level for individuals for the completion of speech language evaluations. As stated with regard to Section R.2, consideration should be given to incorporating additional information in the Facility Speech Language Pathology policy.	
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	For individuals with intellectual disabilities, the use of AAC devices has the ability to change the way an individual is able to communicate their needs in the classroom, home, work and leisure environments, through increasing participation, making choices, and enhancing functional communication skills. Most importantly, when an individual has learned how to use an AAC device to communicate successfully, the perceptions and	Noncompliance

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	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.	stereotypes of a familiar and/or unfamiliar communication partner changes from not believing the individual would be able to communicate to exploring multiple strategies to communicate with an individual. Speech language pathologists must provide sufficient competency-based training and instructional support to staff to provide them with foundational skills and stated competencies to support individuals in the utilization and implementation of individual-specific and generic functional communication devices in multiple natural environments. <u>Rationales and descriptions of interventions regarding use and benefit from AAC are clearly integrated into the PSP.</u> None of the eight records reviewed (Individual #280, Individual #92, Individual #455, Individual #274, Individual #160, Individual #63, Individual #83, and Individual #409) (0%) had a clear rationale and description of communication interventions integrated into the PSP. The Monitoring Team requested PSPs and PSP Addendums for the past year, but these documents were not provided. <u>Communication information is not only present in the PSP, but integrated into the daily schedule.</u> As indicated above, the PSPs of individuals in the sample were not provided as requested. <u>AAC devices are portable and functional in a variety of settings.</u> None of the eight PNMPs reviewed (Individual #280, Individual #92, Individual #455, Individual #274, Individual #160, Individual #63, Individual #83, and Individual #409) (0%) reinforced the use of AAC devices that were portable and functional in a variety of settings (i.e., mealtime, work, leisure, home, community outings). <u>AAC devices are individualized and meaningful to the individual.</u> None of the eight records reviewed (Individual #280, Individual #92, Individual #455, Individual #274, Individual #160, Individual #63, Individual #83, and Individual #409) (0%), for individuals receiving direct speech services clearly, indicated how the direct speech language services would be individualized and/or encouraged the use of speech generating devices beyond the direct speech services sessions to ensure these devices were meaningful and functional for the individual. In addition, none of the eight individual records documented the use of individual communication equipment in their residences. None of the eight records reviewed (0%) had formal communication programs developed with individualized strategies to be implemented by staff to reinforce what was being learned in direct speech therapy related to the individual's AAC device. The absence of formal integration of the AAC communication device in their daily schedules	

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		did not support the AAC devices being functional and meaningful to the individual, and/or provide multiple opportunities to practice the use of their AAC device. <u>Staff are trained in the use of the AAC device.</u> None of the eight individuals' records reviewed (0%) included competency-based staff training documentation. Staff must be able to demonstrate their competency in understanding and operating an AAC system (low tech and high tech), as well as understand how to engage/prompt an individual with the AAC device in multiple environments. Competency-based training should require staff to demonstrate both of these sets of skills. The Speech Language Department had implemented a communication engagement/ integration pilot. The group began meeting in October 2010 to discuss a mission and begin training on Communication Resources and Behavior Therapy Core Competencies This group included Activity Center Staff, BCBA, Psychologist, Psychology Assistant, Speech Language Pathologist, and Campus Active Treatment Coordinator. No documentation was submitted showing competency-based staff training on a set of core competencies. A document entitled "The 6340 Third Street Activity Center Engagement/Integration Pilot Project," dated 1/25/11, identified the following: "Phase One Mission: Offering Choices and Honoring Preferences. ▪ To integrate generic communication resources into activity center programming for people with significant behavioral issues from 6450 Plum and 6460 First Street. These resources should offer people a way to communicate specific choices/preferences of activities and materials. ▪ To offer the same communication resources to everyone who attends the activity center. Resources under development included: object cue mats (used to communicate message using touch or vision, objects attached to the mats represent activities); picture communication cards (multiple cards in each program area used to offer people choices in activities, materials, and colors); put-em-arounds (located by doors and on activity tables these one message devices give people the opportunity to say the name of an activity or communicate a message); and sign language training (activity center staff training on signs began on 1/27/11)." Phase One would end when the generic communication resources were in place. The Monitoring Team was unclear why an Activity Center was chosen to implement the pilot project and not an individual residence. The Communication Equipment Usage data for Residence 6450 revealed zero compliance with individual communication equipment usage for the months of July, August, September, November, December 2010, and January	

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		2011. The month of October documented a 50% compliance rating. Residence 6460's communication equipment usage compliance rating was 0% for July and August, and 33% for September, October, November, December 2010 and January 2011. As stated below with regard to Section R.4, monitoring documentation completed in the residences revealed a low level of staff compliance and engagement. The poor monitoring results suggested the need to designate a residence as the location for the initiation of the pilot project. In addition, the focus of the current project was on generic devices as opposed to individual communication equipment usage. Consideration should be given to the development of a plan to be implemented within a residence. The plan should be developed using an interdisciplinary problem-solving approach leading to the development and implementation of measurable, observable outcomes to support the implementation of functional communication for individuals with staff support within an individual residence leading to an expansion to multiple environments such as work, leisure activities, and experiences within the community.	
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 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.	<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> The Facility Speech-Language Pathology policy was revised, but was not sufficient. The Monitoring Team has offered a number of recommendations in this section for the revision of the content of the policy. The revised policy included the following: ▪ "Augmentative Communication Equipment of Prescribing, Monitoring and Work Orders. o Equipment (e.g., Communication books, sequence pictures, placements, pocket books, augmentative computer systems, talking devices, switches and environmental control) will be provided to assist individuals with specific communication needs as identified by evaluations. Additionally, generic equipment may be provided to the residence, training and work areas as supports and input/informing aids, or the residence may order equipment through catalogues. These latter items need not b evaluation driven no monitored by this department. o Monitoring of the equipment for presence, condition and function is proved monthly by this department. ▪ Additionally, personal evaluation driven AAC equipment is monitored for use. ▪ Use is being charted with a trend line based on 20-minute snapshot monthly. ▪ Currently, the PNMP Coordinator is monitoring this function. ▪ A full system of monitoring is currently in further development. o Work orders (repairs, replacements, new products/mounts or	Noncompliance

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		modifications). Priorities for work orders: ▪ Priority 1: Simple repairs, which can be provided on campus, will be completed within 2 working days. Loaners will be provided, when available. ▪ Priority 2: New equipment and modifications on equipment that is evaluation driven, will be submitted and work completed within 30 days. ▪ Priority 3: For computer or electronic system purchases or repairs (those requiring a return of the equipment to the manufacturer or reordering) 60-90 day completion. Whenever possible, the individual will utilize a communication book in the interim. ▪ Priority 4: General use equipment work orders may be completed within 90 days. An Analysis of Monitoring of Speech (AAC) Equipment, dated 2/2/11, documented the following: ▪ New monitoring tool was put in place in June 2010 to monitor use of equipment for individuals with communication equipment via a 20-minute snapshot once per month. The snapshot would occur at the residence or at the program area. ▪ Generic communication equipment was not included as the focus, the focus would be on prescribed individualized communication equipment. ▪ Baseline monitoring occurred in July 2010 with an average score of 4.3% for use of the communication equipment for individuals in all residences on campus. ▪ Meetings were held with Unit Directors to discuss the monitoring results. ▪ An informal survey of direct support professionals on the barriers to equipment usage was completed from September 23rd to October 26th with the following question: "What are some things that keep you all from using the communication equipment? We are looking for barriers." Some of the their responses were: o "Consumers don't really look at cards due to behaviors; o Short-staffed but would not mind being coached on how to use equipment; o Staff know the importance of using equipment, but still would not mind if speech offered for staff to be coached/in-serviced regularly; o Consumers have their own sign language and prefer not to use their books; o Staff understand the consumers they work with so they don't use equipment; o Consumers have their own way of communicating, staff recognize their sings or mumbles so communication equipment is not needed;	

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		o Well aware but would like to know/learn more sign language. Can we have more signs?; o We try to use it but it would help if speech came to show us how; o Wasn't aware some consumers had equipment, wouldn't mind being shown by speech department; o We get to know them well so we don't need the books to talk to them; o We don't have his equipment; and o Short staffed daily, holding over all the time. In a rush to take care of everyone but don't have time to use equipment." ▪ SLP staff met with the QA Department, and with assistance from QA new trending charts developed, and trend lines were added. ▪ Data indicated the Facility was moving in the right direction by increasing awareness and paying attention to communication equipment use. The following Action Plan was developed to address the low compliance with communication equipment usage: ▪ Beginning in February 2011, each month's results would be reported at the least to Unit Directors, Residential Supervisors, Assistant Director of Programs, and Director of SLPA. ▪ Work would continue with Unit Directors emphasizing the importance of equipment being out and in use, and the need for expectations of supervisors to be reinforced. ▪ Further analysis would occur for the residences that are alike in types and numbers of equipment, and that are best in use of equipment to determine what was working for them. ▪ Further analysis would occur for residences that are alike in types and numbers of equipment, but that have poor results in use of equipment to determine what was not working for them. ▪ Results of analysis would be shared with Unit Directors, and Director of Residential, Residential Supervisors, at a minimum. ▪ Information also would be shared with QA/QI to foster more integration. None of the five individual records reviewed (Individual #92, Individual #455, Individual #274, Individual #63, and Individual # 83) documented a consistent approach to monitoring communication devices. The following individual concerns were noted: ▪ Individual #92's Speech AAC and ECU Equipment Implementation and Monitoring Forms, dated 1/5/11, 1/6/11, and 1/7/11, did not document if her book, jelly beamer/powerlink box for light, radio, TV while in bed, mount, Tufftalker laptop, wheelchair mount, small talk on mount on headboard (to request Tylenol) were in place and being used. Her PNMP, dated 5/4/10,	

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		documented a communication dictionary. The monitoring form also should track the presence and usage of a communication dictionary. ▪ Individual #455's equipment monitoring form, dated 1/2/11, documented that Individual #455's visual schedule and wallet PECs system with four pictures was not available and not in use. There was no monitor's signature on the bottom of the form. There was no documentation of a discussion of the results with the residential supervisor, and there was not supervisor signature. ▪ Individual #274's equipment monitoring form, dated 1/2/11, documented his PECS books with only one page and visual maroon calendar in bedroom was not in place or being used. There was no discussion with the supervisor about the monitoring results and possible solutions. There were no signatures on the form. ▪ Individual #63's equipment monitoring form, dated 1/5/11, 1/6/11, and 1/7/11, did not monitor the Toshiba laptop/mount, Elvis lamp with jelly beamer, select switch control in bed, and twin talker mounted on soft lap tray in bed. Individual #63's communication dictionary was not listed on the equipment monitoring form. There was no discussion with the supervisor about the monitoring results and possible solutions. There were no signatures on the form. ▪ Individual #83's PNMP, dated 12/15/10, listed communication equipment as an EZComm with eye tracking camera running the Grid software, but this equipment was not identified on the equipment monitoring form. None of the 12 individual's (Individual #280, Individual #455, Individual #274, Individual #160, Individual #63, Individual #83, Individual #409, Individual #377, Individual #185, Individual #287, Individual #510, and Individual #228) equipment monitoring forms completed in January 2011 documented their communication equipment was in use. Habilitation Therapies should complete an analysis of all current documents and monitoring forms related to communication devices to ensure consistency across all documents. For example, communication dictionaries were not incorporated into the communication equipment monitoring forms. The Facility Speech Language monitoring policy should be modified to incorporate the following: ▪ Definition of monitoring process to ensure communication equipment is available, functioning, and effective for the individual; ▪ Monitoring forms that include instructions for individual monitoring indicators to support monitor consistency and support inter-rater reliability;	

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		▪ Identification, training, and validation process for monitors to achieve accurate scoring and a high level of inter-rater reliability; ▪ Formal schedule for monitoring to occur; ▪ Auditing process of completed monitoring forms to identify forms completed accurately, and analysis of individual-specific concerns and systemic issues; ▪ Feedback loop identified in which deficiencies are noted and shared with appropriate supervisory staff to ameliorate deficiencies; and ▪ Establishment of thresholds for staff re-training. The Monitoring Team commends the Speech Language Department for the revision and ongoing implementation of monitoring individual communication equipment, but the percentage of usage of individual communication devices continued to be disappointing. Facility Administration, in collaboration with the SLPs, should continue to problem-solve and identify solutions to significantly increase staff compliance with utilization of individual communication systems. Furthermore, SLPs should continue to monitor individual's current communication devices to ensure they are effective to support functional communication. <u>Monitoring covers the use of the AAC during all aspects of the person's daily life in and out of the home.</u> The individual record sample documented that equipment monitoring for January 2011 occurred in the individual's residence only. <u>Validation checks are built into the monitoring process and conducted by the plan's author.</u> There was no evidence that validation checks were built into the monitoring process and conducted by the plan's author.	

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

1. ABSSLC should continue to recruit SLPs to lower the current caseloads of the SLPs, and to ensure SLPs become active members of the PSTs of individuals on their caseloads. In addition, the current caseloads of the two SLPs assigned to the PNMT should be reviewed to ensure that they are able to devote adequate time to meeting the needs of individuals with complex health, physical and nutritional support needs that the PNMTs are responsible for supporting.
2. Habilitation Therapies should re-evaluate the Master Plan for Speech Language Evaluation to ensure evaluations for all individuals will be completed within three years of the Settlement Agreement Effective Date.
3. The prioritization categories and timelines included in the Master Communication Plan should be re-evaluated. For example:
    a. Type of SLP consultations should be prioritized, and not all consultations should be assigned a Priority 1. The completion of multiple consultations could entail significant time and negatively impact SLPs ability to address individuals with significant functional communication needs.

b. Priority 1 should include individuals with a BSP who do not communicate verbally.
c. Priority 2 should include individuals with a BSP who communicate verbally, but have difficulty in being understood. Priority 3 identified "individuals with a BSP who have limited verbal skills," but these individuals have a significant need for a functional communication system and should be evaluated sooner, not later.
d. The timelines assigned to the priority levels should be reconsidered. They did not present an aggressive schedule for the completion of individual evaluations, followed by the development and implementation of a functional communication system.

4. The following information/guidelines should be integrated into the Facility's Speech Language policy:
   a. The policy should define how the SLP should document collaboration with the Psychologist on individuals' BSPs.
   b. The policy should define how the therapist should document the diagnostic period, including, at a minimum, the following: speech language evaluation should provide an analysis of team's findings, including a rationale for diagnostic period; development of a measurable, functional outcome to be achieved during the diagnostic training period; and documentation providing objective data to justify continuation and/or discontinuation of diagnostic training period, and/or a recommendation for continuation of services.
5. To ensure SLPs use a consistent approach during the evaluation process, additional guidelines should be developed to supplement the format. The following domains and/or guidance should be incorporated into the SL Evaluation template:
   a. Description of significant health care issues and risk indicators, including discussion of the impact of health care issues and risk indicators on performance, and current and/or future therapeutic intervention;
   b. Behavioral considerations;
   c. Functional reading skills and literacy;
   d. Assessment process should be sufficiently discreet to identity an individual's functional skills, interest and preferences via observation and clinical assessment;
   e. Assessment data should be analyzed to identify an individual's strengths, abilities, and potentials for skill acquisition; and
   f. Analysis of findings to provide a rationale for functional recommendations and intervention strategies.
   g. Integration of recommendations into an individual's PSP;
   h. Documentation to justify initiation, continuation or discontinuation of direct and/or indirect therapy supports;
   i. Process for implementing change in an individual's supports when progress is made or there is a lack of progress. The lack of progress should identify a re-evaluation timeframe.
6. To ensure SL Evaluations follow established guidelines, the Facility should develop and implement an audit protocol. In addition, the development of procedures defining the SL update process when an individual experienced a change in status would be beneficial.
7. Individual communication programs should be integrated into PSPs through skill acquisition programs, as well as their BSPs to ensure the AAC device is meaningful to the individual and they have a voice in multiple environments.
8. Habilitation Therapies should re-evaluate the Engagement/Integration pilot initiative. The project should be used to promote interdisciplinary planning in the development and implementation of an environment that supports and encourages functional communication throughout the 24-hour day, including the implementation of individual communication strategies, including AAC devices, as appropriate, in addition to generic devices.
9. The Facility Speech Language monitoring policy should be modified to incorporate the following:
   a. Definition of monitoring process to ensure communication equipment is available, functioning, and effective for the individual;
   b. Monitoring forms that include instructions for individual monitoring indicators to support monitor consistency and support inter-rater reliability;
   c. Identification, training, and validation process for monitors to achieve accurate scoring and a high level of inter-rater reliability;
   d. Formal schedule for monitoring to occur;
   e. Auditing process of completed monitoring forms to identify forms completed accurately, and analysis of individual-specific concerns and systemic issues;

f. Feedback loop identified in which deficiencies are noted and shared with appropriate supervisory staff to ameliorate deficiencies; and Establishment of thresholds for staff re-training.

10. Facility Administration, in collaboration with the SLPs, should continue to problem-solve and identify solutions to significantly increase staff compliance with utilization of individual communication systems.
11. SLPs should continue to monitor individual's current communication devices to ensure they are effective to support functional communication.

