**United States v. State of Texas**

**Monitoring Team Report**

**Abilene State Supported Living Center**

**Dates of Review:** August 22 through 26, 2011

**Date of Report**: November 22, 2011

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## I. Background

In 2009, the State of Texas and the United States Department of Justice (DOJ) entered into a Settlement Agreement regarding services provided to individuals with developmental disabilities in state-operated facilities (State Supported Living Centers), as well as the transition of such individuals to the most integrated setting appropriate to meet their needs and preferences. The Settlement Agreement covers 12 State Supported Living Centers (SSLCs), 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.

Pursuant to the Settlement Agreement, the parties submitted to the Court their selection of three Monitors responsible for monitoring the facilities' compliance with the Settlement. Each of the Monitors was assigned responsibility to conduct reviews of an assigned group of the facilities every six months, and to detail findings as well as recommendations in written reports that are submitted to the parties.

In order to conduct reviews of each of the areas of the Settlement Agreement, 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.

Although team members are assigned primary responsibility for specific areas of the Settlement Agreement, the Monitoring Team functions much like an individual interdisciplinary team to provide a coordinated and integrated report. Team members share information routinely and contribute to multiple sections of the report.

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 can 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 Settlement Agreement.

## 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 the tour, the Monitoring Team visited the State Supported Living Center. As described in further detail below, this allowed the team to meet with individuals and staff, conduct observations, review documents, as well as request additional documents for off-site review.
(b) **Review of documents –** Prior to its onsite review, the Monitoring Team requested a number of documents. Many of these requests were for documents to be sent to the Monitoring Team prior to the review, while other requests were for documents to be available when the Monitors arrived. The Monitoring Team made additional requests for documents while on site. 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.
(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, Personal Support Team (PST) 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 addresses each of the requirements regarding the Monitors' reports that the Settlement Agreement sets forth in Section III.I, and includes some additional components that 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 Settlement Agreement, 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 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 Settlement Agreement.

This section summarizes the self-assessment steps the Facility took to assess compliance and provides some comments by the Monitoring Team regarding the Facility Report;

(c) **Summary of Monitor's Assessment:** Although not required by the Settlement Agreement, 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:** A determination is provided as to whether the relevant policies and procedures are consistent with the requirements of the Agreement, and detailed descriptions of the Facility's status with regard to particular components of the Settlement Agreement and/or Health Care Guidelines (HCGs), including, for example, evidence of compliance or noncompliance, 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") is stated; and

(f) **Recommendations:** The Monitor's recommendations, if any, to facilitate or sustain compliance are provided. The Monitoring Team offers recommendations to the State for consideration as the State works to achieve compliance with the Settlement Agreement. 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 Settlement Agreement.

(g) **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, as Individual #45, Individual #101, and so on.) The Monitors are using this methodology in response to a request form the parties to protect the confidentiality of each individual.

## IV. Executive Summary

This report reflects a number of areas in which ABSSLC made progress. Often this progress involved the development of some of the basic foundations for achieving compliance. Many of the staff with whom the Monitoring Team spoke during the week of the onsite review were able to identify the next steps that should occur to continue working towards achieving compliance with the Settlement Agreement. However, much additional work was needed to comply with the Settlement Agreement overall. It will be important to bring projects that are underway to fruition, and to continue to identify and work on additional areas in which progress had not yet been made.

In addition, in some key areas, particularly medical and nursing, which have a direct impact on the health and safety of individuals, concerted and significant effort was necessary to improve the supports, services, and protections provided

to individuals. It is absolutely essential that in the next six months, the necessary actions be taken, and that, as necessary, the appropriate training, mentoring, and supervision be provided to effectuate the needed changes.

As with previous reviews, the Monitoring Team would like to thank the management team, all of the staff, and the individuals who live at ABSSLC for their assistance during the onsite monitoring visit, as well as in preparation before the visit, and the production of many documents after the visit. Everyone with whom the Monitoring Team spent time during the onsite review was helpful in providing valuable information to assist the Monitoring Team in reviewing the Facility's status with regard to the Settlement Agreement.

The following is a brief summary of ABSSLC's status with regard to relevant the sections of the Settlement Agreement:

Restraints

- The trend analysis reports continued to provide an analysis of the data on restraints, and 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.
- In general, the Facility had systems in place for restraint reporting, monitoring, and review processes. However, concerns were noted with 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 Behavior Support Plans (BSPs) in an effort to reduce target behavior and prevent the use of restraint.
- Concerns continued to be 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.
- It was unclear how Restraint Monitors were being trained, and whether a training curriculum with outdated practices was being employed to train medical personnel on the use of restraint.

Abuse, Neglect and Incident Management

- Investigations were completed using a standard format, were processed electronically, and, for the most part, were conducted in a timely fashion.
- Training for staff on abuse and incident reporting was in place, and all but two percent of staff were current on that training. Supervisors had conducted checks with staff members to verify their understanding. However, staff were not consistently informing the Facility Director about incidents in a timely manner.
- Monitoring tools were being used to self-assess compliance and the results specific to individual provisions were provided as evidence of compliance.

- Audits of injury reports had not begun. Non-serious and peer-caused injuries occurred at a significant rate and the causes were not being investigated.
- Tracking of staff reassignment and return needed to be revised to include training provided to returning staff, and the result of any disciplinary action that was taken. The current system of handwriting the reassignment information was difficult to read since handwriting was sometimes illegible, and notations about return were not always entered.

Quality Assurance

- The Quality Assurance/Quality Improvement (QA/QI) Committee, established to review quality management efforts and to strategize solutions to identified issues, merged with the Program Improvement Council and was moving to twice monthly meetings.
- Quality monitoring tools were available for all sections of the Settlement Agreement. The Program Compliance Monitors used most of the tools to assess compliance with the sections of the Settlement Agreement, and departments were conducting self-assessments using the same tools. However, improved guidelines/instructions for and modifications of the monitoring tools were needed to promote inter-rater reliability, as well as the validity of the findings.
- A quality assurance plan had been adopted and procedures put in place to implement it.
- 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.
- Corrective Action Plans will need to be developed to respond to trends identified. Follow-up also will need to occur to ensure that actions are taken to effectively address the trends.

Integrated Protections, Services, Treatments and Supports

- Since the last review, Qualified Developmental Disability Professionals (QDDPs) had undergone additional training on meeting facilitation, and consultants for the State had begun to train teams on the philosophical and historical context of individual planning, as well as on some of the logistics of the development of sound plans. Both the QDDP Coordinator and the State consultants had begun to provide technical assistance to teams at ABSSLC during annual planning meetings. Based on the meetings observed while the Monitoring Team was onsite, these efforts had begun to show positive changes with regard to facilitation skills, more productive meetings, and a more person centered focus. As would be expected, significant changes had not yet occurred in the Personal Support Plan (PSP) documents themselves.

- 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.
- Action plans largely addressed skill acquisition plans and regular medical appointments, but did not comprehensively target other supports, services, treatments, or strategies. Focused effort was needed to improve the scope of action plans, as well as to ensure they included measurable outcomes and objectives.
- Although some person-centered concepts had begun to be incorporated, comprehensive, integrated plans were not yet being developed. 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.

<u>Integrated Clinical Services</u>

- The revised Personal Support Team (PST) format and risk discussions with all disciplines contributed to an integrated clinical approach to the care of the individual.
- A liaison physician was appointed to the Physical and Nutritional Management Team (PNMT) to assist in integrating medical care.
- The morning medical meeting was potentially a forum for integration of all clinical services. Meetings had been held regularly over the prior six months, and minutes were maintained that documented the case reviews, and occasional important issues. However, based on observation of the morning meetings, the discussions of the clinical cases needed further integration across disciplines. Each clinical discipline should be represented and participate, and the meetings should not merely focus on individuals in the Infirmary, although rounding is important on these complex individuals.
- No "round table" or conference room discussions were occurring related to the individuals in the hospital, nor was discussion occurring demonstrating an integrated approach in planning individuals' return to the Facility once discharged. Critical thinking about preventing further acute illness was not evident.
- Additionally, improvement was needed with regard to primary care practitioners (PCPs) documenting their review of consultant reports and recommendations, especially if they agreed or not with the findings, and, if there was disagreement, providing a rationale and alternate action plan.

<u>Minimum Common Elements of Clinical Care</u>

- The Facility had made little progress with regard to this section. The Facility was anticipating the clinical guidelines to be completed in the near future, and clinical indicators should be part of the structure of the guidelines. However, the guidelines are not the only source for clinical indicators, and many could be chosen from the literature and clinical experience of the PCPs.

At-Risk Individuals

- The State Office Consultants had assisted in mentoring the PSTs to develop quality ratings with adequate rationale to justify the ratings. Based on the Monitoring Team's observations of PSPs during the onsite review, the PSTs clearly had made some progress regarding the At-Risk process. However, no improvements were found affecting the clinical outcomes for individuals designated to be at risk. Some of the concerns related to the process included:
  - Teams had improved with the scoring of risk ratings. However, the PSTs did not consistently use specific clinical data when determining risk levels.
  - Lack of thorough assessments needed for determination/completion of an action plan impeded the quality and outcome of the action plans. If the clinical departments do not critically review the health care of the individual, then diagnoses and comorbid conditions will be missed.
  - The PSTs' discussions regarding Action Plans for high and medium risks did not include measurable, functional, outcomes and interventions.
  - Most of the interventions mentioned during the PSP meetings addressing high/medium risks did not reflect clinical intensity in alignment with the level of risk designated by the teams.
  - When discussing interventions for high-risk indicators, the PSTs did not focus on proactive measures for inclusion in the action plans.
  - The Physical and Nutritional Management Team was not adequately involved or integrated with the teams of individuals at highest risk.

Psychiatric Care and Services

- The Facility appeared to be making progress in the area of polypharmacy. The necessity of the current medications was a topic of discussion in almost all of the Psychiatric Clinics that were observed. Many of the individuals who were reviewed had already had substantial reductions in their psychotropic medications, both in terms of the number of medications prescribed, as well as the dosages of individual medications. This was especially true for the individuals who were admitted from the community while on multiple medications.
- The review of the individual records showed progress had been made in completing Comprehensive Psychiatric Evaluations (CPEs) that met both the formatting and content requirements of the Settlement Agreement. The information contained in these documents had positively affected the Facility's performance with regard to the justification of the psychiatric diagnosis, the differentiation of the behaviors that were related to the psychiatric diagnosis, as opposed to environmental factors, the efficacy of the psychotropic medications, and the discussion of the risks versus benefits considerations related to the prescribed medication. However, the Facility was continuing to develop adequate CPEs for the 219 individuals prescribed psychotropic medications.
- Psychiatry staffing remained inadequate. Of the 433 individuals residing at ABSSLC, 219 were prescribed psychotropic medication. The Facility had less than 1.5 full-time equivalent (FTE) psychiatrists.

- The Psychology Department, in conjunction with the Psychiatry Department, had proposed removal of the discussion of the psychiatric medications from the Positive Behavior Support Plan (PBSP). The Staff Psychiatrist was considering moving this information into the PSP documentation, which seemed reasonable. However, it remained to be seen how this process would evolve. The Settlement Agreement is very clear about the need for integration between the Psychiatry and Psychology Departments regarding the individual Treatment Plans, and that will need to be kept in mind as a new system is developed.

Psychological Care and Services

- At the time of the visit, fifteen of 19 Associate Psychologists (79%) were scheduled to begin or continue coursework in pursuit of certification as Board Certified Behavior Analysts (BCBAs). A new BCBA Director of Behavioral Services, who met the requirements of the Settlement Agreement, was providing ongoing supervision as required for certification.
- Both internal and external peer review continued. A review of minutes from the Behavior Support Committee and observation of this meeting during the visit indicated that the focus of the committee had shifted from review of medications to thoughtful feedback and recommendation regarding the content of behavioral assessments and resulting behavior support plans. Consulting BCBA professionals continued to make regularly scheduled visits to the Facility, during which time they worked directly with staff and the individuals served. Exit reports reflected very specific recommendations to apply throughout the home environment or with identified individuals.
- Data collection remained problematic. Observations conducted during the review with follow-up review of data suggested that reported measures of problem behavior were neither accurate nor reliable. Confidence in the recorded data was lacking, yet important clinical decisions were made based on these measures.
- Functional behavior assessment remained a focus for the psychology staff. Staff had worked to complete these assessments for those individuals who had behavior support plans. Revisions to the assessment process and the resulting report are recommended.
- Timely completion of comprehensive psychological evaluations had not been addressed. Formal assessment of cognitive abilities and adaptive behavior was often quite dated.
- Therapeutic services provided to individuals, either in the form of a behavior support plan and/or counseling, remained an area in need of improvement. Programs should be comprehensive in scope, and staff should be effectively trained and supervised in implementing or supporting any treatment protocol. The Facility had made efforts to introduce competency-based training.

Medical Care

- The morning medical meeting was held each business day of the week. Minutes were recorded. The minutes focused on rounds in the Infirmary, with some additional information involving acute care for individuals not in the Infirmary. Occasionally, the minutes included descriptions of medical staff meetings focusing on an area of concern. Generally, there was no critical thinking documented concerning clinical steps (e.g., testing, treatment,

review of diagnosis, additional consultations, level of supervision, etc.) to prevent a repeat hospitalization or Emergency Room (ER) visits. There appeared to be no documentation of closure to ongoing concerns.

- The Facility had begun data collection on the medical quality assurance tool used by the external reviewers. The Facility completed its first external peer review in July 2011. There has been no comparison between the audit results of the PCPs at ABSSLC and the audit results of the external reviewers. A more ambitious review was being undertaken internally.
- According to a list that had been updated as of 7/13/11, 42 individuals had DNRs at ABSSLC. The Facility had reviewed all DNR orders, and five were rescinded. However, the large number of individuals with DNRs for which adequate and current justification had not been established remained a significant concern at ABSSLC.
- Clinical death reviews were up-to-date. The Monitoring Team recognizes and appreciates the enormous work that went into this endeavor. However, the reviews should focus on identifying recommendations for systems improvements in some aspect(s) of medical care. Of the many clinical death reviews, only one had a recommendation involving the Medical Department directly.
- There was little progress in creating a usable system to track medical issues, such issues as osteoporosis and pica.

<u>Nursing Care</u>

- Consistent with the findings from the past reviews, no progress was made in the critical clinical areas addressing nursing Health Management Plans, nursing assessment and documentation in response to changes in status, quarterly and annual nursing assessments, and/or the development and implementation of nursing protocols.
- The Facility had not needed to use any agency nurses, but did use overtime for situations when the Facility needed to augment nursing coverage. Positive staffing changes included the reallocation of a full-time position to a Program Compliance Nurse position, reallocation of a position to allow a nurse to be a dedicated member of the Physical Nutritional Management Team, and conversion of a part-time Quality Assurance (QA) nurse position to a full-time position. Also, since the last review, nine RNs were assigned to the Infirmary, including three for each shift.
- Since the last review, ABSSLC's QA Nurse, Program Compliance Nurse Monitors, and Nursing Department made progress in developing some of the infrastructure, and conducting audits of nursing services. However, many aspects of an adequate QA process were not yet in place, including a lack of adequate instructions for audit tools, and a lack of nursing care protocols to define the standards against which nursing practice at the Facility would be judged. In addition, neither clinical competence of the reviewers nor inter-rater reliability had been established.
- In the area of Infection Control (IC), the Facility had made significant positive gains in building necessary elements of the infrastructure. Some of the progress noted specifically included: the IC staff continued to work with the unit staff regarding accurately reporting individuals with infections for data reliability; the Facility was in the process of implementing root cause analyses for infectious outbreaks; a structured format was

implemented to organize and document actions taken in response to outbreaks that should lend to the Facility's ability to analyze the event more clearly; and the Facility recently had developed a very promising monitoring tool addressing clinical practice items that was to be implemented by the next review.

- Also, some progress was made regarding the Medical Emergency Response system, such as the recent implementation of a Medical Emergency Response Committee to discuss issues related to the Facility's emergency drills and systems.

Pharmacy Services and Safe Medication Practices

- The Pharmacy Department had made substantial progress in many areas. Chemical restraints were tracked separately, and a new procedure that began in March 2011 resulted in marked improvement in the pharmacy obtaining all required restraint forms, and completion of forms in a brief period of time.
- Section N.7 addresses drug utilization evaluations and follow-ups. The Facility had consistently completed them on a quarterly basis. Additionally, the quality of the reviews was impressive, and the pragmatic impact on clinical care demonstrated the value this information being brought to the PCPs.
- With regard to Adverse Drug Reports (ADRs), although significant progress had been made, the submitted data indicated the need for correcting some areas related to documentation. In addition, the Facility needed to put systems in place to ensure timely review of ADRs with prescribing practitioners, and remedial action on an individual and/or systemic level to potentially prevent recurrence.
- There was need to include pharmacy dispensing variances and PCP prescription variances in the medication variance data. The pharmacy currently provided database management and analysis, and additionally had assisted the Nursing Department with action plans for reducing error rates. Although this area still had work to be done, much progress had been made.

Physical and Nutritional Supports

- Since the last review, Facility Administration had appointed a new Director of Rehabilitative Services. This had generated excitement within the Habilitation Therapies (HT) Department.
- On a positive note, the Facility had recruited and hired a dedicated, full-time Nurse for the PNMT. With the exception of the Nurse, no other PNMT member was fully dedicated to the PNMT. PNMT members carried extensive caseloads and additional responsibilities beyond the PNMT caseload.
- The Monitoring Team was concerned that the PNMT only had evaluated eight individuals since the last review. Despite the fact that 31 individuals had been identified at high risk and an additional 170 individuals at medium risk for aspiration, only three of the eight individuals that the PNMT had evaluated had been identified at high risk for aspiration.
- Based on the Monitoring Team's most recent review, problems continued to exist with regard to the PNMT's review of individual Integrated Risk Rating Forms, the completion of evaluations and development of action plans, competency-based training and performance check-offs for staff on the implementation of plan's

developed, individual-specific monitoring, documentation in Integrated Progress Notes, response to hospitalizations, and development of transition plans and discharge planning.

- The Director of Rehabilitative Services was to be commended for beginning the process of reviewing the content for new employee orientation. However, the Monitoring Team observed multiple staff who did not properly implement prescribed physical and nutritional management plans (PNMPs) and dining plans. Additional time was needed to present training on competency-based foundational skills, and complete performance check-offs to ensure staff were able to demonstrate necessary skills and competencies.
- The Facility presented multiple monitoring forms, but no policies and/or procedures existed for the implementation of these forms. In addition, no procedures had been identified for the integration of these monitoring forms into a unified system to enable data to be easily analyzed, concerns identified, and resolutions developed and implemented. As stated in the Monitoring Team's reports, these forms identified repeated individual-specific and/or systemic concerns without resolution, such as staff non-compliance with the implementation of PNMPs.

<u>Physical and Occupational Therapy</u>

- The Facility had six budgeted positions for Occupational Therapists (OTs) and four for Physical Therapists (PTs). At the time of the review, the Facility had no full-time OTs, but had three part-time contracted OTs. Three full-time PTs were employed, with one PT vacancy. These therapy vacancies continued to impact the Facility's ability to achieve compliance with Section P.
- The current OT/PT evaluation did not provide adequate information to support the person-centered planning process, or plan for future community placement. The OT/PT evaluation process should be critically reviewed to determine what modifications are needed to produce a functional evaluation.
- Direct and indirect therapy interventions were not analyzed during the evaluation and/or update process, or in clinical progress notes to determine if progress was being made, and/or if changes needed to be instituted. Justification for therapy interventions was not outlined in the analysis of findings section of the evaluations to provide a rationale for functional outcomes and recommendations. Therapy plans were not integrated into PSP Action Plan objectives. The PSPs did not provide opportunities integrated throughout the day for an individual to practice newly learned skills.
- The Facility did not have formal policies and/or procedures for the PNMP Clinic to ensure individuals' adaptive/assistive equipment was reviewed annually for fit, availability, function, condition, and effectiveness.

<u>Dental Services</u>

- The Dental Department has progressed in both subsections of Section Q, but remained out of compliance. Much creativity had been used in the development of a mock office to be used for desensitization plans. Review and improvement of the environments in the residences to increase cooperation with oral hygiene, as well as researching better tasting toothpastes also had increased compliance with tooth brushing. The oral hygiene rating scores indicated less "good" as well as less "poor" ratings, and more "fair" ratings. With the drop in the

"good" rating, the Dental Department needs to explore the potential reasons, and develop a strategy to improve the oral hygiene index scores across the campus.

- Missed appointments and refusals were tracked through a detailed database. Some of the reasons for missed appointments were correctable, and if addressed, would potentially improve attendance. The missed appointment rate for general anesthesia appointments remained problematic.
- Better tracking of pain or lack of pain, and pain management, as well as monitoring of vital signs before and after a dental procedure were areas requiring better documentation.
- Desensitization programs now had some success stories in the Dental Department. However, the number of participants (18) involved in this programming was small compared to the need at ABSSLC.

Communication

- The Facility had five full-time Speech Language Pathologists (SLPs) and an assistant. However, individual records did not substantiate adequate involvement of SLPs in individuals' programs. An absence was noted of development and integration of therapy recommendations into formal PSP action plan objectives, as well as of development of instructional programs to reinforce direct therapy plans formally and informally.
- The current SLP evaluation did not provide adequate functional evaluation data to support the annual person-centered planning process, or planning for future community placement. Individuals who would benefit from alternative or augmentative communication (AAC) were not consistently identified.
- No competency-based training and performance check-offs were completed to demonstrate staff competency with generic and/or individual-specific AAC system(s).
- A more aggressive approach was needed to ensure staff compliance with the use of generic and individual-specific AAC systems.

Habilitation, Training, Education, and Skill Acquisition Programs

- The concerns raised in the previous report continued to be problematic. Assessment of individuals' needs remained incomplete. 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.
- However, staff had received additional training in the Personal Support Plan process that should result in improved and enhanced services to the individuals served. Two new instruments were being introduced with plans to complete annual comprehensive assessment of functional skills, and more specifically, vocational skills, interests, and needs. Steps also had been taken to improve the teaching format and techniques applied to effect enhanced skill development and independence.

Most Integrated Setting

- At the time of the review, although assessments prepared for annual PSP meetings had begun to include the assessor's recommendation regarding transition to the community, individuals' PSPs generally did not include a summary or conclusion with regard to the professional team members' determination with regard to whether or not community placement was appropriate.
- ABSSLC continued to implement the new Community Living Discharge Plan (CLDP) process. Overall, the revised form was more comprehensive, included more information, and provided more direction to PSTs than did the previous form. The CLDPs reviewed included essential and non-essential supports. However, it appeared that the Facility continued to be struggling with 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 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). However, some concerns were noted with the thoroughness and/or completeness of the monitoring for some individuals. In addition, the post-move monitoring identified some issues with regard to the provision of services at the community sites. Not all of these items were addressed in a thorough or timely manner.
- 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. No aggregate reports were yet available.

Consent

- DADS State Office was still in the process of finalizing policies on guardianship and consent that were expected to provide guidance to the Facilities with regard to the implementation of this section of the Settlement Agreement. The Guardianship/Advocate Policy had been disseminated for final review, and the policy on consent remained in the development phase. As discussed below, this resulted in minimal progress being made at the Facility level.
- At the time of the review, the process for assessing individuals' "functional capacity to render a decision" and provide informed consent was still not being completed using an adequate standardized tool. However, it was anticipated that the State Office policy would set forth a methodical approach for screening individuals to determine a possible need for assistance in decision-making.
- Since the last review, five individuals had obtained guardians. The Guardianship Committee had approved another two individuals for funding to defray the costs of guardianship proceedings. The Guardianship Assistance Program (GAP) had received an additional donation, increasing the amount of funds available to assist family members and other interested in petitioning for guardianship.