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 Section S Plan of Improvement, dated 1/31/11; o Personal Support Plans for: Individual #178, Individual #501, Individual #164, Individual #199, Individual #123, Individual #43, Individual #74, Individual #184, Individual #295, Individual #105, Individual #476, Individual #242, Individual #6, Individual #509, Individual #371, Individual #76, Individual #303, Individual #347, Individual #505, Individual #545, Individual #265, Individual #104, Individual #286, Individual #49, Individual #201, Individual #318, Individual #293, Individual #330, Individual #153, Individual #140, Individual #247, Individual #382, Individual #313, Individual #342, Individual #523, Individual #462, Individual #231, Individual #274, Individual #301, Individual #198, Individual #332, Individual #405, Individual #58, Individual #471, Individual #323, Individual #94, Individual #539, Individual #370, Individual #525, Individual #83, Individual #469, Individual #5, Individual #388, Individual #148, Individual #146, Individual #510, Individual #339, Individual #246, Individual #357, Individual #11, and Individual #304; o Positive Adaptive Living Skills Assessment (PALS): Individual #19, Individual #371, Individual #438, Individual #77, Individual #303, Individual #257, Individual #272, Individual #293, Individual #97, Individual #330, Individual #313, Individual #94, Individual #225, Individual #117, and Individual #69; o Abilene State School Comprehensive Functional Assessment: Individual #180 and Individual #97; o Inventory for Client and Agency Planning: Individual #180, Individual #460, and Individual #384; o Training Documentation Reports for: Individual #138, Individual #19, Individual #180, Individual #26, Individual #506, Individual #192, Individual #438, Individual #77, Individual #460, Individual #257, Individual #272, Individual #97, Individual #313, Individual #225, Individual #98, Individual #117, Individual #326, Individual #69, Individual #264, and Individual #414; o Training Objective Data Sheets for: Individual #387, Individual #199, Individual #393, Individual #123, Individual #371, Individual #76, Individual #303, Individual #505, Individual #545, Individual #293, Individual #330, Individual #140, Individual #313, Individual #274, Individual #94, Individual #522, Individual #324, Individual #146, Individual #246, and Individual #304; o Vocational Services Work Schedules, dated 1/10/11; o Vocational Services Evaluations for: Individual #138, Individual #478, Individual #530, Individual #371, Individual #108, Individual #460, Individual #89, Individual #268, Individual #210, Individual #494, Individual #46, Individual #273, Individual #365,

	Individual #215, Individual #139, Individual #34, Individual #397, Individual #225, Individual #83, Individual #117, Individual #245, Individual #527, and Individual #69; o 6340 Third Street Activity Center Engagement/Integration Pilot Project – Phase One, dated 1/25/11; and o Table providing data regarding the number of people who had attended at least one off-campus activity between July and December of 2010. ▪ **Interviews with**: o Ron Manns, Behavior Analyst, Cheryl Balanay, Speech/Audiology Director, and David Feemster, Speech Therapist, on 2/14/11; o Jeff Branch, Active Treatment Coordinator, and Juan Herrera, QMRP Coordinator, on 2/17/11; and o Leslie Riggins, Liaison to Abilene School District, on 2/16/11. ▪ **Observations of**: o Residence 5961, Residence 5962, Residence 5971, Residence 5972, Residence 6330, Residence 6350, Residence 6360, Residence 6370, Residence 6380, Residence 6390, Residence 6400, Residence 6450, Residence 6460, Residence 6480, Residence 6500, Residence 6510, Residence 6521, Residence 6690, Residence 6710, Residence 6720, Residence 6730, Residence 6740, Residence 6750, and Residence 6760; o Activity Center 5921, Activity Center 5922, Activity Center 5923, and Activity Center 6340; o Recreation and Senior Center 659; o Workshop 657, Workshop 662, and Workshop 680; o Personal Support Planning Meeting for Individual #227, on 2/16/11; o Unit 4 Incident Management Meeting, on 2/15/11; and o Unit 1 Incident Management Meeting, on 2/17/11.
	Facility Self-Assessment: The Facility's Plan of Improvement indicated that it was not in compliance with any of the components of the Settlement Agreement. However, the POI did indicate that the results of the Facility's monitoring efforts reflected a degree of compliance across 127 reviews. What remained unclear, even after meeting with the QMRP Coordinator and the Active Treatment Coordinator, was the method and tool used to determine this progress. Each of the three sections related to habilitation, training, education, and skill acquisition programs, included the following statement: "Work group working on skill acquisition is in the process of developing data collection, graphing, review, and implementation." It was further noted that: "No actions were taken based on the recommendations from the last compliance visit." As the Facility's self-assessment process develops, it will be essential to determine the methodologies and tools that will be used to measure compliance with each of the provisions in Section S. Once these are identified, staff responsible for conducting the audits should be trained, and inter-rater reliability established.
	Summary of Monitor's Assessment: Based on the most recent review, the concerns raised in the previous report continued to be problematic. Assessment of individuals' needs remained incomplete or out-of-date. Resulting Actions Plans were therefore limited in scope. Training Documentation Reports continued to lack specificity with regard to the learning objective, the teaching strategies used to effect behavior change, the consequences applied to ensure the acquisition of new skills, and the plans designed

	to ensure skill maintenance and generalization. Opportunities for learning enhanced skills remained infrequent. Activities offered to individuals remained limited and often were not age-appropriate or individualized. Engagement levels across the residences and activity centers remained low. Training in integrated, community-based settings was limited to only a few individuals who took part in employment opportunities off campus. A pilot project had been initiated to enhance the activities and training provided in one Activity Center. This interdisciplinary effort was commendable. However, there appeared to be very little planning for the continued development of this project.

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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.	A total of 61 Personal Support Plans were reviewed. Each began with a review of the individual's preferences/interests or an overview of what was important to him/her. Also included were reports from different disciplines, a review of the Optimal or Optimistic Living Vision for the individual, and finally the Action Plans for the upcoming year, including identified training objectives. All but three plans (Individual #342, dated 1/12/10; Individual #545, dated 2/11/10; and Individual #265, dated 2/10/10) had been developed within 12 months of the Monitoring Team's visit. One other individual's plan (Individual #295) was expiring the week of the visit. A total of three to 11 training objectives had been identified for 60 of the 61 individuals. The plan for Individual #76 did not identify any training objectives. The mean number of annual training objectives per individual was 6.35. Many of the concerns related to Action Plans noted in the last monitoring report remained applicable. More specifically: ▪ Only 17 of the 60 individuals' PSPs (28%) listed the specific skills to be trained. In the remaining 43 of 60 cases (72%), the skill to be trained lacked specificity. The objective was noted using one to two words. Examples included: Individual #501 (body awareness, dining), Individual #295 (communication book and tooth brushing), Individual #476 (time and social interaction), Individual #382 (activity training objective, attention span objective), Individual #405 (anger management and social distance), Individual #388 (interaction and apply), and Individual #510 (vocation objective and communication objective). ▪ Even where the description of the skill was more complete, (e.g., Individual #74 will learn how to make a purchase, Individual #94 will exercise to improve his health), these lacked specificity to determine what observable and measurable behavior the person was to emit. ▪ The scheduling of activities was not always sufficient for learning. Examples included: Individual #123 (participate in Activity Center and money management once weekly), Individual #105 (clean personal space when at Activity Center), Individual #265 (grasping objects and playing maracas as	Noncompliance

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<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
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scheduled), and Individual #83 (five objectives all scheduled for weekly occurrence).
▪ The location of training was not always specified (e.g., Individual #505).
▪ Some training objectives were continued from previous years (e.g., Individual #293 and Individual #148).
▪ In some plans the name of the individual and/or his/her gender was not appropriately identified throughout the document (e.g., Individual #74, Individual #505, Individual #153, Individual #94, and Individual #339).

In 13 cases, the date of the individual's last full psychological evaluation was noted. Specific information is provided in the table below:

<table>
<tr><th>Individual</th><th>Date of Evaluation</th></tr>
<tr><td>Individual #501</td><td>3/21/01</td></tr>
<tr><td>Individual #347</td><td>3/18/88</td></tr>
<tr><td>Individual #505</td><td>10/1/91</td></tr>
<tr><td>Individual #265</td><td>8/20/90</td></tr>
<tr><td>Individual #286</td><td>8/3/07</td></tr>
<tr><td>Individual #318</td><td>4/6/00</td></tr>
<tr><td>Individual #323</td><td>2/6/02</td></tr>
<tr><td>Individual #539</td><td>2/16/98 (intelligence), 3/29/99 (adaptive)</td></tr>
<tr><td>Individual #370</td><td>1/10/90</td></tr>
<tr><td>Individual #469</td><td>11/23/87</td></tr>
<tr><td>Individual #148</td><td>7/12/92</td></tr>
<tr><td>Individual #146</td><td>9/28/89</td></tr>
<tr><td>Individual #357</td><td>9/3/02</td></tr>
</table>

In every case, the following statement or something similar was included: "Based upon behavioral observations and records, there do not appear to be any clinically significant changes in these functioning levels since his/her last evaluation." For some individuals this suggested that nothing has changed in over 20 years, with the implication being that any efforts at training and habilitation had been unsuccessful. A note was included in the plan for Individual #274, indicating that psychological records from 2006 recently had been obtained and there appeared to be no significant changes in his functioning levels since that time. The individual would have been five years old when this assessment was completed. Not only would one expect changes between five and 10 years of age, but also the Individuals with Disabilities Education Act (IDEA) mandates re-evaluation for school-age children every three years.
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		For 43 of the 60 individuals (72%), the PSP identified the most recent Inventory for Client and Agency Planning (ICAP), but six were outdated. The Facility policy was for these to be completed every three years. The table below identifies the individuals for whom issues were noted: **Individual** / **Date of ICAP** Individual #347 / 11/3/03 Individual #545 / 6/26/06 Individual #201 / 9/26/05 Individual #301 / 10/7/05 Individual #332 / 12/9/05 Individual #146 / 10/24/06 The plan for Individual #201 indicated that neither the Positive Adaptive Living Skills (PALS) nor the ICAP were applicable. The rationale for this statement was unclear. The ICAP for Individual #148 was still current within the three year window, but a note was included indicating this would be valid for four years. Again, this appears to be in violation of the Facility's policy. Individual #123, Individual #476, Individual #509, Individual #198, Individual #525 and Individual #388 were all noted to be blind or functionally blind. Yet, in no case were the services of a mobility and orientation specialist suggested or included as a recommendation in the PFW or the PSP. Several individuals' plans (i.e., Individual #105, Individual #505, Individual #462, Individual #332, and Individual #323) noted that he/she should use an infant fork and/or spoon when eating. The purpose was to limit the amount of food the individual could consume in a bite. Adults should not be using utensils geared to infants or very young children. Rather, in addition to being provided adaptive equipment designed for adults to use (e.g., a spoon with a smaller bowl) individuals should receive training in more appropriate eating styles. A total of 131 Training Documentation Reports for 20 different individuals were reviewed. Task analyses were provided for 44% of the sample. As behavioral objectives were not provided, the following was absent: a) the conditions under which the behavior was to occur; b) the response expected of the individual; and c) the criteria established to determine mastery. Additionally, an operational definition of the individual's behavior was not provided. While training schedules were noted, these did not specify the number of trials to be	

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		conducted. From the manner in which data was recorded (i.e., one space for each designated data recording day), it appeared that only one trial was expected. This, along with many skills scheduled for training only once or two to three times per week, indicated that the time spent addressing habilitation goals was severely limited. Specific examples included: Individual #138, Individual #460, and Individual #414, among others, were scheduled to work on money management skills twice weekly; Individual #180, Individual #257, Individual #97, and Individual #326 were learning this same skill only once per week; Individual #97 was learning to prepare simple foods once weekly, while Individual #26 was scheduled to learn cooking skills twice per week; and Individual #460 was scheduled to learn laundry skills once per week. Additional concerns were raised when the consequences for correct responding were reviewed. For 100, or 76%, of the sample, praise was the identified reinforcer. Praise does not always function as a reinforcer, particularly when someone who might not be a highly preferred person delivers the praise. This highlighted the necessity of completing preference assessments to ensure that individuals are motivated to learn the skills identified in their plans. Further, praise was to be delivered regardless of the level of prompting that was necessary to obtain the correct response. Even if praise is a reinforcer, this guideline suggested a lack of understanding of the necessity to fade prompts to ensure greater independence. In eight of the training documents, the reinforcer was not identified. The remaining training objectives listed praise and encouragement, praise and a pat on the back, access to an item purchased or prepared, access to food, or the opportunity to go for a walk to the destination of choice. One plan for Individual #326 guided staff to provide an item purchased even if he became upset or refused to participate in the activity. This could result in a strengthening of either or both of these undesirable responses. None of the plans identified consequences for incorrect responding. In addition, there were no plans for ensuring the maintenance and generalization of skills learned. In sum, it is important that training guidelines provide clear and comprehensive information that ensures a clear description of the expected outcome, the conditions under which the skill will be learned, and the strategies that will be applied to ensure learning. Plans also should be included to ensure that the individual maintains newly acquired skills and learns to use these skills across all appropriate situations and environments. A total of 118 completed training objective sheets were reviewed for 20 individuals. Schedules of training implementation were identified, as were schedules for data collection. Daily data collection was identified in only three cases. Data was recorded as scheduled between 42% and 100% of the time. The mean compliance rate was 87%.	

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		While this reflected overall good staff attention to the demands of data collection, there remained concerns regarding the degree to which plans were implemented with integrity and the degree to which progress was reviewed with corresponding action taken to ensure growth and development. Treatment integrity can only be assessed through competency-based training in which trainers observe staff implementing the teaching objective. Such training also affords an opportunity to collect inter-observer agreement measures on all objectives. This was not being completed at the time of the review. In addition, careful review of data should trigger action plans or changes to the training objective. Examples where action should have been taken, but was not are provided below: ▪ In some cases, data collected reflected the individual's consistent refusal to participate. For example, Individual #123 had an oral hygiene objective in which he refused to participate for 12 of the 14 days (86%) that data was recorded. This should have alerted training staff to review the teaching protocol to ensure active engagement in this very essential skill. This same individual had a money management objective for which training was provided once per week. The data provided reflected consistent refusal to participate. This skill will not be developed with such limited opportunities to learn, particularly when no action was taken to address the individual's refusal. ▪ Similarly, Individual #387 had an objective to learn to make a purchase. Data was recorded only four times between early December and late January. This objective, scheduled to occur once each week, was not implemented due to the individual's refusal or some other issue ("C" for comment was noted). Again, such difficulty in implementing the objective should have triggered the team to take action to ensure continued learning. ▪ Individual #393 had a total of six objectives. Data for four of these (bed making, pull up clothes, set table, and money skills) indicated that she refused to participate the majority of the time. When 67% of an individual's program is not being implemented, adequate habilitation services are not being offered. ▪ Individual #140 had one objective designed to teach him to make choices. For almost a full month between December and January, the program was not implemented. The comments on the data sheets indicated that: "… all pieces to the take talker are missing." Further concerns were raised because this individual was described as being blind, yet the objective noted that he would remove a picture from an activity board to indicate his choice. ▪ Individual #246 had a hand-washing objective. In December, he was working on Step C of this program and performing independently the majority of the time according to the recorded data. In January, he was moved to Step A of the same program. Based on the fact that the data sheet indicated that Step A was	

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		achieved in September, this change appeared to be a return to a less advanced skill. Graphic display of skill acquisition measures would help clearly identify progress or the lack thereof. When there is consistent refusal by the individual, a lack of progress, or skill regression, members of the team should investigate the reason, and, as appropriate provide staff additional training and/or supervision, and/or revise the training objective to ensure that learning takes place. As necessary and appropriate, Psychology staff should provide behavioral support during this process. Members of the Monitoring Team met with the Behavior Analyst, the Speech/Audiology Director, and a Speech Therapist to learn more about the pilot project that had begun in Activity Center 6340. As explained, members of various departments met to develop a plan to improve the services provided to individuals residing in Residences 6450 and 6460. The Behavior Analyst had identified some core competencies for staff to learn and one of the Speech Therapists had developed some generic communication devices for staff to use with the individuals to promote choice. Staff also reported that initial sign language training had been provided to staff. When asked to describe the next step in the project, staff explained that there was not a written plan and that the next phase would need to "come through" the QMRP and Active Treatment Coordinators. Efforts would also be made to match communication devices/systems to specific individuals and then write these into their plans. An acknowledgement was made that they were "stumbling forward" and did not want to "force" change. Staff had looked at the activities that were offered and made an attempt to group individuals based on preference. When asked about the manner in which preference was assessed, the Monitoring Team was informed that the staff "just know" what the individuals like. Many of the activities described involved music, arts and crafts, grooming, and exercise. Cooking classes were scheduled weekly. This interdisciplinary effort was commendable. However, there appeared to be very little planning for the continued development of this project. <u>Engagement Measures</u> During the visit to the Facility, measures of engagement were collected. These Planned Activity Checks (PLACHECKS) involved a momentary observation of each individual in the environment, noting whether he/she was engaged with an activity. A percentage of engagement was then calculated. PLACHECKS were conducted in the residences, activity centers, and workshop areas during the first four days of the Monitoring Team's visit. A total of 46 PLACHECKS were conducted in the residences. The percentage of individuals actively engaged ranged between zero and 100%, with an average of 26% engagement. While there were observations of staff interacting with specific individuals, other individuals enjoying a video or television show, or, on one occasion, helping to	