Recordkeeping and General Plan Implementation

- To address issues related to the timely filing of information needed to make decisions a new policy and procedure had been implemented. This policy clearly identified roles and responsibilities, and set timelines for completion of specific activities. Although its implementation was in the early stages, both internal monitoring audits, as well as the Monitoring Team's experience with the records during the onsite review indicated that improvements had been made with regard to the availability of needed documents.
- The Facility was continuing to develop and revise policies to address the requirements of the Settlement Agreement. A new policy recently had been implemented on the dissemination of policies, and training of staff on new or revised policy requirements. Its implementation was in the early stages of development.
- The Facility had made some significant progress in formally analyzing aggregated results of monitoring data, and developing and implementing actions necessary to correct systemic deficiencies related to records. For example, the Facility had provided initial training across campus to address issues such as legibility and accuracy of records.
- The Facility did not yet have Individual Notebooks. A workgroup had made a recommendation, which the Facility Director had relayed to State Office. The Facility was awaiting further guidance from State Office.
- 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 maintenance of accurate and complete data had the potential to impact negatively on teams' decision-making ability.

## V. Status of Compliance with the Settlement Agreement

<table>
<tr><th>SECTION C: Protection from Harm-Restraints</th><th></th></tr>
<tr><td>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.</td><td>
Steps Taken to Assess Compliance: The following activities occurred to assess compliance:
<ul>
<li>Review of Following Documents:
<ul>
<li>ABSSLC Policy: Use of Restraints, dated 6/10;</li>
<li>ABSSLC Plan of Improvement (POI), dated 8/12/11;</li>
<li>Restraint Checklist POR-MR-7, revised 12/10;</li>
<li>Administration of Emergency Medication Protocol (Chemical Restraint), POR-MR-9, revised 4/09;</li>
<li>Face-to-Face Assessment, Debriefing and Reviews for Crisis Intervention Restraint, Psychology Department, revised 12/09;</li>
<li>Restraint: Ordering, Assessing and Evaluating (RES0300): Required Training for Registered Nurses and Physicians at State Mental Retardation Facilities, dated 6/28/06;</li>
<li>Prevention and Management of Aggressive Behavior (PMAB);</li>
<li>Texas Department of Mental Health/Mental Retardation (MHMR) ABS: Restraint by Facility, from 1/1/11 through 7/1/11;</li>
<li>ABSSLC Restraints Trend Analysis Report FY11 for the month of June 2011 and the month of July 2011;</li>
<li>Restraint Reduction Plan Minutes, dated 5/31/11;</li>
<li>Do Not Restrain/Modification of Restraint List, undated;</li>
<li>Presentation Book C;</li>
<li>Settlement Agreement Cross Referenced with ICF-MR Standards: Protection From Harm – Restraints, revised 12/10;</li>
<li>The Restraint Checklist, Face-to-Face Assessment and Debriefing Form for each of the following 23 instances of emergency restraint involving 19 individuals (Sample C.1):</li>
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<table>
<tr><th>Individual</th><th>Date of Restraint</th><th>Time of Restraint</th></tr>
<tr><td>Individual #43</td><td>June 3, 2011</td><td>3:50 p.m.</td></tr>
<tr><td>Individual #48</td><td>June 16, 2011</td><td>6:32 p.m.</td></tr>
<tr><td>Individual #74</td><td>May 3, 2011</td><td>10:20 p.m.</td></tr>
<tr><td>Individual #87</td><td>June 30, 2011</td><td>6:30 p.m.</td></tr>
<tr><td>Individual #87</td><td>May 30, 2011</td><td>9:01 p.m.</td></tr>
<tr><td>Individual #95</td><td>June 6, 2011</td><td>3:29 a.m.</td></tr>
<tr><td>Individual #95</td><td>June 3, 2011</td><td>7:28 a.m.</td></tr>
<tr><td>Individual #107</td><td>June 8, 2011</td><td>8:45 p.m.</td></tr>
<tr><td>Individual #132</td><td>June 24, 2011</td><td>7:52 p.m.</td></tr>
<tr><td>Individual #160</td><td>June 19, 2011</td><td>11:24 a.m.</td></tr>
<tr><td>Individual #231</td><td>April 27, 2011</td><td>11:32 a.m.</td></tr>
<tr><td>Individual #303</td><td>June 26, 2011</td><td>10:01 p.m.</td></tr>
<tr><td>Individual #319</td><td>June 13, 2011</td><td>7:59 p.m.</td></tr>
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| Individual #323 | June 21, 2011 | 1:25 p.m. |
| Individual #323 | June 22, 2011 | 7:38 a.m. |
| Individual #332 | April 11, 2011 | 11:20 a.m. |
| Individual #387 | June 17, 2011 | 6:40 p.m. |
| Individual #387 | June 28, 2011 | 10:54 p.m. |
| Individual #444 | June 15, 2011 | 3:08 p.m. |
| Individual #486 | May 22, 2011 | 5:22 p.m. |
| Individual #505 | June 25, 2011 | 7:33 p.m. |
| Individual #530 | June 10, 2011 | 1:31 p.m. |
| Individual #534 | May 7, 2011 | 4:40 p.m. |

- Sample #C.2 included 25 staff drawn at random from the Employee Listing provided by the Facility;
- Sample #C.3 included the following 19 episodes of medical restraint:

| Individuals | Date of Restraint | Time of Restraint |
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| Individual #15 | January 4, 2011 | 9:10 a.m. |
| Individual #15 | April 1, 2011 | 12:30 p.m. |
| Individual #15 | April 12, 2011 | 10:45 unknown time |
| Individual #69 | June 21, 2011 | 6:50 a.m. |
| Individual #118 | June 30, 2011 | 9:00 a.m. |
| Individual #151 | June 17, 2011 | 7:45 a.m. |
| Individual #178 | June 28, 2011 | 7:40 a.m. |
| Individual #217 | June 16, 2011 | 1:45 p.m. |
| Individual #242 | June 13, 2011 | 7:15 a.m. |
| Individual #312 | June 9, 2011 | 2:20 p.m. |
| Individual #440 | March 16, 2011 | 7:00 a.m. |
| Individual #445 | May 23, 2011 | 12:00 p.m. |
| Individual #464 | June 21, 2011 | 1:20 p.m. |
| Individual #469 | June 10, 2011 | 7:15 a.m. |
| Individual #486 | June 22, 2011 | 7:45 a.m. |
| Individual #505 | June 1, 2011 | 7:20 a.m. |
| Individual #510 | March 30, 2011 | 2:55 p.m. |
| Individual #523 | May 11, 2011 | 7:00 a.m. |
| Individual #525 | June 14, 2011 | 8:05 (unknown time) |

- Sample C.4 included: Individual #37 on 3/25 at 11:50 a.m., Individual #59 on 6/15 at 8:51 a.m., Individual #87 on 6/18 at 7:15 p.m.; Individual #95 on 5/26 at 3:55 p.m., 5:35 p.m. and 7:50 p.m.; Individual #324 on 3/31 at 3:30 p.m.; Individual #424 on 4/2 at 2:00 p.m., and Individual #465 on 5/6 at 3:15 p.m.;
- Twenty of the most recently completed Chemical Restraint Checklists;

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| | ○ Personal Support Plans (PSPs) for: Individual #84, Individual #370, Individual #515, Individual #269, Individual #102, Individual #451, Individual #411, Individual #415, Individual #535, Individual #300, Individual #319, and Individual #442;<br>○ Restraint Reduction Committee Meeting minutes, dated 2/17/11and 5/31/11;<br>○ Behavior Support Plans (BSPs) for: Individual #87, Individual #387, Individual #43, Individual #319, Individual #74, Individual #534, Individual #95, Individual #530, Individual #303, Individual #505, Individual #48, Individual #313, Individual #231, Individual #332, Individual #486, Individual #444, Individual #323, Individual #160, and Individual #132;<br>○ Personal Support Plans for: Individual #387, Individual #534, Individual #95, Individual #505, Individual #313, Individual #486, and Individual #323;<br>○ Behavior Protocol for: Individual #107;<br>○ Personal Support Plan Addenda for: Individual #387, Individual #534, Individual #95, Individual #505, Individual #313, Individual #323, and Individual #160;<br>○ Quarterly Reviews for: Individual #505 and Individual #323;<br>○ Restraint Checklists for: Individual #87, Individual #43, Individual #319, Individual #74, Individual #534, Individual #95, Individual #530, Individual #303, Individual #505, Individual #48, Individual #231, Individual #332, Individual #486, and Individual #444;<br>○ Individual Restraint reports for: Individual #87, Individual #387, Individual #303, Individual #505, Individual #48, Individual #107, Individual #486, Individual #323, Individual #160, and Individual #132;<br>○ Dental Desensitization Plans for: Individual #451, Individual #440, Individual #242, Individual #375, Individual #303, Individual #227, Individual #455, Individual #276, Individual #505, Individual #104, Individual #140, Individual #469, Individual #312, and Individual #144;<br>○ Dental Desensitization Data Sheets and/or Behavior Observation Notes for: Individual #440, Individual #242, Individual #375, Individual #303, Individual #227, Individual #455, Individual #276, Individual #505, Individual #104, Individual #469, Individual #312, and Individual #144; and<br>○ Safety Plans for Crisis Intervention for: Individual #387, Individual #95, Individual #505, Individual #313, and Individual #323.<br>▪ **Interviews with**:<br>○ Ron Manns, Director of Behavioral Services;<br>○ Pat Smith, Quality Assurance Director;<br>○ Jason Fry, Psychologist;<br>○ Renay Kellum, Program Compliance Monitor; and<br>○ Various staff in residential units, including 12 Direct Support Professionals.<br>▪ **Observations of**:<br>○ Nine residences including: #6330, #6350, #6360, #6390, #6400, #6500, #6730, #6750, and #6760;<br>○ Restraint Reduction Committee meeting, on 8/22/11; and<br>○ PSP annual meeting for Individual #30. |

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| | **Facility Self-Assessment:** 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 all eight provisions. This was consistent with the Monitoring Team's findings.<br><br>In the Comment/Status sections of the POI, the Facility reported conducting its own monitoring of restraints. The Facility was using a monitoring tool based on the one used by the Settlement Agreement Monitoring Teams. It had not been upgraded to include adequate guidelines, and the numbering system used on the graphs displaying data were difficult to match to the numbers on the monitoring tool.<br><br>The Facility had established a plan to review restraint documentation, and had completed a number of monitoring tools since February 2011. The actual number of the individuals sampled was not evident on the graphs or in the facility self-assessment. Likewise, it was not clear what timeframes the graphs covered. The status column should indicate the overall population from which the sample was drawn (N), the number of records monitored (n), the time frame within which the monitoring took place, and whether the Program Compliance Monitor or psychology department staff completed the monitoring. If inter-rater reliability checks have been done, it would be helpful to report the results.<br><br>In addition, the information included in the POI indicated percentages of compliance, based on the use of the monitoring tools. Although some efforts had been made to provide information in the POI about individual monitoring indicators (e.g., for Section C.5), generally, 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 sub-section of the Settlement Agreement.<br><br>As foundation for the percentages, the Facility presented the Monitoring Team with additional information outside of the POI. This included 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.<br><br>The POI included some narrative descriptions of action steps taken to achieve compliance. However, it should provide more specific references to the evidence supporting the listed status items. For example, with regard to Section C.5, the POI reported that it "continues to assure that face to face assessments are conducted for each instance of restraint, including efforts to monitor and document vital signs and mental status." It would be helpful if the POI referenced the action plan or other documentation to support their |

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| | efforts.<br><br>The POI included two action plans for Section C. One was directed toward providing desensitization plans for individuals who needed repeated restraint for medical or dental procedures. The update indicated plans were in place and being implemented. Tracking of the plans was reported to be in process. The second was to provide a "repeated restraint-tracking tool," for individuals requiring more than three restraints in 30 days. The tool was available and was in use as demonstrated at the August Restraint Reduction Committee meeting. The Facility indicated that some of the steps in each of these plans remained "in process." |
| | **Summary of Monitor's Assessment:** In general, the Facility had systems in place for restraint reporting, monitoring, and review processes. However, concerns were noted with regard to the adequacy with which staff described the antecedent- and consequence-based interventions that were used 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, though progress was noted.<br><br>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 reporting of identifiers for staff and individuals involved in large numbers of restraint was a positive step, as were the activities to prioritize and focus attention on the individuals with large numbers of restraints.<br><br>The Facility's trend reports had documented an increase in the number of individuals restrained in the July Trend Report, and included analysis that concluded the increase could have been the result of "holdovers, increased float or unfamiliar staff." The report noted that the issues had been referred to the Leadership Group for attention. This analysis was much more useful than the data alone, which indicated an upward trend in use.<br><br>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 | A review of the Trend Analysis Report FY11 for June 2011 showed: | Noncompliance |

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>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.</td><td>
<table>
<tr><th>Type of Restraint</th><th>7/1/10 to 12/31/10</th><th>1/1/11 to 6/31/11</th></tr>
<tr><td>Programmatic personal restraints*</td><td>82</td><td>91</td></tr>
<tr><td>Emergency personal restraints</td><td>98</td><td>68</td></tr>
<tr><td>Chemical restraints during a behavioral crisis</td><td>66</td><td>44</td></tr>
<tr><td>Total of the above: restraints used during behavioral crisis</td><td>246</td><td>203</td></tr>
</table>
* Programmatic restraints were prohibited by policy. The terminology remained in the data system to describe restraints made in accordance with an individual's Safety Plan.<br><br>A review of the data found in Texas Department of MHMR – ABS: Restraint by Facility, from 1/1/11 through 7/1/11 showed that Individual #505 was restrained with wrist-to-waist restraints 76 times (down from some 200 times in the previous six-month data). In addition, his restraints were changed from "protective" to programmatic restraint, which were shorter in duration. Individual #146, who had the second highest number of protective restraints during the last reporting period, had not been restrained at all in recent months.<br><br>A comparison of the overall number of episodes of restraint reported in the last review and the overall number included in the Texas Department of MHMR – ABS: Restraint by Facility, from 1/1/11 through 7/1/11 suggested the overall number of restraints had dropped substantially. The Facility should review the data in the latest report to verify that reduction. The Facility had not tallied the total number of restraints of all types, and that number could provide a useful measure of overall restraint use going forward.<br><br>A sample, referred to as Sample #C.1, was selected, based on the number of restraints used in a behavioral crisis from January through June 2011 (as reported on the Facility's Trend Analysis Report for June 2011). Twenty-three episodes of restraint were selected or 11% of the 203 episodes. This sample was selected to ensure that some of the individuals with the highest numbers of restraint were included.<br><br><u>Prone Restraint</u><br>Based on Facility policy review, prone restraint was prohibited.<br><br>Based on a review of the restraint records for individuals in Sample #C.1 involving 19 individuals, including the Restraint Checklists, Face-to-Face sheets and Debriefing Sheets, none (0%) showed use of prone restraint.<br><br>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</td><td></td></tr>
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| | | 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.<br><br>Based on interviews with 12 direct support professionals, all were aware of the prohibition on prone restraint. However, some described it as restraint on the stomach, rather than as prone restraint, which was the less technical term, but showed they had adequate understanding of the prohibited practice. Most of the direct support professionals indicated the reason for the prohibition was to prevent suffocation.<br><br><u>Other Restraint Requirements</u><br>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. Policy also specified that restraints could not be used as part of the Behavior Support Plan, but, if needed, restraints could be specified in a Safety Plan.<br><br>However, despite the policy outlining the parameters for restraint, confusion appeared to continue to exist about the use of restraints in Behavior Support Plans. For example in a newly adopted system for Personal Support Team Review of Repeated Restraints, one example contained in the Presentation Book included an entry on 4/22/11 that read: "team agreed not to include restraint into her BSP at this time." Since it is never appropriate to include restraint in a BSP, this comment suggested that the writer was not aware of the restriction.<br><br>Based on a review of the records for the 23 episodes of restraint in Sample #C.1:<br>▪ In 22 of the 23 records (96%), there was documentation showing that the individual posed an immediate and serious threat to self or others. The one exception was a situation described in a restraint checklist for Individual #95 (6/3/11 at 7:28 p.m.). The observed behavior included "blaring a radio, cursing at staff, yelling, and threatening physical harm to staff." Although attempted aggression and property destruction were noted in the intervention section, staff should clearly describe the individual's behavior that necessitates restraint.<br>▪ In the 23 restraint records, a review of the descriptions of the events leading to behavior that resulted in restraint found that 22 (96%) contained documentation that indicated that there was no evidence that restraints were being used for the convenience of staff or as punishment. One record (Individual #107, on 6/8/11 at 8:45 p.m.) had no Restraint Checklist.<br>▪ In 22 of the records (96%), 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 20 of the 23 records (87%), was the evidence considered minimally sufficient. In the following three records, it could not be determined if a graduated range of less restrictive measures had been tried:<br>o For Individual #107 on 6/8/11 at 8:45 p.m., the checklist and face-to-face documentation was not available.<br>o For Individual #486 on 5/22/11 at 5:22 p.m., it was not clear that placement of pads to protect his head was tried per the Safety Plan before the helmet was used;<br>o For Individual #231 on 4/27/11 at 11:32 a.m., it appeared that the behavior was unanticipated and aggressive (one staff member was bitten on the breast), and staff went to restraint without attempting a series of graduated measures, as was acknowledged on the Restraint Checklist. Due to the limited amount of information on the form, it was difficult to conclude that this was least restrictive. For example, no information was provided about the seriousness of the bite, the ability of staff to move away from the individual, or the actions of the individual after the bite occurred (i.e., was evidence present of continued threat to others).<br>For this review, some explanation was found of graduated steps in written entries beyond the checked boxes on the Restraint Checklist. While this still required attention, there was improvement.<br><br>As is discussed in further detail with regard to Section J.3, in order to assess use of chemical restraint, a sample of the completed documentation for 20 recent administrations of chemical restraint was requested. Concerns were noted with the completeness of the documentation contained on the forms. On all of the 20 forms reviewed, the section that instructed: "Describe events leading to the behavior that resulted in restraint" contained only a brief description of the overt behavior that triggered the request for a chemical restraint, and did not include a description of the environmental or behavior precipitants that might have provoked the individual's aggressive response. A clear description of the antecedents to the aggressive behavior is necessary to accurately determine if the administration of the IM medication was, to some degree, a punishment and/or used in the absence of adequate treatment. Thus, although it did not immediately appear that psychotropic medication was utilized as a punishment for noncompliant behavior at ABSSLC or for the convenience of staff, more complete documentation on the chemical restraint forms that involve the intramuscular injection of psychotropic medication against an individual's will was necessary to fully support this observation. | |

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| | | 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. The policy limited physical restraints to PMAB restraints, except "in rare cases when they cannot be safely applied," and then staff could 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 for safety should be addressed in a Safety Plan. It was noted in the last review that the policy should be amended accordingly. However, there were no policy revisions included in the documentation submitted. This issue required correction.<br>▪ Based on the review of 23 restraints, involving 19 individuals in Sample #C1, all were approved restraints.<br><br>A review was completed of 19 BSPs and one Behavior Protocol. General comments regarding BSPs are provided with regard to Section K.9 of the Settlement Agreement. Overall, staff should develop BSPs that include operationally defined replacement behaviors that will provide the individual with a means of obtaining the same outcome as the targeted problem behavior(s). There should be sufficient opportunities to learn and practice this replacement behavior across all environments. Preference assessments had been introduced, however, schedules of reinforcement remained inadequate. Treatment programs should include individual specific strategies that are based upon the information gained through functional behavior assessment. Staff should review treatment implementation and efficacy on a regular basis to ensure that BSP revisions are made as necessary and in a timely manner. BSPs, as currently written, did not provide adequate or effective treatment. Therefore, it was likely that restraint was sometimes used in the absence of adequate treatment.<br><br>While significant progress appeared to have been made in the reduction of the use of restraints, particularly protective restraints with some individuals, as well as in the quality of the documentation on Restraint Checklists, the Facility was not yet in substantial compliance with this provision. Based on the combination of missing or incomplete restraint records, the lack of clarity in reporting the interventions attempted before restraint was used, concerns about the need for clarification of the policy related to Safety Plans, and concerns related to BSPs, the Facility was found to be out of compliance. | |
| C2 | Effective immediately, restraints shall be terminated as soon as the individual is no longer a danger to | The document "Texas Department of MHMR – ABS: Restraint by Facility" was reviewed. In 83% of the uses of personal restraint for emergency or programmatic reasons, the time in restraint was 10 minutes or less. In only one case, did it exceed 50 minutes. | Noncompliance |

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| | him/herself or others. | The Restraint Checklists involving the 23 episodes of restraint in Sample #C.1 were reviewed.<br>▪ In one of the 23 records, chemical restraint was used. There was no information on release, because given the nature of chemical restraint, a release time cannot be determined;<br>▪ Five episodes of restraint ended when the staff member was unable to sustain the restraint hold and there was not an explanation provided. When an individual breaks free from restraint, it is important to evaluate the problem with the use of that restraint, and determine if an alternate strategy should be employed. In each of these five episodes, staff did not attempt to reapply the restraint.<br>▪ In the remaining 17 records in which release was applicable, 15 (88%) contained sufficient information to show that the individual had been released when he/she was no longer a danger to him/herself or others.<br>o For Individual #107, the form was not available.<br>o On 6/25/11 at 7:33 p.m., Individual #505 was placed in mechanical wrist to waist restraint for 30 minutes. There was no documentation of observations during that time or attempts to release. It appeared that staff were treating the restraint as protective, and leaving the individual in for the maximum time allowed.<br>▪ Individual #323 was appropriately released when he began to cough, suggesting he might be choking.<br><br>While there was progress in providing information about release from restraint, there was still a need to determine how to address staff's somewhat frequent inability to maintain a restraint, as well as to assure that staff do not leave a person in restraint when it is safe to release him. As a result, the Facility was not found to be in substantial compliance with this provision. | |
| 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 | The ABSSLC Policy and Procedure Index was marked as current as of 7/21/11. 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.<br><br>Review of the Facility's training curricula, entitled Prevention and Management of Aggressive Behavior, revealed that it included adequate training and competency-based measures in the following areas:<br>▪ Policies governing the use of restraint;<br>▪ Approved verbal and redirection techniques; | Noncompliance |

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| | 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. | ▪ Approved restraint techniques; and<br>▪ Adequate supervision of any individual in restraint.<br><br>A review of 25 staff, (Sample #C.2), including their start dates and the dates on which they were trained and determined to be competent with regard to the required restraint-related topics, showed that out of 25 staff, 25 (100%) had been trained and were current on restraint and its related topics as required for their position.<br><br>Based on interviews with 12 direct support professionals:<br>▪ Twelve (100%) were able to describe the basic policy governing the use of restraint; and<br>▪ Twelve (100%) were able to describe approved restraint techniques.<br><br>As noted above with regard to Section C.1 of the Settlement Agreement, 87% 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 useful in some cases, because there were no notes describing how or in what order the measures were applied.<br><br>The training on the use of restraints appeared to be comprehensive, staff were being trained in pre-service orientation and annually, and staff were able to respond to basic questions about the restraint policy. However, as noted above, in only 87% of the records reviewed was documentation sufficient to show that the intervention was the least restrictive. While the Monitoring Team noted substantial progress, it did not find the Facility to be in substantial compliance with 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 | In 22 of the 23 records (96%), there was documentation showing that the individual posed an immediate and serious threat to self or others.<br><br>Based on the review of 19 BSPs and one Behavior Protocol, no evidence was found of the use of programmatic restraint.<br><br>At the time of the last review, the Monitoring Team noted that many individuals at ABSSLC had risk factors that would have contraindicated the use of restraint, but that ABSSLC did not have a "Do Not Restrain" list. At the time of the most recent review, the Facility now had a "Do Not Restrain/Modification of Restraint List," which listed individuals by residence who had some limitation on the use of restraint. The list provided was undated, and contained statements that were repetitions of the policy. For example: Individual #207 is listed as "Yes, Restraints should not be used unless there is imminent danger to self or others and less restrictive methods have failed." This is true | Noncompliance |