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		prepare for dinner, often these observations revealed individuals sitting, lying down, or wandering with nothing interesting to do. The following provide some specific examples of concerns noted related to a lack of engagement in meaningful activities: ▪ During a visit to one residence, 13 individuals were observed seated in their wheelchairs around a television as three to four staff members danced to a Wii program. ▪ Other observations revealed staff assembling birdhouses or completing arts and crafts projects, with no involvement of the individuals in the room. ▪ In one residence, Individual #148 was observed sitting on the floor, moving his head back and forth repeatedly. In this same residence, Individual #545 was sucking on a towel. ▪ In another residence, Individual #123 was found in a bedroom at the end of the hallway, with his shirt off and clothing strewn about the floor. He was seated in his wheelchair, moving it back and forth as he repetitively bumped into the wall. A staff member came down the hall, explaining that this individual prefers to be left alone, while noting that he is checked every 15 minutes. ▪ Individual #16 was observed on two different occasions in her residence, both times she was seated in a chair as she manipulated and mouthed a laminated strip of paper. ▪ Individual #284 was observed biting her hand repeatedly as she waited for dinner. She accepted a towel when this was offered and then flicked this across her teeth. ▪ On five different occasions during the week, Individual #246 was observed outside his residence, crouched on the ground as he sprinkled dirt over his head and body. On one of these occasions, he was in full sun in the middle of a hot day. Equally disturbing was an observation made in his residence at dinnertime. As he consumed his meal, his head and shoulders were covered in dirt. ▪ Individuals were often observed to have dirty hair and poorly fitting clothing. Those seated in chairs were often exhibiting very poor posture, while other individuals laid or sat on the floor. ▪ In some residences, it appeared that there were insufficient numbers of staff to do anything more than provide basic care. ▪ The presence of a variety of age-appropriate and interesting materials was absent in all areas. A total of 13 PLACHECKS were conducted in the activity centers. Engagement ranged from zero to 100%, with a mean of 37%. Following a planning meeting at Activity 6340, individuals were observed arriving at 8:30 a.m. to begin their morning activities. One woman immediately began walking on a treadmill. (It should be noted that the Monitoring Team recommended to the Activity Center staff member to ensure that the individual had the "kill" switch attached to her person so that the machine will stop	

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		should the individual slip or fall.) Two other women were present in one of the music rooms. One was listening to a song on a keyboard, while the other listened to a different song on an iPod. This created a very noisy and uncomfortable atmosphere. While musical preference should be honored, it would be appropriate for headphones to be used so that songs can be enjoyed. In another room, staff were encouraging individuals to operate and dance to a Wii program. Other observations were not as positive. Individual #525 was observed in a Snoozelen room. His wheelchair was strapped to a board that simulated a rocking chair. He was vocalizing quite loudly as a staff member reassured him that the music had been changed for him. It was not clear that consideration had been given to the possibility that the rocking motion of his wheelchair might have been uncomfortable or even frightening. On two visits to Activity Center 5921, the kitchen area was vacant, suggesting that this area was underutilized. Cooking would be an age-appropriate and functional skill that certainly would be beneficial for people to learn. Similarly to an observation in a residence, staff were observed in Activity Centers dancing to Wii programs as individuals sat unengaged. In general, the activities offered to individuals were limited in their scope, were not clearly individualized, and resulted in very limited engagement. Engagement in the workshop areas was consistently better than in other areas on the campus. A total of 16 PLACHECKS were conducted. Engagement ranged from 40 to 100%, with a mean of 81%. Most of the work consisted of sorting, folding, or stacking laundry (facecloths, towels, sheets, or blankets). Other individuals were shredding paper and one woman was working at a jig. During one observation, it was good to see two individuals working together to fold blankets. They appeared to enjoy this cooperative activity. While talking with the QMRP Coordinator, Active Treatment Coordinator, and Behavior Analyst, there was no indication that the Facility had developed or implemented measures of engagement. A PLACHECK tool should be developed and all professional staff should be trained on its use. Training should then be provided to direct support professionals to ensure that they understand the definition of active engagement and the purpose of the monitoring tool. This will also afford them an opportunity to contribute to the measure. Once these steps have been implemented, staff are encouraged to collect measures of engagement whenever they visit homes, activity centers, or workshop areas. Ongoing feedback, both positive and constructive, should then be provided to the staff who work directly with the individuals served. This will enhance the Facility's ability to provide on-the-job training. While discussing opportunities for habilitation with the Active Treatment Coordinator, it was noted that many individuals who have more complex needs often remain in their homes. The risk management assessment tool may need to be revised to include a	

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<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>section regarding an individual's ability to leave home for work or other active treatment. This should be the exception, and the medical reasons prohibiting their involvement in off-site day/vocational programs should be clearly identified and justification provided in their PSPs. Plans also should be developed to assist, as appropriate, individuals in overcoming such obstacles. PSTs should review such reasons and justifications regularly, as well as progress made in assisting individuals to overcome such obstacles.

It would also be beneficial to recruit input from all interdisciplinary team members, particularly occupational, physical, and speech therapists, to identify appropriate activities for those individuals who have more complex needs. People who are medically complex, who have limited mobility, and/or who have sensory deficits will require specific habilitation and active treatment that meet their unique needs while not compromising their health and safety.</td><td></td></tr>
<tr><td>S2</td><td>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.</td><td>The Positive Adaptive Living Skills assessment was reviewed for 15 individuals. In no case (0%) was the full assessment completed. The PALS identified 41 specific skill areas, grouped into 16 broader skill domains. While some of the skill areas might not apply to some individuals (e.g., the section is gender-specific, the section relates to adaptive equipment care, the section addresses needs based upon a sensory deficit, etc.), most skill areas are relevant for the individuals served at ABSSLC. The table below provides a summary of the specific skill areas assessed for each of the 15 identified individuals:

<table>
<tr><th>Skill Areas</th><th>Individuals</th></tr>
<tr><td>Self-determination</td><td>Individual #77, Individual #313, Individual #97, Individual #117</td></tr>
<tr><td>Dressing</td><td>Individual #117</td></tr>
<tr><td>Grooming</td><td>Individual #330</td></tr>
<tr><td>Bathing</td><td>Individual #19, Individual #371, Individual #303, Individual #272, Individual #313</td></tr>
<tr><td>Shaving</td><td>Individual #303, Individual #293</td></tr>
<tr><td>Toileting</td><td>Individual #438</td></tr>
<tr><td>Dental Hygiene</td><td>Individual #438, Individual #272</td></tr>
<tr><td>Adaptive Equipment Care</td><td>Individual #117</td></tr>
<tr><td>Receptive Language</td><td>Individual #77, Individual #257, Individual #117</td></tr>
<tr><td>Expressive Language</td><td>Individual #77, Individual #257, Individual #117</td></tr>
<tr><td>Sensory Characteristics</td><td>Individual #438, Individual #77</td></tr>
<tr><td>Personal Management</td><td>Individual #19, Individual #313, Individual #117</td></tr>
<tr><td>Social Skills</td><td>Individual #19, Individual #94</td></tr>
</table></td><td>Noncompliance</td></tr>
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Cleaning and Organization	Individual #94
Laundry/Clothing Care	Individual #303, Individual #225
Dining Room Skills	Individual #19, Individual #438, Individual #303, Individual #272, Individual #293, Individual #97
Food Storage and Preparation	Individual #97, Individual #225
Time Management	Individual #117, Individual #69
Leisure Skills	Individual #19, Individual #257, Individual #272
Leisure Preference	Individual #77, Individual #257, Individual #272, Individual #117
Money Management and Shopping	Individual #19, Individual #371, Individual #438, Individual #77, Individual #303, Individual #257, Individual #272, Individual #293, Individual #97, Individual #330, Individual #94, Individual #225, Individual #117, Individual #69
Reading/Writing	Individual #313
Numbers	Individual #272
Telephone Usage	Individual #69
Community Awareness	Individual #313, Individual #225

The number of skill areas assessed for each individual were the following:

- Two for Individual #371 and Individual #330;
- Three for Individual #293, Individual #97, Individual #94, and Individual #69;
- Five for Individual #438, Individual #303, Individual #257, Individual #313, and Individual #225;
- Six for Individual #19 and Individual #77;
- Seven for Individual #272; and
- Nine for Individual #117.

In no case (0%) did this provide for a comprehensive assessment of an individual's strengths or needs. Unless a person is truly independent and capable in all areas of self-care, communication, relationships, home living, meal management, leisure, and community living skills, these areas should be considered when developing a personal support plan. Individual #438 and Individual #97 were legally blind, yet in neither case were their mobility skills assessed. It was clear in the case of Individual #19 that the information gleaned from the assessment was considered when developing her training objectives.

In eight (53%) of the 15 PALS assessments (Individual #19, Individual #257, Individual #293, Individual #97, Individual #313, Individual #94, Individual #225, and Individual

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		#117), the results were briefly summarized with recommended training objectives to address areas of need. In the other seven PALS assessments (47%), it was unclear whether the information gained had been used to develop appropriate objectives for habilitation. In the case of Individual #272, only seven areas of adaptive behavior were identified. Yet, one of these sections, money management, was not completed, because it was noted that he did not have access to money due to his pica behavior. As a result, information regarding his adaptive skills was provided in only six areas. The Abilene State School Comprehensive Functional Assessment was provided for Individual #180 and Individual #97. In both cases, only certain sections were completed. Although these were identified as tools used when developing the most current Personal Support Plan for these individuals, the assessment for Individual #180 was completed two years previously and almost three years prior to the PSP meeting for Individual #97. The Inventory for Client and Agency Planning (ICAP) was provided for Individual #180, Individual #460, and Individual #384. Although these were provided as one assessment used to guide the development of the current Personal Support Plan, the dates of completion were 4/30/08, 2/21/07, and 3/11/09, respectively. In the case of Individual #460, this was clearly in violation of the Facility's policy for ICAP completion every three years. A Vocational Services Evaluation (VSE) was reviewed for 23 individuals. The format consisted of the following: a) a brief statement regarding the individual's current employment; b) his/her work schedule; c) a list of achievements and abilities; d) recommendations; e) the date of the Behavior Support Plan, if applicable; and f) estimated earnings. In some cases, a personal interview was summarized indicating whether the individual responded positively when asked if he/she liked the current job. None (0%) of the VSEs reviewed represented a vocational profile based on, for example, objective data, situational assessments, and/or a thorough work history or interest inventory. In several cases, the evaluation reported a high number of refusals to attend or participate in work. For example: ▪ Individual #268 had refused 13 shifts in 2.5 months; ▪ Individual #494 had refused 34 shifts in six months; ▪ Individual #215 had refused 194 shifts in six months; and ▪ Individual #397 had refused 58 shifts in six months. Other problems were noted for specific individuals, either in their Vocational Services Evaluation or in their current Personal Support Plan. Examples included: ▪ Individual #501 was noted to often sit idly (PSP); ▪ Individual #460 left work before finishing her shift (VSE); ▪ Individual #153 often refused to go to work and when he did, he left early (PSP);	

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		▪ Individual #210 often left his work station (VSE); ▪ Individual #523 had often refused to attend work (PSP); ▪ Individual #94 was not working, because in the past he had refused to attend or had left early (PSP); ▪ Individual #370 had stopped working because of behavior problems at her worksite (PSP); and ▪ Individual #11 was discontinued from work due to poor attendance. Each of these problems suggested at least two solutions. First, it would be helpful to include an assessment of an individual's areas of interest in the vocational evaluation. The jobs currently offered on campus were quite limited in their scope, with most jobs involving sorting, folding, or stacking laundry items, or shredding paper. Some individuals might prefer jobs outside. Others might prefer a job in a quieter and less crowded environment. Staff at the Facility are encouraged to think about other job options, both on and off campus, that might prove more interesting to an individual, and therefore, result in more active and consistent participation in the job. Secondly, it would be helpful if psychology staff provided behavioral support to the individual and the workshop or vocational staff when problems do arise. There might be strategies that could be put in place to enhance the individual's participation and interest in completing his/her job. Strategies might be related to environmental changes (such as listening to favorite music through headphones or sharing a job with a preferred friend), or could be tied to an improved system of reinforcement. Reducing an individual's hours of gainful employment or discontinuing the individual's participation in work is not an acceptable solution. In addition, in the vocational areas, the Monitoring Team observed limited bathroom accessibility for individuals in seating systems who require staff assistance. There appeared to be multiple individuals who use seating systems who have strengths and potentials that would benefit from having work opportunities. The Facility should provide bathroom accessibility in the vocational areas to enable individuals in seating systems to make the choice to engage in vocational opportunities. A reinforcer/preference assessment was noted in the PSP for Individual #146 only. Regularly scheduled preference assessments should be conducted to ensure that individuals could be adequately motivated to learn new skills.	
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		

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	programs of training, education, and skill acquisition to address each 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 above with regard to Section S.1 of the SA, reviews of individuals' PSPs showed that adequate assessments had not been completed, and that it was unclear how assessment information had been used to develop meaningful goals and objectives. This component of the SA requires that assessment information be used to develop interventions, strategies, and supports that "effectively address the individual's needs for services and supports." These deficiencies will need to be corrected to comply with the SA. Actual teaching of skills was not observed during the review of the Facility. In addition, during the on-site review, it was again apparent that many individuals spend much of their time unengaged, or without access to interesting and meaningful activity (refer to the PLACHECK data reported with regard to Section S.1 of the SA). Further, when activities were provided, they were often nonfunctional, or not appropriate for the individual's age. Consideration must be given to the individual's preferences and the expansion of service delivery beyond what has typically been provided. Of the 61 individuals whose PSPs were reviewed, 31 were scheduled to work as noted on the list provided by vocational services, dated 1/10/11. The scheduled hours per week ranged from a low of one hour (Individual #94) to a high of 30.75 hours (Individual #301). The average schedule was 15.16 hours per week. (Individual #293's were not included in this calculation as his time spent working was listed as "varies.") Only 10 of these individuals were scheduled to work 20 hours or more per week. This was concerning, because the activities observed elsewhere on campus reflected very little development of functional and interesting adaptive skills. While a conversation with the Director of Vocational Services revealed that some individuals travel off campus for work activities, the vast majority of those with jobs were employed on campus.	Noncompliance
	(b) Include to the degree practicable training opportunities in community settings.	Community outings were noted in many individual's plans. Data provided indicated that of the 447 individuals living at ABSSLC, an average of 302 individuals made at least one trip per month to the community during the six month period from July to December. The range of individuals traveling off campus for an activity was between 282 in October and 345 in September. Without a clear understanding of whether the activity afforded an opportunity for individuals to interact with their typical peers, it is difficult to identify these activities as meaningful or educative. In none of the 60 PSPs reviewed (0%) was there an objective dedicated to training in the community.	Noncompliance

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

1. The completion of comprehensive assessment of all areas of adaptive behavior should be conducted annually. If the Positive Assessment of Living Skills is utilized, it should be completed in full. It is also recommended that staff review a variety of assessment tools, including but not limited to the *Scales of Independent Behavior – Revised* (Bruininks Woodcock, Weatherman, & Hill, 1996), the *Checklist of Adaptive Living Skills* (Morreau & Bruininks, 1991), and the *Adaptive Behavior Assessment Scale – Second Edition* (Harrison & Oakland, 2003).
2. The vocational assessment process should be revised to incorporate a vocational profile based on, for example, objective data, situational assessments, and/or a thorough work history or interest inventory.
3. Skills identified for training following comprehensive assessment should be functional, age-appropriate, and matched to the individual's preferences.
4. Curricula for developing more comprehensive training objectives also should be reviewed. One possibly useful tool is the *Adaptive Living Skills Curriculum* (Bruininks, Morreau, Gilman, & Anderson, 1991).
5. The Facility should take concrete steps to raise staff's level of expectation for the individuals served at ABSSLC. A review of the philosophy that all individuals have the ability to grow and develop, as well as the principles of normalization and social role valorization is strongly recommended.
6. Once training objectives are identified, programs should be written to include the following information:
    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 including the number of trials to be provided (ensure that the schedule provides sufficient opportunities for learning to occur);
    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 clear description of data collection procedures.
7. Staff will require ongoing competency-based training to ensure their understanding and application of all training programs.
8. 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.
9. When there is consistent refusal by the individual, a lack of progress, or skill regression, members of the team should investigate the reasons, and, as appropriate, provide staff additional training and/or supervision, and/or revise the training objective to ensure that learning takes place. Psychology staff should be involved to help design programs to improve participation be it through change in presentation, choice in activity, or something similar.
10. Data also should be collected to evaluate the success or failure of maintenance and generalization of newly acquired skills.
11. A plan should be developed to ensure inter-observer agreement measures are collected on all skill acquisition programs.
12. Continued efforts to expand interdisciplinary efforts to improve habilitation and training should be a priority. While the initial work in Activity Center 6340 is commended, a comprehensive plan for continued expansion and improvement should be developed. Necessary steps should be outlined, with responsible parties and expected timelines identified. Such a plan should integrate clearly communication and psychological services in individuals' written plans as well as on a daily basis in their residences and day/vocational programs. A method should be

developed and implemented to determine if the implementation of the pilot project results in improved outcomes for individuals.

13. For those individuals who have more complex needs, greater involvement of occupational, physical, and speech therapies will be necessary to ensure more enriched environments, more expanded training, and improved engagement.
14. Risk assessment should be expanded to include the identification of variables that would prevent an individual from accessing activities outside of his/her home. For any individual that the team determines cannot attend activities outside of his/her home, the medical reasons prohibiting their involvement in off-site day/vocational programs should be clearly identified and justification provided in their PSPs. Plans also should be developed to assist, as appropriate, individuals in overcoming such obstacles. PSTs should review such reasons and justifications regularly, as well as progress made in assisting individuals to overcome such obstacles.
15. A system for monitoring and increasing overall engagement rates is strongly recommended. 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. As noted previously, staff are encouraged to expand the variety of home, leisure, and vocational activities available to the individuals served.
16. The Facility should provide bathroom accessibility in the vocational areas to enable individuals in seating systems to make the choice to engage in vocational opportunities.
17. Opportunities for learning, working, and recreating in the community should be greatly expanded. Individuals should not only have access to events and facilities in the Abilene area, but they should have specific plans for developing skills in the community.
18. As the Facility's self-assessment process develops, it will be essential to determine the methodologies and tools that will be used to measure compliance with each of the provisions in Section S. Once these are identified, staff responsible for conducting the audits should be trained, and inter-rater reliability established.

The following are offered as additional suggestions to the State and Facility:

1. Every effort should be made to address improvements in individuals' personal hygiene, grooming, and dress. Again, staff should consider the core tenets of the principal of normalization and how this applies to these very basic rights.
2. Consideration should be given to reducing the number of individuals residing together in a single residence.

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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 Current Referrals for Community Placement, as of 2/16/11; o Since the last review, list of individuals who have requested community placement, but have not been referred, undated; o List of all individuals who have not been referred solely due to Legally Authorized Representative (LAR) preference, between 8/7/10 and 1/11/11; o List of individuals who have had a Community Living Discharge Plan (CLDP) developed since the last review, undated; o Separation Activity, Community Placement, between 9/1/10 and 2/16/11; o List of individuals discharged pursuant to an alternate discharge, between 8/7/10 and 1/10/11; o Response to request for list of alleged offenders: "None," undated; o In response to request for description of how Facility assesses individual for placement: "Do Not Have," undated; o List of individuals who have returned from a community placement since 1/1/10; o DADS Policy Number 018.1, entitled "Most Integrated Setting Practices", dated 3/31/10; o ABSSLC Policy entitled "Most Integrated Setting Practices," dated 10/20/09; o Community Living Options Information Process (CLOIP) Tracking System for the months of January 2010 through December 2010; o Community Placement Report, dated 1/31/11; o ABSSLC Tour Activity from 8/16/10 through 1/10/11; o List of educational opportunities provided to individuals and families/guardians, from 9/23/10 through 1/14/11; o Since the last review, list of education opportunities provided to staff, including sign-in sheets, various dates; o Presentation entitled: "Community Placement: Facilitation of clients moving into community based programs," undated; o Agenda for ABSSLC State Office Training, dated 11/15/10; o Agenda for training/meeting on 1/14/11; o Supporting Visions: Personal Support Planning Workbook, dated 7/10; o Supporting Visions Tier 2 and 3: Personal Support Planning Workbook; o SSLC Personal Support Plan Meeting/Documentation Monitoring Checklist, dated 7/10; o Since 8/6/10, list of individual for whom a post-move monitor visit was conducted, undated; o In response to request for the most recent report of the Facility's analysis of major obstacles to individuals' movement to community living identified by the SSLC, "Do Not Have," undated;

	○ Personal Support Plans, and related assessments for: Individual #74, Individual #181, Individual #69, Individual #395, Individual #346, Individual #139, Individual #246, Individual #514, Individual #349 and, Individual #176; ○ CLDP, any associated assessments, for the following: Individual #45, Individual #58, Individual #438, Individual #501, Individual #277, and Individual #12; ○ Transition/Discharge Packets for: Individual #79, and Individual #477; and ○ Post-Move Monitoring Checklists for the following individuals: Individual #45, Individual #277, Individual #501, Individual #219, Individual #12; and Individual #72. ▪ **Interviews with**: ○ Pat Smith, Admissions/Placement Coordinator (APC); ○ Laura Wilford, Post-Move Monitor; and ○ Juan Herrera, QMRP Coordinator. ▪ **Observations of**: ○ Community Living Discharge Planning Meeting for Individual #438; ○ PSP Annual Meeting for Individual #283; and ○ Post-Move Monitoring Visit for Individual #45.
	Facility Self-Assessment: Based on a review of the Facility's POI, with regard to Section T of the Settlement Agreement, the Facility found that it was in compliance with 12 of the 17 indicators. This was inconsistent with the findings of the Monitoring Team, which found the Facility in compliance with only five of the 17 provisions. Generally, it appeared that the Facility's reviews addressed the presence of an item, but did not adequately assess the quality of the content. For example, the Facility found itself to be in compliance with Section T.1.b.1, which is the provision that requires PSPs to identify the protections, supports, and services necessary to ensure the safety and provision of adequate habilitation in the most integrated setting appropriate. The Facility indicated it was in substantial compliance, and stated: "Current monitoring results: 100% compliance from 56 reviews since 9/2010. New PSP and CLDP have been implemented and address all areas." As noted in Section F and again with regard to Section T.1.b.1, although the new processes had begun to be implemented, issues related to the quality of these documents continued to exist. In addition to narrative descriptions of steps being taken to attain compliance, ABSSLC provided some summary data from reviews it had completed, which is an important part of the self-assessment process. However, it was unclear specifically what had been measured. For example, in discussing the sections of the Settlement Agreement that relate to the development of CLDPs, the POI indicated that: "1/2011--Current monitoring results: 100% compliance from 56 reviews since 9/2010." The Facility had only completed approximately five CLDPs in that time period, so it was unclear to what the 56 reviews referred. A sample of the CLDPs completed should have been reviewed to determine compliance with these requirements. With regard to Section T.1.a of the Settlement Agreement, which includes numerous requirements, the Facility indicated: "1/2011--Current monitoring results: 95% compliance from 56 reviews since 9/2010. New PSP's and CLDP's have been implemented." No reference was made to a specific indicator(s), making it difficult to interpret the data. For example, no indication was provided as to whether this was a measure of the professionals assessment of the appropriateness of transition to the

	community, that the transfer was not opposed by the individual or his/her guardian, or if once a referral was made, the individual was transitioned within a reasonable time. As is recommended with regard to Section T.1.f, the Facility should continue to expand its self-assessment activities in this area, including identifying the methodology to be used (i.e., documents to be reviewed, staff to be interviewed, samples to be selected); modifying, as appropriate the monitoring tools, particularly to separate out the different types of reviews to be completed using different methodologies and samples; providing specific, written instructions on the implementation of the tools; training staff who will conduct the monitoring using the review tools; and establishing inter-rater reliability. In addition, the Facility should analyze information resulting from monitoring activities, and, as appropriate, develop, implement, and monitor action plans to address concerns identified. Such plans should include action steps, person(s) responsible, timeframes for completion, and anticipated outcomes.
	Summary of Monitor's Assessment: Individuals' PSPs continued to not consistently identify all of the protections, services, and supports that need to be provided 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. At the time of the review, individuals' PSPs did not include determinations by professionals with regard to whether or not community placement was appropriate. 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. The Facility continued to be at the initial stages of identifying obstacles to movement to the most integrated setting appropriate to the individual's needs and preferences, as well as strategies to overcome such obstacles. ABSSLC had begun to implement the new Community Living Discharge Plan process. Overall, the revised form was more comprehensive, included more information, and provided more direction to PSTs than did the previous form. The new process directed the PST to begin the CLDP process at the point of referral. This was an improvement from the previous process. ABSSLC was at the initial stages of implementing these new processes. As a result, a number of the documents reviewed for individuals who had transitioned to the community did not reflect these new expectations. The CLDPs reviewed generally included a number of action steps related to the transition of the individuals to the community. However, many of them did not clearly identify the specific steps that the Facility would take to ensure a smooth and safe transition, and were not sufficiently detailed or measurable. The CLDPs reviewed included essential and non-essential supports. However, it appeared that the Facility continued to be refining this process. Teams did not consistently identify all the essential and non-

	essential supports that the individual needed to transition safely to the community, nor did teams adequately define these supports in measurable ways. Post-move monitoring had been completed in a timely manner for almost all of the individuals who had transitioned to the community. The Post Move Monitor's comments often provided a thorough description of the methods used to evaluate the item and the findings (e.g., interviews, document reviews and observations). Although teams had not always identified all of the needed protections, supports, and services, for those that were identified, the Post Move Monitor reviewed and commented on each one. The post-move monitoring identified some issues with regard to the provision of services at the community sites. Notes demonstrated consistent and thorough follow-up to ensure that issues identified were corrected. The Facility was found to be in compliance with the provisions related to post-move monitoring.

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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 previous reports, 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 generally did not include determinations by	Noncompliance

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		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. For example: ▪ Individual #69's team did not make an independent determination regarding the appropriateness of transition to the community. The team concluded: "The PST determined the most integrated setting at this time is: [Individual #69's] current living environment… This is [Individual #69's] adamant preference, and the PST agrees that he can continue to receive the supports and services that he needs in his current placement. The PST agreed that if [Individual #69] were interested in community placement, he could certainly be successful there as well with the correct supports in place." In one of the CLDPs reviewed, it appeared that the team had made a decision regarding a referral to the community that was separate from the individual's mother, who was not her guardian. Specifically: ▪ Individual #277's CLDP indicated that her mother preferred "continued place (sic) at Abilene State Supported Living Center. However, it was the team's opinion, that [Individual #277] wanted to move to a group home in the community." The Monitoring Team did not have a copy of the full PSP, so was unable to further determine the team's assessment or decision-making process. 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.	
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 previous reports, in response to a request for the Facility's policy, the Facility submitted a copy of the State's policy, which it had adopted. The Facility policy was entitled: "Most Integrated Setting Practices," and was dated 10/20/09. It was not clear that it had been updated to reflect the changes made to the State policy, dated 3/31/10. However, the Facility had not individualized the policy, or provided additional information that would be important to describe the Facility-specific procedures that would be used to implement the policy. Reportedly, the State policy was under revision, but the current State policy and corresponding Facility policy did not accurately reflect some of the positive changes that had begun to be made with regard to practice. The following provide examples of some of the concerns noted: ▪ Section II of the policy entitled: "Staff Training" made the general statement that:	Noncompliance

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		"The training will be provided to all applicable disciplines and all PSTs." However, it did not provide any additional Facility-specific information, such as which staff would complete what type/level of training, timeframes for staff completing training (e.g., as part of orientation training, within so many weeks/months of hire, etc.), what the specific topics the training would include, and/or how mastery of the information would be evaluated (i.e., competency evaluation methods). ▪ In conjunction with the State Office, the Facility had decided to complete pre-move monitoring visits to ensure that essential supports were in place prior to an individual's transition. A specific format for the reviews was being used. This process or related expectations were not documented in the section of the policy entitled: "Procedures for Identifying Needed Supports and Services to Ensure Successful Transition in the New Living Environment." Rather, the written policy described a process in which the Facility was relying on the Mental Retardation Authority to complete this process. ▪ Based on interviews and observations of team meetings, it was clear that expectations had begun to be set at the Facility regarding significant involvement of individuals' teams in activities related to, for example, visiting proposed homes and day/vocational sites in the community, training community provider staff on key elements of individuals' plans prior to the individual conducting overnight visits, and meeting to discuss options after individuals had conducted pre-selection visits. These expectations were not clearly set forth in the policies/ procedures. ▪ The post move monitoring process had been modified in practice to involve individuals' teams meeting after each monitoring report was completed to review the information, and determine if any action needed to be taken. This process was not yet included as part of the written policy/procedures. ▪ Likewise, it appeared that monitoring was occurring at the various settings in which supports were being provided. However, neither the State Office policy nor the Facility policy had been modified to specifically require that reviews be completed at each site at which essential and/or non-essential protections, supports, and services were being provided for each of the required monitoring visits. It will be important for State policy as well as Facility policy to be modified to reflect changes in procedure so that expectations regarding practice are clearly delineated. In addition, as appropriate, the Facility should include in its local policies any Facility-specific details that are relevant to full implementation of the State policy. The Facility had made progress in this area by adopting the State Office policy and incorporating it into the Facility policy manual. In addition to concerns noted above with	

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		regard to the policy and procedures, the Facility remained out of compliance with the implementation of the policy. This is discussed below with regard to each of the subsections of provision T.1.b of the Settlement Agreement. As a result, an overall finding of noncompliance has been made for Section T.1.b.	
	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 indicated in previous reports, 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 medical and physical and nutritional supports); 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 three 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; 2) given the extensive histories of many individuals served by ABSSLC, it is important to have one document that summarizes the most relevant historical and current information about an individual to ensure that none of the important components of treatment are lost in the transition process; and 3) 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, and non-essential supports are provided in a timely and complete manner. 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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		Review of 10 of the PSPs that were developed using the new format and processes showed some progress in teams more effectively identifying individuals' specific needs for supports and services. However, none of the plans reviewed (0%) included a comprehensive list of the protections, supports, and services needed to support the individual. Often this appeared to be due to staff's assumptions that supports were being provided at the SSLC, and that they did not need to be spelled out in detail. In other instances, the continuing deficits in assessments from various disciplines appeared to stymie the teams' ability to create a comprehensive list. In other instances, the lack of integration across disciplines and lack of incorporation of the various plans (e.g. BSPs, PNMTs, health care plans, psychiatric treatment plans, communication plans, etc.) continued to result in incomplete PSPs. <u>Identification of obstacles and strategies to overcome them</u>: Teams continued to be struggling with the identification of obstacles and strategies to overcome them. The following issues were noted: 1) the obstacles sometimes 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; and 2) the plans to overcome the obstacles often were not measurable, did not identify person(s) responsible or timeframes for completion. The new format for the PSP included a section on obstacles identified by the PST. In reviewing the sample of 10 PSPs that utilized the new format, often some obstacles were identified. It often was unclear if: 1) the lists of obstacles were based on the team's knowledge of what was or was not available in the community, because often they were written in terms of the needs of the individual as opposed to lack of availability of such supports in the community, or the lists included items that were not actually obstacles; and 2) if the lists were complete. Of the 10 PSPs reviewed, seven had some obstacles defined (70%) (i.e., Individual #349, Individual #514, Individual #139, Individual #181, Individual #74, Individual #345, and Individual #395). Moreover, action plans to overcome the obstacles identified generally were not present. Of the 10 PSPs, two (20%) included an action plan to address educational opportunities for the individual and/or family/guardian. None (0%) included plans to address other identified barriers. The following provides some examples of concerns noted with regard to the identification of obstacles and plans to overcome obstacles to individuals' transition to the most integrated setting appropriate to their needs: ▪ At the PSP meeting for Individual #238, which a member of the Monitoring Team observed, the team briefly discussed the supports she would require if she moved to the community, including "24-hour nursing," day habilitation, a	

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		wheelchair accessible environment, and bathing equipment, such as an Arjo tub. Although the team had not defined what "24-hour nursing" meant (e.g., RNs available 24 hours a day, or LPNs available 24 hours a day), or what the specific needs were that necessitated 24-hour nursing (medication administration, feeding tube care, assessment of potential for illness, etc.), the MRA representative stated that 24-hour nursing could not be provided in the community unless she went to a nursing home, and the Arjo tub would be difficult to meet, so it would be best if she remained at ABSSLC. The team agreed. The team engaged in no discussion regarding these perceived obstacles or plans to overcome them. ▪ For Individual #176, the team concluded: "There are no known obstacles for community placement, or for her to live anywhere else. She could be sent to a home in a community setting, and would likely eventually adapt. However the PST is of consensus that this is not in her best interest since she does not like change, and appears content with her current home." The team noted that she had gone on a visit to a home in the community, but it had to be cut short because she clearly did not want to be there. The team did not provide any further definition of or plan to overcome Individual #176's dislike for change. For example, given that one of her stated preferences was "all off-campus activities," the team did not discuss pairing favored activities with visits to other community living options. The team did not develop a plan to try to find out what it was about change that Individual #176 did not like. This discussion also was confusing, because later in the plan, the team documented community visits that Individual #176 went on in the spring of 2010 to which they described her reaction as "neutral." ▪ Individual #514's team described the obstacles to community transition as follows: "[Individual #514] has significant medical issues that require daily nursing care. Transportation (at times, if an off-campus trip is desired or medically required), due to an inadequate number of high-top vans with lifts. Specialized transportation – public transit is reluctant to serve people with mobility devices that have unusual configurations. Lack of extensive therapies – occupational therapies, physical therapies, oral feeding therapy, etc. in a centralized location. Inability or unwillingness to grasp an object for more than a few seconds (although he is currently receiving formal training in this area.)" This list included a number of obstacles, which if accurate, would require potential solutions to be identified at the State Office level versus the Facility level, such as the lack of adequate therapy services or transportation supports. Other obstacles were not well defined, such as the reference to "daily nursing care." In order for this information to be useful, it would be helpful for the team to identify exactly what type of nursing services (e.g., RN or LVN), the role of the nurse (i.e., what tasks the nurse needed to perform), and the time spent daily on	