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| | eliminate the need for restraint. | of all individuals and need not be repeated on this type of list. Better entries were: "Particular care to right upper and right lower extremities," or "Great caution, no pressure to chest." Once the list is established, it needs to be made available to staff in the residences and to psychologists who are writing programs, to help assure that restraints are never used when medically contraindicated.<br><br>A review of the records in Sample #C.1, compared to the "Do Not Restrain" list revealed that no one in the sample had been restrained in contradiction of medical orders.<br><br>Dental desensitization plans were reviewed for 14 individuals. These plans followed a similar format: a) the goal and objective were stated; b) baseline measures were noted; c) the plan was outlined (i.e., setting, schedule, materials needed, reinforcer, special considerations, and implementation steps); d) assessment and evaluation protocols were described; and e) the date and author of the plan were recorded. Each component of the plan is addressed below.<br>▪ With a goal of increasing the individual's compliance or cooperation with dental exams, each objective indicated the individual was to participate with verbal prompts for one trial across a designated number of sessions.<br>▪ Baseline was reported as the current need for sedation and restraint (six plans), sedation or restraint (two plans each), refusal to participate (three plans), or demonstrated aggression towards staff (one plan). None of the plans reflected the collection of data to determine the individual's ability to complete activities outlined in the plan. This was problematic in that there was no objective measure against which to assess the individual's progress or lack thereof.<br>▪ Further, it appeared that in at least three cases, the steps outlined in the task analysis might not have been necessary. This could result in time spent on training steps that have already been mastered. For example:<br>o The data provided for Individual #455 indicated that on two of eight occasions, he allowed staff to brush his teeth while he stood in the hallway outside the dental office. Yet, the step recorded indicated that staff were simply to greet the individual.<br>o The data sheet for Individual #469 indicated that he worked on steps 1, 4, 6, and 10 of the task analysis with no apparent determination of his current performance.<br>o In the case of Individual #104, step 1 was noted on the data sheet (allow staff to touch instruments to his bottom teeth without gagging), but the comments described staff brushing the individual's teeth. The task analysis did not address tooth brushing.<br>It is recommended that the individual's performance on all steps of the task analysis be determined prior to teaching. A true baseline is necessary to determine the needs of the individual. | |

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| | | ▪ For eight of 14 individuals (57%), training was limited to one trial per week. The maximum number of trials identified was three times per week for three individuals. It is suggested that so few training opportunities will result in very slow and limited progress.<br>▪ Additional concerns were raised when reviewing the reinforcer to be applied for cooperation in this activity that had proven to be so difficult for these individuals. In six of 14 plans (43%), praise alone was identified as the reinforcer. The remaining plans (57%) indicated the individual was to receive praise and an edible reinforcer for his/her cooperation. Completion of formal preference assessments is recommended to ensure that individual specific reinforcers are incorporated into these plans.<br>▪ The task analysis outlined in these plans frequently provided a more in-depth description of staff behavior than the individual's behavior. Eight of 14 plans (43%) included task analyses in which the majority of the steps described staff behavior. It will be essential to describe the individual's observable and measurable response to allow for objective assessment of his/her progress. | |
| 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 schedule. For all individuals subject | At the review in February 2011, the Monitoring Team found that staff responsible for restraint monitoring had received some training in completing the Face-to-Face/Debriefing forms as part of Psychology Department meetings, but it was unclear that those who participated were determined competent to monitor restraints. This is discussed in further detail in the previous report.<br><br>For this review a list of all staff trained as restraint monitors was provided. A comparison of the names on the list provided with the names of restraint monitors appearing on Restraint Checklists in Sample #C.1, revealed that 19 of the 23 episodes of restraint (83%) were monitored by a listed monitor. The checklists for three of the remaining four had illegible names for the restraint monitors (i.e., for Individual #323 on 6/21 and on 6/22; and Individual #332), and Individual #107 had no Restraint Checklist.<br><br>A copy of the curriculum for "Restraint: Ordering, Assessing, and Evaluating (RES0300): Required Training for Registered Nurses and Physicians at State Mental Retardation Facilities" was provided in response to the request for a copy of the training curricula for completion of face-to-face assessment. It was not clear, however, whether the people trained as restraint monitors successfully completed that course, and if so, when they completed it. The course appeared to be designed for nurses and physicians, not the behavioral services staff and Residential Campus Coordinators who appeared on the list as designated restraint monitors.<br><br>A review of the curriculum for RES0300 revealed that:<br>▪ It contained information on programmed restraint that was in conflict with | Noncompliance |

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| | 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. | current policy that permitted restraint only to be used as crisis intervention.<br>▪ It indicated that restraints could be in place for 55 minutes before allowing range-of-motion exercise, while policy required restraint for no more than 30 minutes.<br>▪ It addressed the use of restraints that were not on the approved restraint lists (i.e., restraint boards.)<br>▪ There were numerous other references that had not been updated to reflect current policy and Settlement Agreement requirements.<br><br>To demonstrate compliance with the training requirements of this provision, the Facility should:<br>▪ Develop and maintain a list of the staff who serve as Restraint Monitors, including the dates they were trained and when they were determined competent.<br>▪ Develop and maintain a list of nurses who have been trained to evaluate individuals in and after restraint, including the dates of their training and when they were determined competent.<br>▪ If training used to train nurses on their responsibilities regarding restraint is the course RES0300, together with the competency check (Document Request II.12.c), then the course should be revised to comply with State and Facility policy and with the requirements of the Settlement Agreement.<br><br>Based on a review of 23 restraint records (Sample #C.1), a face-to-face assessment was conducted:<br>▪ In 0 out of 23 incidents of restraint (0%) by a trained staff member. With four exceptions, there was evidence that a monitor was present whom the Facility deemed to be trained. However, as explained above, it was not clear what the training was, how competency was judged, or what curriculum was used.<br>▪ In 20 out of 23 instances (87%), the monitoring staff 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 #107 (no Restraint Checklist), Individual #323 on 6/21/11, and Individual #332 on 4/11/11 (not within 15 minutes).<br>▪ In 21 instances (91%), the documentation showed that an adequate assessment was completed of the application of the restraint. Records that did not contain documentation of this included: Individual #107 (no Face-to-Face/Debriefing form), and Individual #444 for whom the form was incomplete.<br>▪ In 0 instances (0%), the documentation showed that an adequate assessment was completed of the circumstances of the restraint. Section 5.5 of the Face-to-Face, Debriefing and Reviews for Crisis Intervention Restraint form required information regarding the whole episode of restraint: what worked, what did not | |

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| | | work, and what might be used to prevent restraint. All the forms in the sample contained some information about what did work (the restraint) and some contained information about what did not work (everything else that was tried.). There were no instances where suggestions were provided about strategies that might be considered to prevent the use of restraint, even when the description of the antecedent behaviors on the Restraint Checklist provided some clear possibilities. For example, Individual #74 was restrained when he became upset after finding sodas in the refrigerator that he could not have. This information should have elicited a recommendation that sodas not be kept where he would find them, that sodas be kept in a box in the refrigerator to disguise them, that alternatives to soda be available, and/or that his team consider developing a program if this reaction to soda was a persistent problem.<br>▪ The sample did not contain any episodes where the physician had authorized an alternative monitoring schedule.<br><br>Based on a review of 42 restraint records for 30 individuals (i.e., Sample C.1 and Sample C.3) for restraints that occurred at the Facility, there was documentation that a licensed health care professional:<br>▪ Conducted monitoring at least every 30 minutes from the initiation of the restraint in 38 (90%) of the instances of restraint. Records that did not contain timely documentation of this included: Individual #48, on 6/16/11; Individual #387, on 6/28/11; Individual #486, on 5/22/11; and Individual #510, on 3/30/11. These findings reflected an increase in compliance from 61% during the last review to 90% for the current review.<br>▪ Monitored and documented vital signs in 35 (83%). Records that did not contain documentation of this included: Individual #48, on 6/16/11; Individual #231, on 4/27/11; Individual #319, on 6/13/11; Individual #323, on 6/21/11; Individual #332, on 4/11/11; Individual #486, on 5/22/11; and Individual #523, on 5/11/11. Restraint Checklists that were marked "refused" for respirations were scored as noncompliance for this indicator. These findings reflected a slight improvement in compliance from 82% during the last review to 83% for the current review.<br>▪ Monitored and documented mental status in 41 (98%). Records that did not contain documentation or appropriate documentation of this included: Individual #469, on 6/10/11 (no description of "stable"). These findings reflected a significant increase in compliance from 88% during the last review to 98% for the current review.<br><br>Clearly, there was noted improvement in the nursing staff's documentation regarding restraints for the above indicators. However, from discussions with the Program Compliance Monitor for this area, the Nursing Department did not audit the required | |

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| | | documentation regarding restraints to ensure that the quality of the nursing documentation was in alignment with standards of practice for nursing. The auditor indicated that she scored the nursing items in compliance as long as they had been completed, and not based on the quality of the documentation. In addition, although a review of the Facility's raw data from the Restraint monitoring tools from February through June 2011 indicated that the Facility had been regularly auditing the nursing documentation for episodes of restraint each month, from discussions with the Chief Nurse Executive (CNE) and the Program Compliance Monitor, there had been no collaboration or communication regarding the findings of the audits with the Nursing Department. The Facility should ensure that items addressing nursing documentation regarding the use of restraint are audited by nursing and/or nursing QA staff, the findings of the restraint audits are shared with the appropriate disciplines, and that the Nursing Department reviews items addressing nursing, and develops plans of correction for any problematic areas noted.<br><br>Sample #C.3 included the 19 episodes of medical restraint (i.e., 19% of the 99 instances of medical restraint reported in the document "Restraint by Facility 1/1/11 – 7/1/11"). Ten of these restraints were chemical, four were personal (hand-hold or arm-hold), and five were a combination of chemical and personal. 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:<br>▪ In none of 19 episodes of medical restraint (0%) did the physician or dentist 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.<br>▪ In each of the 19 episodes, (100%) the Restraint Checklist included monitoring by a nurse. Each case varied depending on the procedure, and the chemical restraint. Some monitoring was every 10 to 15 minutes for two hours and some was every 30 minutes to an hour for as long as 24 hours.<br><br>Based on the lack of adequate documentation to show appropriate training of restraint monitors and nurses, the inconsistency between the training curricula provided and the State and Facility policies, as well as a lack of direction from physicians for the monitoring of medical restraints, the Facility was not in compliance with this provision. | |
| C6 | Effective immediately, every individual in restraint shall: be checked for restraint-related injury; and receive opportunities to | Based on review of Sample #C.1, consisting of 23 Restraint Checklists for individuals in non-medical, that is emergency or programmatic (in accordance with a Safety Plan), restraint, the following compliance rates were identified for each of the required elements: | Noncompliance |

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| | 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. | ▪ In 22 (96%), continuous one-to-one supervision was provided;<br>▪ In 22 (96%), the date and time restraint began was documented;<br>▪ In 22 (96%), the location of the restraint was documented;<br>▪ In 22 (96%), the time in restraint was between one and 30 minutes with only one episode extending beyond 13 minutes. In such short time periods, opportunities for exercise, meals, fluids and toileting were not noted.<br>▪ For each of the indicators above, the one issue was the absence of a Restraint Checklist for Individual #107.<br>▪ In 14 (61%), information was documented about what happened before, including the change in the behavior that led to the use of restraint. This was an improvement from the compliance rate of 30% in the previous report. Three of these instances of restraint involved soda: seeing and wanting one, sitting in front of the soda machine for four hours hoping for one, or wanting one ahead of schedule. Three involved waiting for parents, coming back from a visit home with inappropriate things (i.e., metal handcuffs), or returning from a visit wanting soda and sweets that were not part of the individual's diet plan. Such information offered an opportunity for analysis and the development of additional strategies to prevent restraint.<br>▪ In 12 (52%), the actions staff took prior to the use of restraint were described well enough to permit adequate review per Section C.8 of the Settlement Agreement. In the remaining records, boxes were checked to indicate actions taken, but there was little description beyond a repetition of that was already indicated in the checked boxes. An example of an adequate description was for Individual #87 on 5/30/11. An example of an inadequate description was for Individual #43.<br>▪ In 22 (96%), the specific reasons for the use of the restraint were identified. For Individual #107, the Restraint Checklist was not available. Many of the 22 Restraint Checklists included better descriptions of the behavior that caused the restraint, such as kicking, hitting, rather than "aggression to staff," or attempting to throw the toilet tank cover, rather than throwing objects. This was an improvement over what the Monitoring Team previously had reviewed.<br>▪ In 22 (96%), the method and type (e.g., medical, dental, crisis intervention) of restraint was documented;<br>▪ In 22 (96%), the names of staff involved in the restraint episode were listed;<br>▪ Observations of the individual and actions taken by staff while the individual was in restraint were noted, including:<br>o In 22 (96%), the observations were documented every 15 minutes and at release.<br>o For the 22 episodes of personal or mechanical restraint, in 21 (95%), the specific behaviors of the individual that required continuing restraint were documented. However, in one case of mechanical restraint, | |

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| | | Individual #505 was restrained due to self-injurious pinching of his leg and was not released for 30 minutes. There were no reported interim checks to see if he was no longer a danger to himself.<br>▪ In 22 of 23 restraints (96%), the documentation identified the level of supervision provided during the restraint episode as one-to-one.<br>▪ In 21 of 22 restraints that were not chemical (96%), the date and time the individual was released from restraint was on the Restraint Checklist. In one case (Individual #107) there was no Restraint Checklist.<br><br>Based on a review of Samples C.1 and C.3, in 37 of the 42 records reviewed (88%), the results of assessment by a licensed health care professional as to whether there were any restraint-related injuries or other negative health effects were documented. Records that did not contain documentation of this included Individual #48, on 6/16/11; Individual #95, on 6/6/11; Individual #231, on 4/27/11; Individual #469, on 6/10/11; and Individual #523, on 5/11/11. These records did not include appropriate documentation regarding the specific descriptions of injuries. These findings reflected an increase in compliance from 76% during the last review to 88%.<br><br>In a sample of 23 records (Sample #C.1), restraint debriefing forms had been completed for 22 (96%). For Individual #107, the debriefing form was not available.<br><br>A sample of 19 records of individuals subject to medical restraint was reviewed (Sample #C.3). While none (0%) had a schedule of monitoring specified by the physician or dentist, the Restraint Checklists for all had documentation of monitoring by a nurse.<br><br>Sample #C.4 was selected from those who had chemical restraint as an emergency or programmatic restraint as listed on the "Behavioral and Chemical Restraints List" provided in response to the Document Request II.7.a. The sample included nine episodes of chemical restraint, or 23% of the listed episodes. Of those reviewed, the Restraint Checklists indicated that a psychologist was either present or was consulted at some time during the episode. However, the form that provided for the documentation of contact between the psychologist and the licensed medical professional was not present in two instances (Individual # 424 and Individual #465.) For one instance (Individual #87), an older version of the form was used and did not prompt the contact. In three forms, (Individual #95 on 5/26 at 4:30 p.m. and 5:35 p.m., and Individual #324), it was clear that the psychologist had completed the protocol, but it was not clear whether the information on the protocol was shared with the medical staff involved in the restraint. The procedure for the use of the "Administration of Emergency Medication Protocol" should provide space for the names of both the psychologist consulted and the name of the licensed medical professional who called for the consultation. The procedure to include both names should be described in the training for psychologists and medical | |

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| | | personnel as well.<br><br>As illustrated throughout this section, a number of documentation issues continued to exist related to the use of both emergency personal and chemical restraint. In addition, continued efforts were needed to improve the descriptions of antecedent behaviors on the Restraint Checklists. 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: | | |
| | (a) review the individual's adaptive skills and biological, medical, psychosocial factors; | According to the restraint review provided by the Facility, during the six-month period (February to July) prior to the onsite visit, a total of 16 individuals were placed in restraint more than three times in any rolling 30-day period. A sample of six (38%) of these individuals was selected for review to determine if the requirements of the Settlement Agreement were met. The six individuals reviewed included: Individual #387, Individual #534, Individual #95, Individual #505, Individual #313, and Individual #323. The following documents were reviewed: Behavior Support Plan, addenda to the Personal Support Plan, Safety Plan (excluding Individual #534), and Personal Support Plan. The results are discussed below with regard to Section C.7.a through C.7.g of the Settlement Agreement.<br><br>For six of the individuals (100%) reviewed, the individual's team met to discuss the restraints.<br><br>For two of the individuals (33%) reviewed, the team reviewed the individual's adaptive skills. The following are examples of individuals for whom this was done appropriately:<br>▪ The team for Individual #534 had recommended the addition of four training skills. Three programs had been recommended by occupational and physical therapy, and one work objective had been added following acquisition of a previously identified skill.<br>▪ Individual #95 had recently been admitted to the Facility. A referral was made to vocational services in an attempt to provide a more structured daily schedule. Approximately three weeks after the referral was made, this individual began attending workshop.<br><br>The following are examples where teams failed to do this adequately: | Noncompliance |

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| | | ▪ Individual #387 had only one training objective identified in his Personal Support Plan. Although difficulty with communication was clearly identified as a variable related to his problem behavior, there were no identified training objectives to teach this essential skill. The replacement behavior in his BSP did refer to ways to make his wants and needs known, but this referred to a variety of alternative communication forms.<br>▪ Individual #387 had been getting up at night and refusing to return to bed. A later addendum to his Personal Support Plan indicated that he was refusing to use the bathroom. There were no recommendations to develop teaching programs to address these two needs, rather staff were advised how to respond when these events occurred.<br>▪ A Quarterly Review was provided for Individual #505. There was no indication that data had been reviewed to assess progress. Where training steps were noted, there had been no change for three quarters, yet changes to the teaching program were not recommended.<br>▪ Quarterly Reviews were provided for Individual #323. No data were reviewed to determine progress, and although the same step of a program was identified for multiple quarters, no changes to the teaching program were recommended.<br><br>For six of the individuals reviewed (100%), the individual's team reviewed biological, medical, and psychosocial factors. However, for only four of these individuals, were the actions taken complete and/or timely (67%). The following are examples of individuals for whom this was done appropriately:<br>▪ For all of the individuals, ongoing referral to psychiatry or follow up in psychiatry clinic were advised regarding medication management.<br>▪ Individual #387 was recommended for an MRI as a result of an increase in SIB. This was appropriate to determine any medical cause for the increase and to rule out any acquired head injury.<br>▪ Individual #387 was referred for an Ophthalmology consult to rule out a detached retina following a serious incident of self-injury.<br>▪ Individual #534 was observed to have behavioral difficulties when working with male staff. The team recommended interaction guidelines be developed and provided to male staff. Additionally, the individual was referred to counseling. Notes indicated that counseling services began within one month of the referral.<br>▪ Individual #534 was observed to have difficulty awakening in the morning. As her work was scheduled to begin mid-day, her morning routine was adjusted to allow her to sleep later.<br>▪ Individual #505 was scheduled for a gastroenterology exam for possible H-Pylori, described as typical for this individual.<br>▪ It was determined that Individual #313 had not been receiving her 2 p.m. dose of medication until 4 p.m. due to her workshop schedule. Her schedule was revised | |

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| | | so that she would return home at 2 p.m. while engaged in her job delivering mail. Once she obtained her medication, she would then transition to workshop.<br>▪ Individual #313 was referred to counseling, specifically participation in anger management courses. Staff should report on the outcome of this recommendation in later PSP Addenda notes.<br>▪ Individual #323 was referred for counseling. Staff should report on the outcome of this recommendation in later PSP Addenda notes<br><br>The following are examples where teams failed to do this adequately:<br>• Although healthcare issues were identified as potential setting events for self-injurious behavior for Individual #505, follow-up examination for H-Pylori was not scheduled to occur until nine days later. There was no discussion regarding preventative strategies to reduce recurrence of H-Pylori.<br>• The team noted that regular direct support professionals were not available to work with Individual #505 during shifts where restraint occurred. While this was insightful information, no recommended action was offered to address this issue.<br>▪ Individual #313 sustained an injury to her arm after breaking a window in a locked home. Reportedly, the individual had left her home seeking a nurse. Staff in surrounding homes were advised to lock the doors. There was no indication that alternatives to gaining the attention of a nurse were explored. | |
| | (b) review possibly contributing environmental conditions; | For four of the individuals reviewed (67%), the individual's team reviewed the possibly contributing environmental conditions. The following are examples of individuals for whom this was done appropriately:<br>▪ The team identified preferred foods for Individual #387. A request was made of the dietician to ensure these foods were available in the residence for this individual.<br>▪ Direct support professionals reported that Individual #387 was having difficulty completing a nighttime routine. Observations suggested that an opportunity for a van ride or other activity immediately after dinner resulted in better cooperation with this routine. The team agreed to implement a van ride or activity from 6:30 p.m. to 7:30 p.m. each night. Staff should assess and report on the efficacy of this intervention through data collection and analysis.<br>▪ Individual #534 had experienced difficulties in her evening work routine. Within one month's time, she had begun working in a community restaurant. Staff should note the outcome of this placement, because within approximately three months, notes in a PSP Addendum suggested that she was no longer working as originally scheduled.<br>▪ A recommendation was made to review the work schedule for Individual #505. | Noncompliance |

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| | | Staff should document the outcome of this recommendation in later PSP addenda.<br>▪ A change in the work schedule for Individual #323 was advised.<br>▪ Staff were advised to continue to offer choices to Individual #323. | |
| | (c) review or perform structural assessments of the behavior provoking restraints; | For six of the individuals (100%), a functional behavior assessment had been completed within the previous year. For Individual #95 who had recently been admitted to the Facility, there was evidence that the psychologist had tested some functional hypotheses during an observation. There was also a recommendation for follow-up consultation to be provided by external Board Certified Behavior Analysts. External peer review and consultation was also evident for Individual #505. Although individuals in this sample had functional assessments, they were not of adequate quality. An in-depth review of functional behavior assessments is provided with regard to Section K.5 of the Settlement Agreement. As a result of concerns related to the quality of assessments, the Facility remained out of compliance with this provision. | Noncompliance |
| | (d) review or perform functional assessments of the behavior provoking restraints; | Refer to Section C.7.c. above. | Noncompliance |
| | (e) develop (if one does not exist) and implement a PBSP based on that individual's particular strengths, specifying: the objectively defined behavior to be treated that leads to the use of the restraint; alternative, positive adaptive behaviors to be taught to the individual to replace the behavior that 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 | For six of the individuals reviewed (100%), the individual had a Behavior Support Plan (BSP). The following was found:<br>▪ Six (100%) specified the objectively defined behavior to be treated that led to the use of restraint;<br>▪ One (17%) specified the alternative, positive adaptive behaviors to be taught to the individual to replace the behavior that initiated the use of the restraint. The remaining five plans identified adaptive behaviors to be taught, but did not define the behaviors in objective and measurable terms;<br>▪ Six (100%) reviewed the results of the functional behavior assessment;<br>▪ Six (100%) listed potential reinforcers, yet only three (50%) clearly referenced a completed preference assessment; and<br>▪ Six (100%) specified the treatment strategies to utilize to reduce the identified target behavior that led to restraint.<br><br>The following provides feedback specific to the individual BSPs:<br>▪ The BSP for Individual #387 included responses to target behaviors that had the potential to reinforce these identified problem behaviors. If the target behavior (aggression, self-injury, or elopement) was exhibited "in response to wanting an item," staff were advised to prompt an appropriate form of communication after which the individual would receive the desired item. This chain of responding could result in a strengthening of the very behaviors targeted for reduction. | Noncompliance |