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		these tasks. This would help to define if a nurse needed to be present at all times, or if a visiting nurse would be appropriate. The final obstacle the team identified (i.e., being able to grasp objects) did not appear to be an obstacle at all. No action plans were included to address any of the obstacles identified. ▪ Although the team did not identify any obstacles, based on the narrative in Individual #69's PSP, the only obstacle appeared to be his reluctance to consider a community option. The team documented in the PSP that he had previously attended a community visit, and after that had been adamant he did not want to move to the community. The team did not appear to pursue the reasons for his reluctance. For example, the reason for his negative experience on the community visit he attended was not noted. It would be extremely important for the team to try to define these reasons to determine if actions could be implemented to address Individual #69's concerns about community transition. ▪ Individual #74's team listed his behaviors, such as self-injury, property destruction, and biting as the obstacles. They did not identify what, if anything, was missing from the community system to allow him to live successfully in a community home. ABSSLC remained at the beginning stages of identifying obstacles to community transition, and developing plans to overcome such obstacles. This deficiency, in addition to PSPs that did not adequately identify individuals' needs for protections, supports, and services, resulted in a finding of noncompliance with this provision of the Settlement Agreement.	
	2. The Facility shall ensure the provision of adequate education about available community placements to individuals and their families or guardians to enable them to make informed choices.	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 had taken a number of forms, including: ▪ On 9/23/10, a provider fair was held. Based on review of the sign-in sheets, a number of individuals and staff from ABSSLC attended, but very few families participated. Approximately four family members signed in at the provider fair, 68 individuals, and 88 ABSSLC staff. Approximately 17 community provider staff attended, representing approximately 10 providers. ▪ On the same day as the provider fair, Mental Retardation Authorities (MRAs) also provided training on services and supports available in the community. Families, individuals, and staff were invited. According to the sign-in sheets, approximately 20 ABSSLC staff attended, and two family members. ▪ Visits to community group homes and day programs continued to occur on two Fridays per month. Based on documentation between 8/16/10 and 1/10/11, nine such visits occurred. Approximately 34 individuals from 14 residences participated in the visits. Based on review of individuals' PSPs, at times, teams included this as an action step to provide individuals with greater exposure to	Noncompliance

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		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. ▪ As noted in the baseline report, ABSSLC was fortunate to have a number of staff, including the Post-Move Monitor who 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 might 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 Optimistic Living Vision section of the 10 PSPs reviewed often mentioned exposing an individual and/or his/her guardian further to community options, but the plans to overcome the obstacles identified in this area often were not present or adequately individualized. Of the 10 PSPs reviewed for individuals who were not referred for transition to the community, five (50%) identified a need for further education (Individual #246, Individual #349, Individual #514, Individual #181, and Individual #346), but only two out of the five (40%) included a written action plan (Individual #346 and Individual #181). 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 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. Although the Facility was continuing to complete some of the basic activities related to education, little progress had been made since the last review in individualizing the process.	
	3. Within eighteen months of the Effective Date, each Facility shall assess at least	The Monitoring Team requested for the past 12 months, a list of individuals who had been assessed for placement, the date of the assessment, and resulting recommendations. The Facility provided a list by month, from January 2010 through	Noncompliance

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	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.	December 2010, of individuals who had a CLOIP Assessment completed. No information was included related to recommendations that were made as a result of the CLOIP Assessment. The Monitoring Team made another document request for a description of how the Facility assesses an individual for placement. In response to this request, ABSSLC submitted a document that stated: "Do Not Have." As is discussed above with regard to Section T.1.a of the SA, generally, 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 been achieved, and indicated that this assessment was done every year as part of each individual's annual PSP process. The State should provide the Facility with guidance regarding the process to be used for assessing individuals for placement/transition to the most integrated setting appropriate to meet the individuals' needs.	
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:	ABSSLC was in the initial stages of implementing the new Community Living Discharge Plan process. The Admissions Placement Coordinator, and Post Move Monitor had completed training with the State Office on the new process. In January 2011, the Post Move Monitor and Admissions Placement Coordinator trained the QMRPs on the new process. They also had met with each of the disciplines (e.g., psychology, nursing, medical, and habilitation therapies) to discuss the new process. Additional training was in the process of being provided to PST members. Many of the changes to the CLDP format were in response to discussions that Monitoring Teams had with Facility and State staff during onsite monitoring visits, as well as in response to findings noted in baseline monitoring reports. The Monitoring Teams appreciate and acknowledge the Facility and State's responsiveness. Additional comments regarding the specific CLDPs reviewed are offered later in this section. The following comments are based upon a review of the blank template: ▪ Overall, the form was more comprehensive, included more information, and provided more direction to PSTs than did the previous form. ▪ The new process directed the PST to begin the CLDP process at the point of referral. This was an improvement from the previous process. This will provide an opportunity for PST members to be involved in all aspects of transition, including visiting potential community providers, ensuring that all relevant assessments are completed and reviewed, and following up after the individual	Noncompliance

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		has moved by reviewing the results of each post-move monitoring visit. ▪ The form included a section for documentation of key events, such as dates referral packages were sent to the MRA, dates potential provider lists were sent to the PST, dates the PST met to decide upon providers for pre-selection visits, information related to pre-selection visits, and results/deliberations of such visits. Because the CLDP is a document that would need to be updated at many stages of the process, it is recommended that dates be included each time the document is revised. For example, such dates could be added to the first page, or placed in the footer. ▪ A list of standard items to be completed and in place prior to every individual's move now appeared on page six (e.g., 30-day supply of medications, signed physician orders, required adaptive equipment). In the previous format, these items filled (i.e., unnecessarily cluttered) the list of essential supports and, thereby, detracted from the PST's ability to focus on identifying those essential and non-essential supports that were truly based upon individual needs and preferences. ▪ The list of summaries and recommendations on page nine was also an improvement. It was designed to help the PST remain focused on its primary task related to reviewing assessment, that is, ensuring that all recommendations are reviewed and, moreover, that recommendations are then included in the list of essential or non-essential supports. ▪ Psychiatry should be added to the list of summaries and assessments. ▪ Likewise, if the PNMT has conducted specific assessments, and/or made recommendations, these should be included. ▪ The review of every action plan (i.e., training objective and service objective) was another good addition to the process. The final statement on page 12, however, indicated that the PST could only make recommendations about action plans. It is the opinion of the Monitoring Team that the PST can, and should, make certain action plans (training objectives and/or service objectives) essential or non-essential supports, if the PST believes that implementation of any of these plans is important. The CLDP is the PST's chance to specify the supports and services that the provider must agree to provide. PSTs should be assertive in this area and not squander this opportunity. DADS should remove the statement on page 12 because it appeared to be at odds with the State's desire for transition to grow out of the PSP process. ▪ Many of the person directed planning questions included on pages 13 and 14 should assist teams in planning for individuals' transition to the community. It will be essential, as the process is implemented, to ensure that the information gathered from this component of the new process is incorporated into the essential and non-essential supports. ▪ It was also good to see that the CLDP required a description of the evidence to	

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		indicate whether or not an essential or non-essential support was in place. This was a new component to the CLDP. PSTs will need to be thoughtful and ensure that the requirements look for observable, objective evidence with specific criteria. ▪ The pre-move site review should also be sure to include the list of standard items on page six. This could be added to the list on page 23. ▪ Neither the pre-move nor post-move monitoring forms included a column in which to state definitively the findings (i.e., Yes, No, N/A). In reviewing completed forms, the narrative in the comments section had to be analyzed to determine if the monitor had found the items/activity to be present and/or completed. These forms should be revised to clearly indicate the presence of absence of an essential or non-essential protection, support, or service. Based on interviews with staff, some of the changes that were beginning to be seen for individuals supported by ABSSLC included: ▪ CLDPs were beginning to be developed at the time of referral. Reportedly, from the first meeting, essential and non-essential protections, supports, and services were being identified. ▪ Teams were becoming more involved in the process. Expectations had begun to be set that, depending on the needs of the individual, members of the PSTs would attend visits with the individual to assist the individual and LAR in selecting a provider and ensure the specific sites/programs would meet the individual's needs. ▪ Prior to overnight visits occurring, teams were expected to provide training to community provider staff on the implementation of the individual's programs and plans (e.g., BSPs, PNMPs, etc.). ▪ As team members were updating assessments, they were being asked to ensure that the recommendations included were transferable to the community. ▪ Teams were continuing to provide follow-up after the individual transitioned to the community. This might take the form of answering questions for the community provider, or actually going out to retrain staff. ▪ As is discussed in further detail below, the Post Move Monitor was completing pre-move visits, usually on the same day that the teams were providing in-service training to community provider staff. Although there were concerns related to documentation, it had improved the process being used to ensure that essential supports were in place prior to the individual transitioning to the community. Community Living Discharge Plans were reviewed for four individuals, including Individual #12, Individual #277, Individual #501, and Individual #58. This sample was drawn from the list of five individuals had transitioned to the community since the last	

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		review. With regard to the timeliness of the development of the plans, it appeared that two of the four plans (50%) were developed in a timely manner, even though the dates on these two plans were within weeks of the individuals' transition. This is explained in the examples below regarding Individual #12, and Individual #58. The other two CLDPs reviewed were developed only a few weeks prior to the individual's discharge, making adequate transition planning difficult. More specifically: ▪ Individual #12's plan was dated 12/7/10, and his transition occurred on 12/27/10. However, it is important to note that based on the narrative, and the information included in the CLDP regarding the team's deliberations and discussions, for example, regarding essential supports as far back as October 2010, it appeared this individual's planning had occurred over a sufficient period of time. As noted above, a way of noting the various dates on which the team revises a CLDP either on the first page or in the footer of the document would be beneficial. ▪ Individual #58's CLDP was dated 1/18/11, and he transitioned to the community on 2/7/11. However, based on both the review of the newly formatted CLDP and on a observation the Monitoring Team made in August 2010 of the initial CLDP planning meeting, it was clear that planning had begun, and was documented on the new form months prior to Individual #58's actual transition. At the meeting in August, the team began discussing essential and non-essential supports, as well as plans for pre-selection visits. ▪ Individual #277's CLDP was developed on 9/17/10, and her transitioned occurred approximately a month later on 10/18/10. ▪ Individual #501's CLDP was developed on 9/22/10 for a transition that occurred on 10/12/10. Although the Facility remained out of compliance with this provision, progress was being made. The implementation of the new CLDP process should effectively address concerns regarding the timely development of CLDPs.	
	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. All four (100%) 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 #12 included action steps for staff from ABSSLC to provide "in-service" training to provider staff on supervision levels, personal hygiene needs, mealtime assistance, medications,	Noncompliance

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		and his behavior support plan. 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 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.). In addition, no responsibilities were defined in relationship to communication that needed to occur between clinicians. For example, Individual #12 was undergoing a medication reduction with his psychotropic medications. No action step was included for the ABSSLC psychiatrist to discuss the plan with the receiving psychiatrist. ▪ The CLDP for Individual #58 did not include some action steps for which Facility staff should have been responsible, and which the team had identified in its discussion, but not included in the essential and/or non-essential portion of the plan. For example, in the discussion section, the community provider asked that ABSSLC contact the Department of Assistive Rehabilitation Services (DARS) to request that the referral that had been initiated in Abilene be transferred to the office closest to where Individual #58 would be living. This was not included as an essential or non-essential support. Likewise, the medical summary included a recommendation to have the community primary care provider contact the Family Nurse Practitioner at ABSSLC to "assure continuity of medical care." This was not included as an essential or non-essential support, nor was any justification provided for not including it. On a positive note, an action step was included as an essential support for the counselor at ABSSLC to provide information to the counselor identified in the community. The Facility remained out of compliance with this provision. Although the plans included a number of appropriate action steps for Facility and community provider staff, none of the plans reviewed contained a comprehensive list of such action steps, and/or they were not consistently measurable.	
	2. Specify the Facility staff responsible for these actions, and the timeframes in which such actions are to be completed.	All four of the CLDPs reviewed (100%) included a date of completion, as well as the specific name of the Facility or provider staff responsible for the completion of the actions identified. The Facility was found to be in substantial compliance with this provision.	Substantial Compliance
	3. Be reviewed with the individual and, as appropriate, the LAR, to facilitate their decision-making regarding the supports and services to be	Based on review of four CLDPs, all of them (100%) included documentation that the plans had been reviewed with the individual and/or the LAR, as appropriate. The Facility was found to be in substantial compliance with this provision. As discussed above, the new CLDP format requires that teams meet multiple times to complete various portions of the transition process. This is a positive development. To	Substantial Compliance

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	provided at the new setting.	ensure continued compliance with this provision, it is recommended that the Facility maintain with the CLDP document sign-in sheets that show the attendance at the various meetings held.	
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.	As noted in the previous report, 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 two of the four CLDPs reviewed (50%), including Individual #277 and Individual #501, it was difficult to confirm that all of the relevant assessments had been updated. In order for this item to be in substantial compliance, some sort of checklist or tracking tool should be used that lists all required and optional (i.e., as needed depending upon the individual) assessments, so that PSTs and community providers can be assured that no relevant assessments are missing. For Individual #12, and Individual #58 the new CLDP format was used, and it included a list of assessments that needed to be provided for the CLDP meeting. However, for both of these individuals, some of the assessments attached were more than 45 days old. In addition, concerns were noted with regard to the quality of assessments completed for individuals transitioning to the community. The Discharge Nursing Assessments of four individuals who transitioned to the community were reviewed, including: Individual #501, Individual #219, Individual #277, and Individual #12. Based on this review, the Facility appeared not to have an adequate and consistent procedure regarding the requirements for nursing and nursing documentation. Although a Comprehensive Nursing Assessment was completed for all four individuals, it appeared that these assessments were actually the most recent quarterly Nursing Assessment, and not an assessment for someone who was being discharged from the Facility, where they had resided for a number of years. An appropriate Nursing Discharge Assessment would include an analysis of each of the individual's health/mental health issues since admission, including diagnostic tests that were conducted, and the results; treatments, and their effects on the health/mental health issue; frequency of laboratory work and the most current results; consultations with other specialty areas and the recommendations generated; the positive and negative effects of medications prescribed; the strategies from the Nursing Care Plans that were effective; and, any other information that would assist the providers receiving the individual to continue care and services that promoted optimal health/mental health, and that prevented the complications of these issues.	Noncompliance

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		Consistent with the finding above, none of the four (0%) Comprehensive Nursing Assessments for individuals transitioning out of the Facility were adequate. 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 previous reports, the CLDPs reviewed included essential and non-essential supports. Improvements continued to be 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, not all of the plans consistently identified preferences of the individuals that might affect the success of the transition. 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 four plans reviewed (0%), was a comprehensive set of essential and non-essential supports identified in measurable terms. In previous reports, the Monitoring Team has provided numerous examples of CLDPs that did not adequately define essential and non-essential supports. Based on review of the more recent CLDPs, the following are just a few examples of issues identified with regard to the identification of measurable essential and non-essential supports: ▪ Individual #12's CLDP utilized the new format and process. It contained more information, particularly with regard to team deliberations, than previous CLDPs. Significant concerns, however, continued to be noted regarding the delineation of measurable and thorough essential and nonessential protections, supports, and services. Often times, information included in the narrative portion of the CLDP was not transferred into the section of the plan that identified the essential and nonessential supports. Examples of concerns noted included: o With regard to Individual #12's preferences, the QMRP's assessment included reference to the need for him to "have access to a quiet space where he can go when he is upset," "community outings to eat, shop, and see different forms of entertainment," and "access to outdoor	Noncompliance

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		activities of his choosing. He should be allowed to spend as much time outdoors as possible." Assessments also indicated he did not like loud and busy places. The only non-essential support that addressed activities did not specifically address any of his individual preferences, and it was not measurable. It read: "Opportunities to participate in leisure activities with peers." The OT/PT evaluation discussed his preference for certain types of clothing, as well as not wearing underwear. It referenced a history of ripping clothing, and an implication that one reason for this might have been the feel of different clothing. His preferences for clothing were not addressed at all in the CLDP. o The psychiatrist at ABSSLC was reducing his medications slowly. His CLDP merely stated: "Psychiatric services for medication monitoring." No plan was set forth for the current psychiatrist communicating with the receiving psychiatrist to discuss the medication plan, and progress thus far. Moreover, the support identified in the CLDP was not measurable in terms of the frequency of the psychiatric visits, any particular credentials for the community psychiatrist, and/or the need for community provider staff and/or the community psychologist to share specific behavioral data with the psychiatrist. This would always be important, but particularly in a situation in which medications were being reduced. o The CLDP included a support for the QMRP to provide in-service training to community staff on the need for Individual #12 to receive regular supervision, and more than one staff for community outings. However, regular supervision was never defined in the CLDP. Another essential support was listed as "Staff to ensure supervision at all times when awake." It was not clear if this meant line-of-sight supervision, or some other level of supervision. o For a number of supports, staff were required to undergo in-service training, but there was no requirement for the actual service or support to be provided. The evidence for these items was the sign-in sheets for the training, not proof that the actual service was being provided. For example, in-service training was required for mealtime assistance, and his behavior support plan. However, there was no corresponding requirement that these plans and/or supports be provided, and no requirement that evidence, such as data and/or observation by the Post Move Monitor, be reviewed to confirm the community provider was implementing these essential supports. In other instances, supports that Individual #12 was receiving at ABSSLC were not included at all in the CLDP. For example, he had a 1200-calorie diet with snacks three	