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| | individual's ISP; | ▪ Once each shift, staff were to ask Individual #534 if there was anything she wanted. This was problematic for two reasons. First, the individual was not learning to make requests spontaneously, because training required the posing of a question first. Second, the schedule for training was severely limited.<br>▪ In the plan for Individual #95, staff were advised to "use pivot in response to all inappropriate behavior." Although pivot was one strategy identified in the five core competencies, it would be clearer for staff if their response was described in observable terms.<br>▪ The outline for teaching replacement behavior to Individual #505 suggested that the individual should obtain a picture of an activity that staff had identified. If the individual made a mistake, he was to be shown the correct picture. It is unclear how this was teaching independent communication skills, because the individual might want to engage in a different activity at that time. These correction trials also might prove increasingly effortful for the individual. Staff are reminded that replacement behaviors should be less effortful than the target behaviors.<br>▪ The plan for Individual #313 included instructions for additional reinforcement to be applied when she began to display symptoms of anxiety. Later in this plan, staff were advised to provide attention before the individual displayed anxiety symptoms, yet the reinforcement plan as written increased attention contingent upon these very symptoms. Staff should review the plan to ensure that reinforcement is appropriately applied and that guidelines are consistent throughout.<br><br>Safety Plans were provided for five of the six individuals. The PSP Team for Individual #534 had determined that a plan was not necessary due to behavioral improvement. In the five plans reviewed, the following information was provided:<br>▪ The type of approved restraint was identified, the maximum duration of the restraint was 30 minutes, situations in which restraint could be applied were described, and criterion for termination of restraint was identified as when the individual was no longer a danger to self or others.<br>▪ None of the plans were signed.<br>▪ Two plans were dated. Of the remaining three plans, one had no date and two were identified as drafts. The draft plan for Individual #323 contained objectives for the time period 8/10 and 7/11, and the tracking sheet for Safety Plans indicated an implementation date of 1/28/11.<br>Steps should be taken to ensure that Safety Plans are developed, approved, and implemented in a timely manner. Further, documentation provided to staff should be dated and signed by the plan author.<br><br>Concerns specific to individual Safety Plans are reviewed below. | |

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| | | ▪ The plans for Individual #387 and Individual #505 referenced "Sensory Gym" or "Sensory Diet" respectively. "Sensory Gym" was prescribed for Individual #387 to assist "in teaching him to how to self-regulate his behaviors." Unless self-regulation is operationally defined with data collected on observable and measureable behavior(s), it is difficult to analyze the efficacy of "Sensory Gym." Further, the individual's resistance to "Sensory Gym" was noted in a Personal Support Plan Addendum dated 3/24/11. Similarly, Individual #505 was to have components of his "Sensory Diet," including a weighted vest, applied even when in restraint. In his Safety Plan staff were guided to apply this vest even if he seemed resistant. This may constitute contingent application of a punishing stimulus and should be reviewed carefully. As noted in previous reports, sensory integration therapy remains an approach to treatment for which the efficacy has not been supported in the scientific literature.<br>▪ The present situation in the plans for Individual #387, Individual #313, and Individual #323 referenced the individual "attempts or does attack you." Staff should describe the individual's behavior in observable and measureable terms (e.g., the individual repeatedly hits another).<br>▪ The plan for Individual #387 suggested that the individual could be given a desired item in order to avoid restraint. As written this could result in a strengthening of his aggressive behavior. Similarly, the plan for Individual #323 advised staff to take him for a walk, sing a song, or go to the chapel to avoid restraint. As these might be reinforcing activities, their contingent application following aggression might only strengthen the unwanted behavior.<br>▪ For Individual #95, staff were advised to move outside if necessary in order to avoid restraint. As the situation was described as one in which the individual was already trying to harm himself or others, or had engaged in property destruction, this might only make the situation worse as a greater number of people could potentially observe this behavior. As obtaining attention was identified as one function of these behaviors, the additional attention might only reinforce these undesired behaviors. Further, the individual's privacy should be protected at all times when engaged in problem behavior.<br>▪ Several plans advised staff to be "mindful of their tone of voice, body posture, and what they are saying." Specific examples of statements to avoid were included in the plan for Individual #505, but no examples were provided in the plans for Individual #313 or Individual #323.<br>▪ Individual #505 was directed to sit before his gloves were applied. There were no guidelines for staff regarding actions to take if the individual refused to sit. | |
| | (f) ensure that the individual's treatment plan is implemented with a high level of treatment | At the time of the visit, the Facility staff were beginning to monitor the implementation of treatment plans (as discussed in further detail with regard to Section K.12). Strategies to ensure high levels of treatment integrity will require ongoing support and training of the | Noncompliance |

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| | 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 | direct support professionals as they carry out their job responsibilities. | |
| | (g) as necessary, assess and revise the PBSP. | In none of the records reviewed (0%), was there documentation that the individual's BSP had been revised as appropriate. | Noncompliance |
| 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.<br><br>According to policy and procedure, 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.<br><br>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.<br><br>A sample of documentation related to 23 incidents of non-medical restraint was reviewed (Sample #C.1), including the Face-to-Face/Debriefing forms, Unit Team meeting notes, Restraint Reduction Committee minutes, and PSP addenda. This documentation showed that:<br>▪ In 23 (100%), the review occurred within three days of the restraint episode;<br>▪ In 14 (61%), the circumstances under which restraint was used were determined. As indicated in Section C.4 of this report, the Face-to-Face/Debriefing forms did not always provide adequate assessments of the circumstances under which restraints were used. For the Unit Team Review to be adequate, it would have been necessary to point out the problems with the | Noncompliance |

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| | | Face-to-Face/Debriefing form information. Likewise, the Incident Management Team would need to point out where the Unit Team missed an opportunity to raise questions and make corrections. In cases where the review did not determine the circumstance, the Unit team or the Incident Management Team had not raised questions about descriptions of antecedent behaviors,<br>▪ In 7 (30%), an adequate review was conducted. Where the circumstances were not determined as in the last bullet, the review was not adequate. In addition some of the reviews did not identify issues, such as the inability of staff to hold restraints or environmental conditions that might have contributed to the restraint use. The following provide some examples of issues that this review should have identified and addressed, but did not:<br>o As one strategy to avoid restraint, staff offered Individual #319 an opportunity to listen to music. This might strengthen the aggressive behavior that resulted in restraint.<br>o Individual #74 became self-injurious and aggressive when he entered the kitchen, and his request for soda was denied. Staff should respond to appropriate requests even if alternative items must be provided. As noted above with regard to Section C.5, the team should have been asked to consider a variety of options for reducing the likelihood of a recurrence of restraint.<br>o An individual restraint report for Individual #486 indicated he had become "upset about something, either the food or he wanted some more food" after dinner. Neither his Personal Support Plan nor Behavior Support Plan included objectives for teaching appropriate communication skills.<br>o Individual #444 became aggressive when metal handcuffs that had been provided by his father were removed. Although a rights restriction, staff should develop guidelines for inappropriate personal items in a group living environment, if not already in place, and share these with individuals, as well as their families.<br>o An addendum to the PSP for Individual #160 indicated that he had begun requesting restraint. The interpretation was that there was a change in his sensory needs and an OT evaluation should be completed. Staff should consider that the attention and contact might be what was reinforcing, and the revision to the behavior support plan should be reviewed.<br>o Individual #132 was asked to terminate a phone call with school friends. He became aggressive and was placed in a hold. Staff should develop guidelines or a teaching program for calling/texting friends. | |

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| | | At the end of each month, the Quality Assurance staff issued a summary of the data collected through this process, and the Psychology Department prepared a trend analysis of the data. The Restraint Reduction Committee, which had changed from monthly to quarterly meetings, reviewed the summaries and trend analyses to determine where to apply efforts at reduction from both from an individual and a systemic perspective. As observed at the meeting of this committee during the Monitoring Team's visit, extensive review and discussion occurred regarding identified individuals. The membership of this committee had been expanded to include a home supervisor, the Coordinator of Residential Services, and members of the medical staff. Committee members agreed to increase their schedule of meetings to once monthly. These efforts are commendable.<br><br>The trend analyses included information about individuals experiencing high levels of restraint, and possible causes of the increase in behavior such as "holdovers and increased float" which were noted as being addressed by the Leadership Team. They continued to identify specific individuals, which made the information easier to use. The Committee's minutes included updates on recommendations made in the previous month, but those updates were not specific. This was an excellent process that, if pursued with determination and in conjunction with the new Personal Support Plan process, should result in further reductions in restraint use. It would be helpful to use the committee minutes to document some of the focused attention provided to individuals with a history of high restraint use, such as use of consulting time and modeling of programs by psychologists, and the results of that attention.<br><br>Although some positive activity was occurring with regard to the timeliness of the review of restraints, improvements continued to need to be made with regard to the documentation of the reviews and resulting actions at the unit level. To determine the circumstances of the restraint and to produce adequate reviews, those reviewing the documentation need to have information about the antecedent behaviors, and when such information is missing or insufficient, they should ask questions to clarify and document that process in the minutes. The Restraint Reduction Committee should focus on identifying the potential causes for restraint, and developing and implementing plans to reduce the use of restraint.<br><br>The Facility process for reviewing restraints was in place, but it was not being completely carried out. As a result, the Facility was not yet in substantial compliance with this provision. | |

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

1. ABSSLC policy on restraints should be amended to remove references (in II.E.2) to the use of mechanical restraints in Behavior Support Plans.

(Section C.1)

2. As recommended with regard to Section J.3, the documentation contained in the Chemical Restraint forms that involve the intramuscular injection of a psychotropic medication during crisis situations should be fully completed, and should include a description of the events that led up to and/or provoked the behavior that resulted in the chemical restraint. (Section C.1)
3. Staff should clearly describe the events that lead to restraint application. (Section C.1).
4. Staff should address the following components of Behavior Support Plans: a) results of a comprehensive functional behavior assessment, including direct observation of problem behaviors; b) formal preference assessment; c) operationally defined replacement behaviors, with adequate teaching guidelines and opportunities for learning; d) preventative strategies; e) dense schedules of reinforcement; f) individual specific consequences relevant to the hypothesized function of the problem behavior(s). (Section C.1).
5. A review of instances of restraint where the restraint cannot be maintained should be undertaken to determine alternative training for staff or to determine whether the restraint was necessary at all. (Section C.2)
6. 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. (Section C.3)
7. The "Do Not Restrain/Restraint Modification List" should be revised to include only instructions that go beyond the routine instructions that apply to all individuals. Once revised, the relevant list should be posted in residences in places to which only authorized staff have access (e.g., staff offices) so that staff are aware of the extra limitations on restraint for some individuals. (Section C.4)
8. Staff should revise Dental Desensitization Plans to include the following: a) increased opportunities for training; b) collection of objective baseline measures; c) personal task analyses that clearly describe the individual's behavior; and d) application of individual specific reinforcers as determined by formal preference assessment. Staff should also consider changes to teaching objectives as outlined with regard to Section S.1 of the Settlement Agreement. (Section C.4).
9. The Facility should ensure that restraint monitors are in place within the 15 minutes the Settlement Agreement requires. (Section C.5)
10. The Facility should ensure that a licensed health care professional timely monitors and documents vital signs 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. (Section C.5)
11. The Facility should ensure that audit tool indicators related to nursing staff's documentation on the use of restraint are audited by Nursing and/or Nursing QA staff, the findings of the restraint audits are shared with the appropriate disciplines, and that the Nursing Department reviews items addressing nursing, and develops plans of correction for any problematic areas noted. (Section C.5)
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, filling in all information, and recording antecedent behaviors. (Section C.5)
13. 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 required to write legibly. (Section C.5)
14. To avoid confusion, the "programmatic" terminology should be removed from the data reports and training curricula. (Section C.5)
15. With regard to restraint monitoring, the Facility should:
    a. Develop and maintain a list of the staff that serve as Restraint Monitors, including the dates they were trained and when they were determined competent.
    b. Develop and maintain a list of nurses who have been trained to evaluate individuals in and after restraint, including the dates of their training and when they were determined competent.
    c. If training used to train nurses on their responsibilities regarding restraint is the course RES0300, together with the competency check (Document Request II.12.c), then the course should be revised to comply with State and Facility policy and with the requirements of the Settlement Agreement. (Section C.5)
16. Restraint Monitors and nurses need to be trained to complete the review of the use of restraints and to document the results accurately on the appropriate forms. (Section C.5)
17. Physicians and dentists who order medical restraint should indicate a schedule of monitoring and indicate the time the monitoring may stop.