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		times a day. It appeared that the team discussed this at the meeting, but it was not included in the essential/non-essential support section. Likewise, the SLP recommended that he have access to a picture communication book, as he did at ABSSLC, but this was not included. o The clinical services that he required were not well defined. For example, a non-essential service read: "Psychological Services for Behavior support plan." No parameters were included with regard to the frequency of such services, or what such services would entail. The only evidence listed for this support was "Medical Appointment document." This did not provide an adequate description of what quality indicators the Post Move Monitor would need to review to determine if adequate psychological supports. Similar concerns were noted with regard to the psychiatric supports listed. Other clinical supports, Individual #12 was provided at ABSSLC, such as dietary and nursing were not mentioned at all, and no justification was provided for their not being included. o Day/vocational supports were not defined well. A non-essential support was listed as: "Day habilitation with outdoor activities or work if he chooses." At ABSSLC, he was working shredding paper a few days a week for a few hours. Although this was not identified as a strong preference, he seemed to enjoy it. The non-essential support did not adequately define expectations with regard to the days or hours in which he should be involved in day and/or vocational activity, staffing needs during day and vocational activities, specific skills or competencies day/vocational staff would need to have, or expectations with regard to implementation of specific programs or supports at the day/vocational site (e.g., BSP, mealtime needs, etc.). ▪ Individual #277 had a feeding tube, and was at risk due to a diagnosis of dysphagia, and silent aspiration. Her CLDP made reference to ABSSLC staff providing in-service training to community provider staff on her PNMP, nothing by mouth status, medications, specific requirements for slow drip feeding, use of binder for G-tube, and history of gastritis and gastrointestinal bleeding. No action steps were included or evidence identified to ensure that community provider staff were competent in implementing the plans or procedures on which they were provided in-service training. In addition, the CLDP did not include requirements or evidence to be provided that these essential supports actually were being implemented after Individual #277 transitioned to her new home. Her CLDP only identified the need for "24-hour awake staff." No mention was made with regard to any nursing staffing or oversight that should be provided to Individual #277. Likewise, the only delineation in the CLDP of habilitation therapies supports was a requirement that approximately a year	

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		from the time Individual #277 transitioned to the community that she would have an "OT Consult." No details were provided regarding the parameters of such a consultation, and it was unclear in reviewing the CLDP who would be responsible for monitoring and modifying, as necessary, her PNMP. She also had been receiving supports from a dietician while at ABSSLC to monitor her weight as well as laboratory values, and make changes, as appropriate to the formula she was receiving. No mention was made of the need for such supports to be available to Individual #277 in the community, and no justification was provided for discontinuing such services. Individual #277 also had a BSP to address aggression, and self-injurious behavior. She was prescribed psychotropic medication as well. The psychological and psychiatric supports were not well defined in her CLDP either. They merely stated that within 30 days, Individual #277 would have an appointment with a psychiatrist, and psychologist. As discussed above with regard to Individual #12, this is not adequate. With regard to monitoring by the MRA or other means to ensure essential supports are in place prior to an individual's transition, the Monitoring Team requested "all completed pre-move and post-move monitoring checklists for the last 10 individuals who moved to the community." This sample was further reduced to include review of only individuals who had moved since the time of the previous review. It included five individuals, including Individual #277, Individual #501, Individual #219, Individual #12, and Individual #72. For none of these five individuals was adequate evidence provided to confirm that each of the essential supports was in place at the time of the transition. At ABSSLC, this monitoring took three forms. One the MRA completed, and the other the Post Move Monitor completed. Based on the records reviewed, the MRA process appeared 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 was 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 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.	

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		In an attempt to correct this deficiency, the Facility had developed a form entitled "Verification of Essential Supports and Services." This form was submitted for two of the five individuals, including Individual #12, and Individual #72. 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. Finally, the Post Move Monitor was noting on the seven-day, 45-day, and 90-day monitoring forms that she had confirmed the essential supports were in place prior to the individual moving. Based on interview with the Post Move Monitor, she provided examples of efforts she had made to confirm the existence of such supports. However, this did not provide documentation that the review had been conducted and provided to the team confirming the existence of the essential supports. Such documentation is necessary to allow the team to review the findings, and make decisions regarding the appropriateness of the individual's transition. The revised CLDP format includes a pre-move monitoring form. This should help to resolve the issue of proper documentation being present to confirm the existence of the essential supports prior to the individual moving.	
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.	As noted in the previous report, ABSSLC had begun utilizing the Monitoring Teams' review tools to review PSPs, CLDPs, and post-move monitoring documentation related to the community living and transition processes. As noted above in relation to the Facility's self-assessment, called the POI, a number of issues were identified with regard to the Facility's implementation and use of these tools. Some of these are discussed in the Facility self-assessment section, and others are discussed below. However, it should be noted that based on interview with staff, it was anticipated that State Office was finalizing a revised monitoring tool with instructions, which the Facility planned to implement. These concerns included: ▪ Provision T.2 requires the Facility to use a standardized form to conduct post-move monitoring visits at seven, 45, and 90-day intervals to confirm that the essential and non-essential protections, supports, and services are in place, and if deficiencies are found, to make best efforts to ensure the needed supports are provided. The Facility stated: "1/2011--Current monitoring results: 100% compliance from 56 reviews since 9/2010. Substantial Compliance noted by SAMT on 8/2010." It was unclear which sample was used to review 56 post-move monitoring reports, because the Facility had not	Noncompliance

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		conducted that many since 9/10. Moreover, there should have been more than one indicator identified to address this section of the Settlement Agreement. As part of a complete self-assessment process, the dates should have been analyzed and a summary provided to determine the timeliness in meeting the seven, 45, and 90-day intervals, and a sample of post-move monitoring forms should have been reviewed to determine the quality of the monitoring completed, and if adequate action had been taken to address any deficiencies noted. The results of these distinct reviews should have been summarized. Although the Facility's finding of substantial compliance was consistent with that of the Monitoring Team, this did not appear to be based on adequate review or data. ▪ For Section T.1.b.3, which required the Facility to conduct assessment of each individual to determine his/her appropriateness for transition to the most integrated setting appropriate, the Facility found itself in compliance. However, there was a discrepancy in the data provided. The POI stated: "1/2011--Current monitoring results: 43% compliance from 56 reviews since 9/2010. 100% were assessed under the old PSP tool, and we are now in the process of assessing individuals under the new PSP tool." Two different compliance ratings were provided. One showed compliance, and the other indicated noncompliance. Although some progress had been made in this area, the Facility was at the beginning stages of developing and implementing quality assurance processes necessary to assess its implementation of Section T. The Facility should continue to expand its self-assessment activities in this area, including identifying the methodology to be used (i.e., documents to be reviewed, staff to be interviewed, samples to be selected); modifying, as appropriate the monitoring tools, particularly to separate out the different types of reviews to be completed using different methodologies and samples; providing specific, written instructions on the implementation of the tools; training staff who will conduct the monitoring on the review tools and their implementation; and establishing inter-rater reliability. In addition, the Facility should analyze information resulting from monitoring activities, and, as appropriate, develop, implement, and monitor action plans to address concerns identified. Such plans should include action steps, person(s) responsible, timeframes for completion, and anticipated outcomes.	
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	In response to a document request, the Facility provided a list that for 21 individuals identified one obstacle or reason for not referring the individual. For four individuals, the obstacle listed did not appear to be an obstacle, because the report stated "exploring community options." Four individuals had "LAR choice" listed as the obstacle. Six individuals had "medical" listed as the reason, and the remaining seven individuals had "behavior/psychiatric" listed as the obstacle. As noted above, the obstacles that teams	Noncompliance

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	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 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.	were identifying were not yet adequately defined. It would be more helpful if obstacles to placement were more specifically defined. The broad categories of "LAR Choice," and "Behavior/Psychiatric," for example, provided little information about what the obstacle or barrier was. In order for the State and the Facilities to adequately address barriers, they should be: 1) defined with sufficient detail to allow the State to identify and address issues related to the current community system; and 2) identify the protections, supports, and/or services that are currently lacking or not available to allow transition to the community. 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, or the timeliness with which services can be accessed in the community (e.g., certain types of medical services) might be an issue, etc. Such detail is essential to ensuring that the State has the information necessary to make changes to the community system. 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 perceived not to be available in the community, etc. The State needs to collect and analyze such information, and address such concerns to the extent possible.	
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	In response to a document request, the Facility submitted to the Monitoring Team a Community Placement Report. For the time period between 8/6/10 and 1/10/11, the report listed: ▪ Current Referrals: This included individuals who had been referred by their teams for community placement and had an open referral, including the individual's name, the date of referral, and the status of the referral. Five individuals were included on this list. ▪ Community Placements: This included individuals who had transitioned to the community, including their name, date of referral, and date on which their transition to the community occurred. This included four individuals. ▪ Rescinded Referrals: This list represented individuals who had been referred for community transition, but whose referral later had been retracted. It included the individuals' names, date of referral, date on which the referral was rescinded, and a brief reason for the closure of the referral. One individual was included on this list. The reason for referral being rescinded included the LAR's choice.	Substantial Compliance

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	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 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.	During December 2010, the Monitoring Panel requested some additional information regarding transition in order to capture categories of individuals who have either requested community transition, or whose teams have determined they can be appropriately placed in the community. The State worked with the Monitoring Panel to add categories to the Community Placement Report template each of the Facilities uses. For meetings occurring between 9/1/10 and 1/31/11, the report listed: ▪ Individual Prefers Community, Not Referred – LAR Choice: This list included the name of one individual with the date of the meeting at which the decision not to refer was made. ▪ Individual Prefers Community, Not Referred – Other Reasons: This list included five individuals, including the date of the meeting and a brief description of the reason for the referral not being made. For one individual, the MRA was not present, which is a requirement for a referral to be made. In this case, the team reconvened two days later, and referred the individual. This individual was listed as currently referred, as well. For one of the other individuals, the reason was noted as "exploring community options." For two individuals, the reason was listed as "medical," and for one individual, it was listed as "behavior/ psychiatric." ▪ LAR Prefers Community, Not Referred: No individuals were listed in this category. The Monitoring Panel asked that a final category be added that includes a list of names of individuals who would be referred by the team except for the objection of the LAR whether or not the individual himself or herself has expressed, or is capable of expressing, a preference for referral. As noted above with regard to provision T.1.a of the Settlement Agreement, professionals on individuals' teams need to make independent recommendations regarding the appropriateness of an individual for community placement. The State indicated that at this time, its data system did not include this information, but it was working toward being able to produce the data the Monitoring Panel requested. The Monitoring Team looks forward to reviewing this information in the future.	
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	<u>Timeliness of the Checklists</u> Post-move monitoring documentation was reviewed for six individuals (Individual #277, Individual #501, Individual #219, Individual #12, Individual #72, and Individual #45).	Substantial Compliance

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	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.	For these individuals, 15 reviews should have been completed. Of the 15 required visits, 14 (93%) had been documented as having been completed on time, and the remaining one (7%) was not provided (i.e., 45-day review for Individual #12). It was unclear if this was merely an oversight in providing requested documentation. The outstanding visit was to have occurred the week prior to the Monitoring Team's onsite review. While onsite, the Monitoring Team requested: "Any post-move monitoring checklist completed since the original document request was produced." Individual #12's 45-day review was not included in the response to this request. Progress had been made in ensuring that if visits had been made to both the residential and day sites of the individuals, this was clearly documented in the reports. For all of the 14 reports reviewed (100%), the Post Move Monitor had visited the individual at his/her home, as well as day/vocational site. In addition, the Post Move Monitor often noted that a visit had been made to the community provider's office to review paperwork, and/or interview staff. <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. The Facility had not yet begun to use the new format that State Office was finalizing. Each of the items on the checklists reviewed had been addressed. Efforts clearly were being made to add additional information regarding the interviews conducted, the documents reviewed, and the observations made. This should be improved further when the new CLDP format is implemented, and teams are better defining the evidence expected to confirm the existence of an essential or non-essential support. 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. For example: ▪ Individual #12 was supposed to be receiving a 1200-calorie diet, but staff, including the house manager, were not familiar with this requirement at the time of the seven-day review. In addition to speaking with staff about this at Individual #12's home, the Post Move Monitor also followed-up with an email to their supervisor. An email from the provider confirmed that issues related to staffing were being addressed, and that the individual's new physician had discontinued the 1200-calorie diet. ▪ For Individual #72, there was a delay in obtaining psychological services due to the community provider's psychologist cancelling appointments. The Post Move Monitor continued to follow-up on this with the community provider, and by the 90-day review had received confirmation of an appointment with a newly	

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		contracted psychologist. Likewise, Individual #72 had been transitioned from another SSLC, and that SSLC did not provide the required in-service training to the provider staff. The Post Move Monitor recommended that the provider contact the SSLC and request the delinquent training. She continued to follow-up until the training was provided. At the time of the most recent review, post-move monitoring visits were generally being conducted timely, and thoroughly. In addition, it appeared that when issues were identified, they were being addressed, and efforts made to ensure they were rectified. A finding of substantial compliance has been made. It is important to emphasize that because CLDPs continue to include minimal requirements, the Post Move Monitor's job will grow exponentially as the CLDPs begin to include more of the essential and nonessential supports. In order to sustain compliance in this area, considerable effort will be necessary to confirm the existence of these protections, supports, and services.	
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 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.	During the week of the on-site review, a member of the Monitoring Team accompanied the Post-Move Monitor on a post-move monitoring visit for Individual #45. The Post-Move Monitor followed the format, asked many good questions, reviewed documentation, and conducted observations. The review for Individual #45 consisted of visits to the individual's and home, as well as to the office of the community provider. Although he was in school, his CLDP included no measurable requirements for the school, except that he enroll in school, a request be made that he participate in vocational training classes, and after 30 days, the provider meet with the school to determine the appropriateness of his riding the bus to school. Confirmation of these minimal supports did not require a visit to the school. During the review, the Post Move Monitor was helpful in providing ideas to address issues raised, and/or offering to be in touch with staff from the SSLC from which Individual #45 transitioned to clarify issues or obtain additional information. For example, clarity was needed with regard to the hygiene needs on which staff needed to be trained, as well as the transfer of funds from the SSLC. His SSLC team had specifically included counseling as a needed support, but Individual #45 had been screened out after an initial appointment. In addition to requesting that the provider follow-up to determine the reason for his being screened out, the Post Move Monitor also indicated she would follow-up with the SSLC team. The Monitoring Team appreciates that the Post Move Monitor quickly completed the report for this review. In reviewing the report, the Post Move Monitor's findings and recommendations were well documented.	Substantial Compliance

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		Based on the review that was conducted for Individual #45, 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 additional measurable services, supports, and protections are included in the plans, the expectations for the Post-Move Monitor will increase. At this juncture, the CLDP plans, including the one for Individual #45 that was developed by another SSLC, 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 provisions of this Section T, the Facility will comply with CMS-	At a parties' meeting on December 2 and 3, 2010, it was agreed that in addition to the categories listed in the Settlement Agreement, other circumstances of an individual moving from a SSLC might fall under the category of "alternate discharges." One of these	Noncompliance

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	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.	reasons was a LAR choosing to discharge an individual from the Facility, and another was an individual transferring to another SSLC. Since the last review, at the guardian's request, Individual #477 had moved back home with "no more services," and Individual #79 had transferred to another Facility. Based on a review of the discharge summaries completed for Individual #477 and Individual #79, they contained the categories consistent with the Centers for Medicare and Medicaid Services (CMS) requirements. They included a summary of the individual's developmental, behavioral, social, health, and nutritional status. However, in some cases, these summaries did not "accurately describe the individual, including his/her strengths, needs, required services, social relationships and preferences" as required by the CMS guidelines [42 Code of Federal Regulations (CFR) §483.440(b)(5)(i), and W203]. In addition, the discharge plans did not appear to meet the CMS requirement [42 CFR §483.440(b)(5)(ii), and W205] to provide a discharge plan "sufficient to allow the receiving facility to provide the services and supports needed by the individual in order to adjust to the new placement." Some examples included: ▪ The content of the summary information was limited, and did not appear to consistently provide all of the most recent information related to the individuals' strengths, needs, and preferences. For example: o Individual #477's summary indicated that she had many medical consultations while living at ABSSLC. However, the status of each of these was not provided, nor were dates on which follow-up should occur listed. Similarly, Individual #79 had medical diagnoses that placed her at high risk, but no summary was provided of her current status, or the need for regular follow-up with certain specialists. o Although based on the description of Individual #79's behaviors, it was assumed that she had a behavior support plan. However, her transition/discharge summary did not mention the existence of a behavior support plan, or include a status with regard to her progress in meeting the goals of such a plan. Similarly, Individual #477's transition/discharge summary provided no status update on her progress with her behavior support plan, which was mentioned in the summary. ▪ The section of the transfer/discharge summary that identified "Referrals and/or Necessary Services Required in New Environment" included very minimal recommendations for each of the summaries reviewed. For example: o Both Individual #79 and Individual 477 were described as having significant behavior challenges, and both had psychiatric diagnoses. However, neither of their transfer/discharge summaries included recommendation for behavioral or psychiatric follow-up, and/or the	

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		implementation of the existing behavior support plans. o Individual #477 had a specialized diet related to her diagnoses of diabetes and GERD. There was no recommendation or plan to continue this diet, or for a nutritionist to monitor her diet. The Facility was not in compliance with this provision due to the fact that it did not meet the CMS requirements for transition/discharge planning.	

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

1. The State should provide the Facility with guidance regarding the process to be used for assessing individuals for placement/transition to the most integrated setting appropriate to meet the individuals' needs.
2. 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.
3. With regard to policy:
    a. State policy, as well as Facility policy, should be modified to reflect the changes that have occurred regarding transition procedures so that expectations regarding practice are clearly delineated.
    b. In addition, as appropriate, the Facility should include in its local policies any Facility-specific details that are relevant to full implementation of the State policy.
4. 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. ABSSLC also should add creative and individualized educational activities to meet the needs of various individuals and families/guardians, including action plans in individuals' PSPs designed to meet their specific needs. Consideration should be given to developing a written plan that identifies the actions that will be taken, persons responsible and timeframes for completion.
5. With regard to the revised Community Living Discharge Plan template and process:
    a. Because the CLDP is a document that would need to be updated at many stages of the process, dates should be included each time the document is revised. For example, such dates could be added to the first page, or placed in the footer.
    b. Given that the new process requires the teams to meet multiple times, sign-in sheets should be maintained with the CLDP document that show the attendance at the various meetings held.
    c. Psychiatry should be added to the list of summaries and assessments.
    d. Likewise, if the PNMT has conducted specific assessments, and/or made recommendations, these should be included.
    e. The PST can, and should, make certain action plans (e.g., training objectives and/or service objectives) essential or non-essential supports if the PST believes that implementation of any of these plans is important. DADS should remove the statement on page 12 related to the team only being able to recommend the implementation of action plans, because it appears to be at odds with the State's desire for transition to grow out of the PSP process.
    f. The pre-move site review also should include the list of standard items on page six (e.g., provision of 30-day supply of medication, current physician orders, etc.). This could be added to the list on page 23.
    g. The pre-move and post-move monitoring forms should be revised to clearly indicate the presence of absence of an essential or

non-essential protection, support, or service (i.e., Yes, No, N/A).

6. 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. 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;
    c. 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
    d. 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.
7. 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.
8. 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.
9. Teams should be provided with training on the development of action plans/strategies to overcome identified barriers. Such training should be competency-based.
10. 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.
11. 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.
12. 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.
13. As requested by the Monitoring Panel, a final category should be added to the Community Placement report that includes a list of names of individuals who would be referred for community transition by the team except for the objection of the LAR.
14. ABSSLC should review the transition/discharge summary process that it is using for individuals who undergo "alternate discharges" to ensure that the requirements set forth by CMS are met, including a process that:
    a. "[A]ccurately describes the individual, including his/her strengths, needs, required services, social relationships and preferences" [42 Code of Federal Regulations (CFR) §483.440(b)(5)(i), and W203]; and

b. Provides a discharge plan "sufficient to allow the receiving facility to provide the services and supports needed by the individual in order to adjust to the new placement" [42 CFR §483.440(b)(5)(ii), and W205].

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 Guardianship Priority Tools for Priority I and Priority II, with instructions, undated; o Priority I and Priority II lists of individuals needing guardians, updated 1/7/11; o List/Name of individual who obtained a guardian, undated; o ABSSLC Policy entitled "Rights of Individuals Residing at Abilene State Supported Living Center," revised 2/3/10; o Client Assignment and Registration System (CARE) blank form, revised 1/10; o Statement in response to TX-AB-1102-XVII.7 stating: "AbSSLC does not currently utilize a decision making functional capacity assessment"; o Letters (18) mailed explaining the Guardianship Assistance Program; and o List of individuals with CARE designation regarding need for an advocate, current guardianship status, frequency of family/guardian/correspondent contact, undated. ▪ **Interviews with**: o Shae Butts, Human Rights Officer.
	Facility Self-Assessment: In its POI, the Facility recognized that it was not in compliance with the requirements of Section U of the Settlement Agreement. This was also reflective of interviews with staff, and was consistent with the Monitoring Team's findings. Although compliance had not been achieved, the POI indicated that staff had taken steps to develop a prioritized list of individuals requiring guardianship, and was awaiting the final State policy on the subject. In addition to narrative descriptions of steps being taken to attain compliance, ABSSLC also provided some summary data from reviews it had completed, which is an important part of the self-assessment process. However, it was unclear as to specifically what had been measured. For example, for Section U.1 of the Settlement Agreement, the POI stated: "Current monitoring results: 0% compliance from 87 reviews since 9/2010." Although based on the context of the paragraph, it appeared that the reviews were conducted to

	determine if assessments of individuals' capacity had been completed, this was not entirely clear. In future self-assessments, it will be important to state precisely to what the data refer.
	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. In August 2010, the Monitoring Panel provided comments on the draft policy. According to Facility staff, at a meeting in January 2011 of all of the Human Rights Officers (HROs), assignments were made to re-draft portions of the draft policy and its attachments. It was anticipated that a final policy would be completed by July 2011. The State is encouraged to finalize this policy, as it will assist the Facilities to move forward with regard to the implementation of the Section U Settlement Agreement requirements. In the meantime, ABSSLC had continued to use tools it had created to attempt to prioritize a list of individuals in need of guardians. Through the individual planning process, for individuals who did not have guardians, teams had reviewed the level of involvement of individuals' families/correspondents, if any existed. In addition, a "Guardianship Priority" tool had been used to review factors related to the need for decision-making (e.g., medical decisions, financial decisions), as well as the use of restrictive procedures, and lists had been developed of individuals with Priority I and Priority II levels of need for guardianship. Within each list, priority scores had been assigned to each individual. Until the DADS State Office defines the more formalized methods to be used to assess an individual's capacity to provide informed consent, ABSSLC had made efforts to identify individuals, with higher needs related to assistance with decision-making, using an objective process. Since the last review, only one individual had obtained a guardian. The Guardianship Committee had approved another three individuals for funding to defray the costs of guardianship proceedings. In addition to seeking creative alternatives to identify guardians for individuals, 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.

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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	At the time of the review, DADS Central Office was still in the process of finalizing a policy on guardianship and consent. In August 2010, the Monitoring Panel provided comments on a draft policy. Comments also had been solicited from the Facilities. According to Facility staff, at a meeting in January 2011 of all of the HROs, assignments were made to re-draft portions of the draft policy and its attachments. It was anticipated that a final policy would be completed by July 2011. The State is encouraged to finalize this policy, as it will assist the Facilities to move forward with regard to the implementation of the Section U Settlement Agreement requirements. As indicated in previous reports, as part of the annual individualized planning process,	Noncompliance

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	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.	individual teams at ABSSLC were identifying whether an individual had a Legally Authorized Representative or not. Some of the previously stated concerns related to the 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 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. At the time of the most recent review, the Facility recognized the lack of an adequate process for assessing individuals' capacity to provide informed consent. A document the Facility provided as part of the pre-review request stated: "AbSSLC does not currently utilize a decision-making functional capacity assessment." Based on the Monitoring Team's review of the draft State policy on guardianship and consent, it appeared that there were plans to address this issue, as well as concerns related to teams' responsibilities when an individual lacked adequate capacity to make some or all decisions. As noted in previous reports, Facility staff interviewed recognized guardianship as a restrictive procedure that, at times, is necessary to protect an individual who has limited ability to make or express informed decisions. Likewise, the Texas Guardianship Statute recognized guardianship as a restrictive procedure that required due process. The statute also offered limited guardianship as a less restrictive option to full guardianship. Therefore, it is important that assessments of an individual's capacity to provide informed consent detail the areas in which the individual is able to make informed decisions, as well as those areas in which he/she cannot make such decisions. Further, it is important for such assessments to identify if there are supports or resources that could enable an individual to make informed decisions, or increase their capacity to make such decisions. As noted by Facility staff during the on-site review, implementation of the policy the State Office was developing was expected to require significant effort and changes to a number of practices at the Facility, including more intense involvement of individuals' PSTs in assessing individuals' "functional capacity to render a decision" and provide informed consent. This might require ABSSLC to modify further its policies and procedures, to ensure the State policy is implemented thoroughly and with integrity. In the meantime, ABSSLC had developed a document entitled "Guardianship Priority," and it was used by QMRPs to assist teams in determining an individual's priority need level for guardianship. It included a checklist for individuals considered Priority I, which included individuals without a family member/correspondent to advocate for them, and one for individuals considered Priority II, individuals with a family member/	

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		correspondent, but who did not advocate for the individual on a regular basis. Since the last review, the Facility had attempted to more objectively define the level of involvement of family members/correspondents. This included quantifying the number of visits or contacts an individual had with his/her family or correspondent throughout the course of the year, and assisted the Facility in determining individuals who were considered Priority Level I and Priority Level II. This prioritization was then further defined by considering a number of factors including, for example, the need for medical decision-making, use of psychotropic medications and other restrictive procedures, and the need for decisions to be made regarding financial matters. Using the "Guardianship Priority" tool, a numeric score was calculated, and the higher the score (i.e., the more risk factors the individual had related to decision-making), the higher their levels of priority on the guardianship list. At the time of the most recent review, approximately 38 individuals had been identified as Priority I, and approximately 53 individuals had been identified as Priority II. Each of these individuals had been given a priority score based on the completion of the "Guardianship Priority" tool. The Facility recognized that this might not include all individuals who were in need of assistance with making decisions and/or advocacy supports. The Facility also recognized that once the State policy was issued, modifications to this list might occur, based on the more formalized screening and assessment processes contemplated by the draft State policy. However, based on even these initial projections, approximately 91 out of the 447 individuals residing at ABSSLC (20%) were in need of guardians. Progress was being made, but the Facility remained out of compliance with this component of the Settlement Agreement. Although the Facility had at least a partial prioritized list, a standardized process for determining individuals' functional capacity to render informed decisions still was not being used. In lieu of such a process, the Facility had developed a relatively objective process for prioritizing individuals whose teams believed they needed the support of a guardian. Once the State Office policy is finalized, the Facility is encouraged to implement it expeditiously.	
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	Since the last review, only one of the individuals identified as requiring a guardian, Individual #259, had been appointed a guardian. ABSSLC had continued to take some steps to identify potential guardians for individuals who needed them. Specifically, staff had ongoing discussions with family members, and others involved in the individuals' lives, to determine their interest in petitioning the court to become guardians. Since the last review, approximately 18 letters had been sent to interested parties explaining the availability of funding through the Guardianship Committee, for those who qualified, to help defray the costs of the guardianship proceedings. Individual #259 had benefitted	Noncompliance

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	LARs for individuals lacking LARs, through means such as soliciting and providing guidance on the 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.	from this program, and in January 2011, an additional three individuals had been approved for funding. According to the HRO, activity related to a petition for guardianship was underway for at least two of these three individuals. As was discussed in previous reports, another alternative that teams could have 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 reportedly, guardians from the private guardianship organizations 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. In addition to seeking creative alternatives to identify guardians for individuals, 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 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. 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.	

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		ABSSLC was not in compliance with this provision of the Settlement Agreement. Facility staff continued to take actions to identify guardians for individuals, but at the time of the review, these efforts were minimal.	

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

1. The State should finalize the State Office 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 policies on guardianship and consent to reflect the State policy.
4. Based on any additional information provided in the State policy regarding prioritization for guardianship, ABSSLC should review the list that identifies individuals who need the support of a guardian, and re-prioritize the list, as appropriate.
5. Likewise, once the State identifies the tools and processes to be used to assess individuals' decision-making capacity, teams should screen/assess all individuals served by the Facility.
6. ABSSLC staff should collaborate with staff from other SSLCs to identify and implement potential initiatives and resources for identifying guardians (e.g., Lubbock SSLC's initiative to collaborate with local Mental Retardation Authorities and community agencies in an attempt to identify guardians for individuals they support).
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 List of persons responsible for management of records and for auditing records, including names and titles; o ABSSLC Active Record Order and Maintenance Guidelines, revised 12/30/10; o Master Folder Table of Contents, undated; o Statement that ABSSLC did not have Individual Notebooks, and list of locations where relevant information could be found; o Description of sampling technique for records reviews, undated; o Completed review tools for last 10 records reviewed; o Emails showing request for follow-up to address issues identified in the records reviewed for the previous three months, various dates from September 2010 through February 2011; o Email dated 12/2/10 entitled "12/2/2010 Monitoring Tool Meeting Minutes," from Vickie Allmand to a variety of recipients; o Email dated 12/14/10 entitled "Clerk Responsibilities," from Vickie Allmand to Jolene Willis; o Various memoranda to staff regarding results of record audits and need for corrective action on a systemic level; and emails sent to staff requesting modifications to individuals' records; o Description of electronic records used as part of the active record; o List of new or revised policies and procedures completed since the last compliance visit, including copies of policies; and o ABSSLC Active Employee Course Participation Reports for: ▪ Supporting Visions: Personal Support Planning Introduction, from 10/1/10 through 1/10/11; and ▪ Basic Oral Hygiene for Direct Care Staff, from 1/1/10 through 1/11/10. ▪ **Interviews with**: o Kalana Allen, Records Coordinator; o Vickie Allmand, Unified Records Coordinator; and o Gloria Sprecher, Unified Records Coordinator ▪ **Observations of**: o Record storage systems and individual records in homes and day programs
	Facility Self-Assessment: In its POI, the Facility recognized that it was not in compliance with the requirements of Section V of the Settlement Agreement. This was also reflective of interviews with staff, and was consistent with the Monitoring Team's findings. Although compliance had not been achieved, the POI indicated that staff had taken steps to conduct record reviews and had taken actions to ensure

	compliance with Appendix D of the Settlement Agreement. In addition to narrative descriptions of steps being taken to attain compliance, ABSSLC also provided some summary data from reviews it had completed, which is an important part of the self-assessment process. However, it was unclear specifically what had been measured. For example, for Section V.1, the Facility indicated: "Current monitoring results: 74% compliance from review of 104 records since 9/2010." No information was provided about what indicators this data measured and/or if this was meant to be an overall score. As has been discussed in previous reports, the review tools the Monitoring Teams developed, and which the Facility had adopted with some modifications, were not designed to provide an overall score. For example, the indicators on them had not been weighted. Likewise, for Section V.3, the Facility indicated: "Current monitoring results: 83% compliance from review of 104 records since 9/2010." Again, no reference was made to a specific indicator(s) referenced, making it difficult to interpret the data. If this was meant to be an overall score, there was a discrepancy with the information provided with regard to the data provided for Section V.1.
	Summary of Monitor's Assessment: According to staff, all of the individuals at ABSSLC had Active Records and Master Records. The conversion of the records to the new Table of Contents was a substantial accomplishment, and demonstrated impressive teamwork on the part of the Records Department and the Home Clerks assigned to the Units. As Facility staff recognized, challenges remained with regard to ensuring that the records met all of the requirements of Appendix D. The Facility had identified some of these issues and was working to correct them. Since the last review, State Office had provided the Facilities with guidance regarding the Individual Notebooks. Based on this guidance, ABSSLC had decided not to create Individual Notebooks, but instead provided a list of where information "referenced in the Individual Notebook" could be found. This is an area that requires further consideration. As indicated in the previous report, the Monitoring Team recognizes that this should be done in the least cumbersome, and most normative fashion. However, ABSSLC's current methodology did not appear to address fully the requirements of the Settlement Agreement. The Facility was continuing to develop and revise policies to address the requirements of the Settlement Agreement. However, based on documentation provided, the Facility had not, but should develop standardized processes for the dissemination of policies, and training of staff on new or revised policy requirements. With regard to auditing records, progress continued to be made, but issues remained with regard to the reliability and validity of the monitoring data. The Facility also was still in the process of looking more formally at aggregated results of monitoring data, and developing and implementing actions necessary to correct deficiencies identified systemically. Based on observations of team meetings, teams were not consistently using data, and other information contained within individuals' records, to make care, treatment, and training decisions. In addition, issues

	related to the timely and accurate filing of information, and the maintenance of complete data, had the potential to impact negatively on teams' decision-making ability.

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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.	According to staff, all of the individuals at ABSSLC had Active Records and Master Records. The conversion of the records to the new Table of Contents was a substantial accomplishment, and demonstrated impressive teamwork on the part of the Records Department and the Clerks assigned to the Units. As Facility staff recognized, challenges remained with regard to ensuring that the records met all of the requirements of Appendix D. Some of the issues the Facility had identified and were working to correct are discussed below. Since the last review, State Office had provided the Facilities with guidance regarding the Individual Notebooks required by Appendix D. Based on this guidance, ABSSLC had decided not to create Individual Notebooks, but instead provided a list of where information "referenced in the Individual Notebook" could be found. The document the Facility provided indicated that the information was maintained in locations that were always available to home staff. The list included the Behavior Support Treatment Notebook, Training Goals, Information Risk Cards, the PNMP, the Diet Book, and the Treatment Book. 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." This is an area that requires further consideration. The list provided specifically stated that these binders and resources were available to home staff. Throughout the day, individuals attend day and vocational activities, as well as recreational activities. Staff supporting individuals during these activities should have ready access to information, as well as a place to document necessary data and information. As indicated in the previous report, the Monitoring Team recognizes that this should be done in the least cumbersome, and most normative fashion. However, ABSSLC's current methodology did not appear to address fully the requirements of the Settlement Agreement. The State Office should provide additional guidance on this issue. At the time of the review, there were 20 Home Clerks, and one vacant position for a home clerk. The staff in these positions had a number of job duties, one of which was filing documents in the active records. Reportedly, at times, depending on the activity level of the residence to which they were assigned and the corresponding demands on their time, Home Clerks had difficulty maintaining the active records in a timely manner. On 12/14/10, one of the Unified Records Coordinators sent an email to the Assistant	Noncompliance

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		Director of Programs articulating these concerns. The Medical Records Coordinator reported that an initial meeting had been held with Facility Administration to discuss potential modifications to the Home Clerks job duties, to ensure adequate time to complete their filing duties. As is discussed in further detail with regard to Section V.3 of the Settlement Agreement, the Facility had begun to self-identify issues related to their compliance with Appendix D and to take action to correct deficiencies noted. For example: ▪ In a 2/2/11 memorandum, the Unified Records Coordinator indicated that in 99.9% of the audits completed during the past 12 months, legibility had been identified as a concern. The memorandum further stated that many of these concerns related to the legibility of signatures and titles. Supervisors were asked to provide reminders to staff of the importance of writing legibly in records, in order to attain compliance with this section of the Settlement Agreement. ▪ Similarly, on 1/31/11, a memorandum had been sent to all medical staff asking that attention be paid to ensuring that any gaps in documentation had lines written through to prevent any out of chronological order documentation. ▪ The Facility's self-assessment activities identified some patterns of documents being misfiled. Memorandums were sent to file clerks and QMRPs related to ensuring, for example, that PALS Summaries, Health Care Service Plans, and Eating Nutritional Management Plans were filed according to the standard record order. Based on interview, a specific training also was provided to a small group of approximately four or five Home Clerks who seemed to have misunderstandings about the filing of certain documents. While the Facility had made progress with regard to the conversion of the Active Records to the new Table of Contents, it was not yet in compliance with this provision of the Settlement Agreement. In addition to better addressing the requirements for an Individual Notebook for each individual, ABSSLC should continue to address issues related to the quality of the records, as well as the timely filing of information.	
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	As is discussed throughout this report, policies and procedures necessary to implement the Settlement Agreement were in various stages of development. This included policies that DADS State Office was developing, as well as those being developed or revised at the Facility level. As was reported previously, 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	Noncompliance

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	this Agreement.	within the manual for ease of use. Shortly before the most recent review, the Information Technology Department had given the Records Department sole access to modify policies maintained on the Facility's server. This was due to the fact that other staff had been making changes to policies without going through the established channels for modifying policies. Since July 2010, a policy had been in place 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. One of the questions that had arisen related to the definition of policies versus procedures, and whether or not all related procedures needed to be included as part of the Facility's policy manual. For example, there was an entire manual of nursing procedures, which, at the time of the review, was simply referenced in the policy manual. It will be important to ensure that there are clear instructions to guide the development of policies and procedures, adequate approval processes for both, and regular review to ensure that they meet the requirements of the Settlement Agreement, as well as all applicable regulations. The Policy Committee should define the difference between policies and procedures, as well as the review and approval requirements for each. In defining the review and approval requirements, the Committee should delineate who has responsibility for reviewing and approving them, as well as the frequency of review. In its document request, the Monitoring Team asked for a list of each new or revised policy since the last review, and "a copy of communication to staff to inform them of the policy, a description of training provided (with a copy of training materials), and/or blank competency evaluation tools." Lists of staff who had participated in training were submitted for two of the new policies related to PSPs and dental care. Neither of these rosters indicated if, or how, staff competency was determined. Moreover, for the remaining policies, which totaled approximately six, although this appeared to be an underestimate, no information was provided with regard to how the policies were disseminated to the staff responsible for their implementation, the training provided, or whether or not efforts were made to ensure staff had the necessary knowledge and skills to implement the policies. This is an essential component to ensure compliance with this section of the Settlement Agreement, which requires that "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" (emphasis added). The Facility was making progress in updating and/or developing policies to address the	

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		various requirements of the Settlement Agreement. However, it was not yet in compliance with this provision. In addition to continuing to develop and revise policies in concert with the issuance of State Office policies, the Facility also should develop standardized processes for the dissemination of policies, and training of staff on new or revised policy requirements.	
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 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.	Progress had continued to been made with regard to the auditing of records. At the time of this review, both the Records Department and the QA Department were continuing to conduct record reviews. These reviews were being conducted using the review tool developed by the Settlement Agreement Monitoring Teams with some modifications. At least five record reviews were being completed each month, and these reviews generally were identifying issues that needed correction. The process for ensuring such corrections were made is discussed in further detail below. As was discussed in the last report, in conducting monitoring, it is important to establish inter-rater reliability. Some actions had been taken to address the need for consistent procedures and standards to be used in monitoring. For example, on 12/2/10, the staff responsible for auditing records from the Quality Assurance and Records Departments met and discussed some common discrepancies. Decisions were made, and documented in the minutes, to resolve the issues identified. However, in reviewing monitoring forms the Unified Records Coordinators completed, some discrepancies and/or concerns were noted. Specifically, in the portion of the tool that reviewed the records to ensure compliance with the record order, one of the Unified Records Coordinators appeared to mark many items as "No," or not found (e.g., record reviews for Individual #307, Individual #50, Individual #485, and Individual #505), while the other Unified Records Coordinator appeared to mark many similar items as "N/A," or not applicable (e.g., record reviews for Individual #529, Individual #238, Individual #390, and Individual #127). This difference in rating items should be reviewed to determine if a legitimate explanation exists, or if it represented an inter-rater reliability issue. In addition, the basis was not always clear for an item being judged as being in compliance, when related quality issues were noted in the comments section or in other sections of the monitoring tool. Some examples of this included: ▪ The record review conducted for Individual #307 on 12/20/10 found compliance with the indicator requiring records to include signatures and titles. However, there was a notation later on the form that stated: "Training goals dated 10-9-10, 10-6-10, need staff signatures. This record review also had "Yes" marked for the presence of Quarterly Drug Regimen Reviews, but the comments section noted that one QDRR was missing.	Noncompliance

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		▪ For Individual #50, the comments section indicated that the HRC Rights Assessment was outdated, but "Yes" was checked. Compliance also was found with the indicator requiring records to include signatures and titles. However, a notation was made that the QMRP signature was needed on one skill acquisition form, and staff signatures were needed on two other forms. ▪ For Individual #485, "Yes" was checked despite a note that indicated: "Only 2 Moses forms found in the chart." The maintenance guidelines listed on the review tool stated that four forms should remain in the record. ▪ On the review tool dated 12/8/10, for Individual #505, the indicator for entries being dated "with complete date and time" was marked as a "Yes" for being in compliance. However, later on the review tool, in the comments section, a notation was included that: "Behavior Ob(servation) notes have several entries that have no time entered on them." This issue was identified in follow-up emails, and staff were required to complete in-service training to correct it. With regard to follow-up activity to correct deficiencies noted as a result of record reviews, the Facility was taking a number of positive steps. After each record review was completed, the Unified Records Coordinators were sending emails to staff who needed to take actions to correct identified problems. A copy of the completed record review tool was sent, along with a summary of action that the Unified Records Coordinators were requesting be taken. Based on interview, as well as document review, the Unified Records Coordinators were then completing a follow-up review of the record. This had been taking as much as 90 days, but the goal was to complete these within 30 days. At the time of the review, this process was taking an average of 60 days. The Unified Records Coordinators were documenting their findings of this second review. In the documents the Monitoring Team reviewed, there were some examples of effective and strong follow-up to ensure deficiencies were corrected. For example: ▪ The Unified Records Coordinator completed a review of Individual #238's record on 12/14/10. Amongst other corrections that needed to be made, the Hepatitis screening was missing. At the time of the follow-up review on 2/10/11, it was still missing. The Unified Records Coordinator sent an email giving a 10-day deadline for correcting the issue, and indicating that an email also had been sent to the Archives office to determine if a copy was available. A note indicated that the Hepatitis screening had been obtained from Archives and sent for filing in Individual #238's Active record. ▪ A record review on 12/8/10 for Individual #505 identified that staff were not completing the behavior observation notes properly, were using the form for incorrect purposes, and were not including the time of the note. An email dated 12/9/10 requested that staff participate in in-service training on the correct use and proper completion of the forms. On 1/5/11, a follow-up email was sent as a reminder that the in-service training needed to be completed, and	

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		documentation forwarded to the Records Department. ▪ When a follow-up record review showed that necessary changes had not been made in Individual #390's record, a second email was sent requesting that specific changes be made, including obtaining a picture of the individual for the record, and filing the PSP and training objectives. Based on document reviews, although no formal action plans had yet been developed to address systemic issues related to records, less formally, the Facility continued to take steps to address some of the issues identified. As noted above, with regard to Section V.1 of the Settlement Agreement, some of the systemic issues identified included legibility, ensuring that lines were written through blank spaces to ensure that chronological notes were maintained, and misfiling of certain specific documents. Some of the actions the Facility took are outlined in the section of this report that addresses Section V.1. As indicated in the last report, some steps had been taken specifically to address legibility of medical notes. These 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 Medical Records Coordinator, the only drawback appeared to be the time delay in filing the resulting reports. This was more of a potential problem during 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 individuals 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. Although progress continued to be made with regard to this provision of the Settlement Agreement, issues remained with regard to the reliability and validity of the monitoring data. The Facility also was still in the process of looking more formally at aggregated results of monitoring data, and developing, and implementing actions necessary to correct deficiencies identified systemically.	
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, as well as staff's use of the records in making care, medical treatment, and training decisions: ▪ Observation of individual planning meetings showed mixed results with regard to staff's use of information in the records to make care, medical treatment, and training decisions. For example: o At Individual #283's PSP meeting, her record was present. However,	Noncompliance

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		staff did not use the data within the record to make decisions. For example, the nurse on the team listed Individual #283's nursing care plans, but provided no data for the team's consideration to illustrate whether the current plans were working and/or needed to be modified. Moreover, although the team did not explicitly discuss her risk levels, it appeared that the team signed off on assigned risk levels without considering any objective data from the record. Similarly, when her skill acquisition goals/objectives were discussed, the team did not reference data in her record, but rather made general statements, such as "she's doing well," and made decisions to continue and/or modify goals based on such subjective statements. o At a meeting for Individual #100, to discuss and develop a plan related to his high-risk conditions, his multi-volume record was present. At times, members of the team used it effectively to inform the group's decision-making. For example, his physician used the record as a reference several times to clarify issues or identify information necessary to assist the team in its decision-making. However, some information was missing from the record, specifically an x-ray, and the transcription of the physician's findings with regard to the x-ray, had not yet been completed and/or filed. There were other times during the meeting when the team should have referred to the record to obtain objective data, but did not. For example, in discussing his seizure disorder, nursing staff estimated when his last seizure activity was, and the frequency of his seizures, as opposed to utilizing the seizure record to provide the team with objective data on which to base its 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 processes were not in place to ensure data reliability. ▪ During the Monitoring Team's review, members of the Monitoring Team had difficulty finding some items in the records, and, when asked for assistance, Facility staff had similar difficulties. In some cases, items were found, but had been misfiled, and in other cases, copies needed to be obtained from elsewhere. The Facility needs to continue to ensure that documents are filed in a timely and accurate 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 was awaiting guidance from State Office on methodologies for monitoring	

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		this component of the Settlement Agreement. As had previously been discussed, 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., 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.	

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

1. Facility Administration should continue to work with records management staff to ensure that resources at the unit level are adequate to maintain the records in the new format.
2. The State Office should provide additional guidance with regard to 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.
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. The Facility should develop a standardized system to disseminate new or revised policies to the staff responsible for their implementation, train staff, and ensure staff have the necessary knowledge and skills to implement the policies.
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.

The following is offered as an additional suggestion to the State and Facility:

1. The Policy Committee should define the difference between policies and procedures, as well as the review and approval requirements for each. In defining the review and approval requirements, the Committee should delineate who has responsibility for reviewing and approving them, as well as the frequency of review.

List of Acronyms Used in This Report

Acronym	Meaning
2°	Due to
≥	Greater than or equal to
≤	Less than or equal to
AAC	Alternative or Augmentative Communication
ABA	Applied Behavior Analysis
ABSSLC	Abilene State Supported Living Center
ADR	Adverse Drug Reaction
AED	Automatic External Defibrillator
AED	Antiepileptic Drug
APC	Admissions/Placement Coordinator
APEN	Aspiration Pneumonia/Enteral Nutrition
APS	Adult Protective Services
ASAP	As Soon As Possible
AWC	Advanced Wound Care
BCABA	Board Certified Assistant Behavior Analyst
BCBA	Board Certified Behavior Analyst
BSC	Behavior Support Committee
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
CBC	Complete Blood Count
cc	Cubic Centimeter
CD	Communication Dictionary
C-Diff	Clostridium difficile
CFR	Code of Federal Regulations
CLDP	Community Living Discharge Plan
CLOIP	Community Living Options Information Process
CME	Continuing Medical Education
CMS	Centers for Medicare and Medicaid Services
CNE	Chief Nurse Executive
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

dc'd	Discontinued
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
ECU	Environmental Control Unit
EGD	Esophagogastroduodenoscopy
EKG	Electrocardiography
ER	Emergency Room
FBA	Functional Behavioral Assessment
FTE	Full-time Equivalent
FY	Fiscal Year
GERD	Gastroesophageal Reflux Disease
GI	Gastrointestinal
G-tube	Gastrostomy feeding tube
HCG	Health Care Guidelines
HCS	Home and Community-Based Services
HIV	Human Immunodeficiency Virus
HMP	Health Management Plans
HPT	Home Program Technician
HRC	Human Rights Committee
HRO	Human Rights Officer
HST	Health Status Team
IC	Infection Control
ICAP	Inventory for Client and Agency Planning
ICD	International Classification of Diseases
ICF/MR	Intermediate Care Facilities for persons with Mental Retardation
ID/DD	Intellectual Disabilities/Developmental Disabilities
IDEA	Individuals with Disabilities Education Act
IDT	Interdisciplinary Team
ILASD	Instructor Led Advanced Skills Development
ILSD	Instructor Led Skills Development
IM	Intramuscular
IMC	Incident Management Coordinator
IMRT	Incident Management Review Team
IPN	Integrated Progress Notes
IV	Intravenous

J-tube	Jejunostomy feeding tube
L	Liters
LAR	Legally Authorized Representative
LPM	Liters per Minute
LRA	Labor Relations Alternatives
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
MOU	Memorandum of Understanding
MR	Mental Retardation
MRA	Mental Retardation Authority
MRSA	Methicillin-resistant Staphylococcus aureus
NEPT	New Employee Pre-service Training
NG	Nasogastric
NM	Nutritional Management
NMT	Nutritional Management Team
NOS	Not Otherwise Specified
NP	Nurse Practitioner
NPO	Nothing by Mouth
O2	Oxygen
OHR	Oral Health Rating
OIG	Office of Inspector General
OT(R)	Occupational Therapist
PA	Physician Assistant
PALS	Positive Adaptive Living Skills
PBSP	Positive Behavior Support Plan
PCM	Program Compliance Monitor
PCP	Primary Care Practitioner
PDR	Physician's Desk Reference
PECS	Picture Exchange Communication System
PEG Tube	Percutaneous Endoscopic Gastrostomy Tube
PERRL	Pupils Equal, Round, and Reactive to Light
PFW	Personal Focus Worksheet
PIC	Performance Improvement Council
PICC	Peripherally Inserted Central Catheter
PLACHECK	Planned Activity Check
PMAB	Prevention and Management of Aggressive Behavior

PMM	Post Move Monitor
PNM	Physical and Nutritional Management
PNMP	Physical and Nutritional Management Plan
PNMT	Physical and Nutritional Management Team
PO	By mouth
POI	Plan of Improvement
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
RCA	Root Cause Analysis
RD	Registered Dietician
ROM	Range of Motion
RWR	Recommended Weight Range
QA	Quality Assurance
QA/QI	Quality Assurance/Quality Improvement
QDRR	Quarterly Drug Regimen Review
QE	Quality Enhancement
QMRP	Qualified Mental Retardation Professional
RN	Registered Nurse
SA	Settlement Agreement in U.S. v. Texas
SAC	Settlement Agreement Coordinator
SAMS	Self Administration of Medication
SFAR	Structural and Functional Assessment Report
SIB	Self-Injurious Behavior
SLA	Speech Language Assistant
SLP	Speech and Language Pathologist
SSLC	State Supported Living Center
STD	Sexually-transmitted disease
TIVA	Total Intravenous Anesthesia
TOC	Table of Contents
TST	Tuberculin Skin Test
USPSTF	United States Public Health Task Force
UTI	Urinary Tract Infection
VNS	Vagus Nerve Stimulator
VTE	Venous Thromboembolism