(Sections C.5 and C.6)

18. 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. (Section C.6)
19. The Restraint Reduction Committee should place 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. (Sections C.6 and C.8)
20. The Facility should ensure that there is appropriate documentation by a licensed health care professional as to whether there were any restraint-related injuries or other negative health effects, and if so, that adequate descriptions are provided. (Section C.6)
21. Staff should consistently review teaching of adaptive skills to individuals who experience frequent restraint. (Section C.7.a).
22. Staff should consistently review the biological, medical, and psychosocial factors related to individuals who experience frequent restraint, and implement timely and complete action based on this review. (Section C.7.a).
23. Staff should consistently review environmental conditions for individuals who experience frequent restraint. (Section C.7.b).
24. As recommended with regard to Section K.5, improvements should be made to functional behavior assessments, including increased direct observation. (Section C.7.c and Section C.7.d).
25. Staff should review the section of this report that addresses Section K.9 of the Settlement Agreement in which recommendations are made regarding revisions to Behavior Support Plans. (Section C.7.e).
26. Staff should ensure that necessary Safety Plans for Crisis Intervention are developed, approved, and implemented in a timely manner. (Section C.7.e).
27. Ongoing improvement to competency-based training should occur to ensure high rates of treatment integrity. (Section C.7.f).
28. As appropriate, staff should make changes to the Behavior Support Plan and/or Personal Support Plan when events leading to restraint are identified. (Section C.7.g).
29. Staff should ensure timely follow-up to all recommendations made by the Personal Support Team. (Section C.7).
30. 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. (Section C.8)
31. 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 C.8)
32. With regard to the Facility's self-assessment processes:
    a. Monitoring instruments should include guidelines to ensure inter-rater reliability and validity of monitoring results.
    b. With regard to the back-up documentation for the Facility's POI, numbering of associated forms and graphs should match.
    c. The POI's status column should indicate the overall population from which the sample was drawn (N), the number of records monitored (n), the time frame within which the monitoring took place, and whether the Program Compliance Monitor or Psychology Department staff completed the monitoring. If inter-rater reliability checks have been done, it would be helpful to report the results.
    d. The Facility should review and report on data related to the individual indicators within each sub-section of the Settlement Agreement.
    e. The Facility should ensure that the quality of efforts as well as the quality of the documentation is evaluated thoroughly.
    f. With regard to the narrative descriptions of actions taken to comply, the Facility should provide more specific references to the evidence supporting the listed status items. In addition, it would be helpful if the POI referenced the action plan or other documentation to support their efforts. (Facility Self-Assessment)

| **SECTION D: Protection From Harm - Abuse, Neglect, and Incident Management** | |
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| 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:<br>▪ **Review of Following Documents**:<br>o ABSSLC Policy #021.1: Protection from Harm-Abuse, Neglect and Incident Management, revised 7/21/11;<br>o ABSSLC Policy #002.2: Incident Management, dated 6/18/10, revised 1/14/11;<br>o ABSSLC Plan of Improvement, dated 8/12/11;<br>o MH & MR Investigations Streamline Policy, referencing dates of June and December 2010;<br>o List of DFPS-Investigated Cases from 2/1/11 through 7/19/11;<br>o List of unusual incidents from 3/1/11 to 6/7/11;<br>o ABSSLC Unusual Incidents Trend Report, for June 2011;<br>o ABSSLC Injury Trending, for June 2011;<br>o ABSSLC Allegations of Abuse/Neglect/Exploitation Trend Report, dated June 2011<br>o Reassignments list;<br>o DADTX Course delinquency list for Abuse/Neglect/Exploitation (A/N/E) Training dated 7/25/11;<br>o ABSSLC Annual Employee Registry Check and Fingerprint Criminal History Submission, dated 9/17/10;<br>o Fingerprinting date and Annual Name-based check for Foster Grandparent Program – Abilene, undated;<br>o Criminal Background Checks FY 2010 Results (Summary Report);<br>o Criminal Background Check and Fingerprint Check for Volunteers;<br>o Individual Training Records for 25 employees in Sample #C.2;<br>o List of serious injuries investigated from 1/1/11 through 6/23/11;<br>o Sample #D.1 included a sample of 36 DFPS investigations of abuse, neglect, and/or exploitation with the Facility investigation reports that were related. This sample included the following DFPS investigation numbers: #40009307, #40039068, #40046447, #40111347, #40118868, #40124348, #39535248, #39552387, #39591348, #39601471, #39615427, #39753527, #39829467, #39831989, #39836488, #39855849, #39855487, #39860307, #39888747, #39893147, #39896387, #39942789, #39950187, #39224069, #39240527, #39266147, #39290509, #39290847, #39335387, #39361247, #39364251, #39373947, #39400609, #39403707, #39434048, and #39463427;<br>o Sample #D.2 included a sample of seven investigation reports completed by the Facility only or by the Facility in conjunction with DFPS. Sample D.2 included cases: #2839, #2843, #2840, #2648, #I264, #11-04-003, and #11-06-024;<br>o Sub-sample #D.6 included ten of the DFPS investigations from Sample #D.1where abuse or neglect was confirmed and three of the Facility investigation from Sample #D.2: Sample #D.6, included the following investigations: Facility investigations #2840, #2648, #1264, and DFPS cases # 39601471, #39290509, #39535248, #39753527, #39893147, |

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| | #39942789, #39290847, #39335387, #39361247 and #39434048;<br>o Personal Support Plans (PSPs) for: Individual #84, Individual #370, Individual #515, Individual #269, Individual #102, Individual #451, Individual #411, Individual #415, Individual #535, Individual #300, Individual #319, and Individual #442.<br>▪ **Interviews with**:<br>o Linda Hinshaw, Facility Director;<br>o Jolene Willis, Assistant Director of Programs;<br>o Luee McCreary, Incident Management Coordinator;<br>o Patricia Smith, Quality Assurance Director;<br>o Ron Manns, Director of Behavioral Services;<br>o Tracyl Gandee, Settlement Agreement Coordinator;<br>o Clinical staff re: death of Individual #10;<br>o Shane Butts, Human Rights Coordinator; and<br>o Various staff and individuals receiving services.<br>▪ **Observations of**:<br>o Nine residences including: #6330, #6350, #6360, #6390, #6400, #6500, #6730, #6750, and #6760;<br>o PSP annual meeting for Individual #30; and<br>o Self-advocates meeting. |
| | **Facility Self-Assessment:** The ABSSLC Plan of Improvement indicated the Facility was in substantial compliance with nine of the 22 provisions in Section D of the Settlement Agreement. The Monitoring Team found the Facility to be in compliance with 10 of the 22.<br><br>Some of 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 February 2011 visit. The Facility had established a plan to review incident management and investigation documentation, and reported completing 30 monitoring tools since March 2011. The information included in the POI indicated percentages of compliance for some provisions, based on the use of the monitoring tools. For some provisions of the Settlement Agreement, the percentages provided were stated as a percentage in compliance on a specific indicator. However, for many provisions, the Facility did not indicate that an objective review had been completed to determine its findings of substantial compliance or noncompliance (e.g., Sections D.2.a, D.2.b, D.2.c, D.5, etc.). In addition, when data resulting from monitoring reviews/audits was cited, it was unclear what the monitoring methodology was (e.g., Section D.2.f), and/or what the population was versus the sample selected.<br><br>In addition to collecting data on indicators, the Facility addressed some of the Monitoring Team's recommendations from the last visit. An Action Plan was included in the POI to enhance staff understanding of their responsibilities to report serious incidents and all other unusual incidents to the Facility Director, as well as to other authorities, such as DFPS. A monitoring tool was developed for supervisors to check staff understanding of their reporting responsibilities, and the use of the tool was implemented. |

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| | **Summary of Monitor's Assessment:** The systems for reporting and investigating unusual incidents had become an established part of the day-to-day management of ABSSLC. As with most mature 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.<br><br>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. Issues from previous Settlement Agreement Monitoring Reports, such as recording supervisory reviews and their content, and the review by Department of Family and Protective Services (DFPS) investigators of past investigations appeared to be resolved.<br><br>Training for staff on abuse and incident reporting was in place, and 98% of staff was current on that training.<br><br>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. |

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| D1 | Effective immediately, each Facility shall implement policies, procedures and practices that require a commitment that the Facility shall not tolerate abuse or neglect of individuals and that staff are required to report abuse or neglect of individuals. | The Facility's policies and procedures:<br>▪ Included a commitment that abuse and neglect of individuals would not be tolerated; and<br>▪ Required that staff report abuse and/or neglect of individuals.<br><br>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:<br>▪ 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 last review, QDDPs just had been trained on this process. Additional training was provided to QDDPs in March 2011 on education of individuals, and their primary correspondents/LARs on identifying and reporting unusual incidents and instructing QDDPs to document that education in the annual PSP. Posters aimed at reminding individuals of their rights to report abuse were found in all residences visited. | Noncompliance |

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| | | ▪ Staff had been retrained on reporting abuse, and specifically on reporting to the Director as well as to DFPS.<br>▪ When a staff member did not act to stop abuse as required by policy and emphasized in training, that lapse was noted and addressed in case #39855487.<br><br>However, the Monitoring Team did not find follow-through on all of the efforts to support reporting of abuse. Specifically, QDDPs were not providing information to individuals and their LARs on abuse reporting during PSP annual meetings, nor were they documenting the provision of abuse reporting materials in the PSPs reviewed.<br><br>In summary, there has been a concerted effort to train staff to report abuse, and to train QDDPs to make individuals and their LARs/correspondents aware of the processes to report abuse, However, there was no evidence that individuals and their LARs were receiving the abuse reporting information. As a result, the Monitoring Team concurs with the Facility that this provision is not yet in compliance. | |
| D2 | Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall review, revise, as appropriate, and implement incident management policies, procedures and practices. Such policies, procedures and practices shall require: | | |
| | (a) Staff to immediately report serious incidents, including but not limited to death, abuse, neglect, exploitation, and serious injury, as follows: 1) for deaths, abuse, neglect, and exploitation to the Facility Superintendent (or that official's designee) and such 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 | According to Policy #021.III.1-5, staff who discovered or learned 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.<br><br>With regard to serious incidents, the Facility policy #002.2.III.A required staff to report 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.<br><br>Although in the paragraphs that follow, the Monitoring Team has provided some figures with regard to allegations and incidents, it is essential to note that reviewing pure numbers provides very little meaningful information. For each of these categories, the Facility would need to conduct analyses to determine causes, and to review carefully whether for incidents that were preventable, and adequate action had been taken to prevent their recurrence. Determining the reasons or potential reasons for increases or decreases in numbers also is essential. Although the ultimate goal is to reduce the overall | Noncompliance |

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<tr><td></td><td>report these and all other unusual incidents, using standardized reporting.</td><td>numbers of preventable incidents, care needs to be taken to ensure that the result of such efforts is not the underreporting of incidents. For an incident management system to work properly, full reporting of incidents is paramount, so that they can be reviewed, and appropriate actions taken. The Facility's progress in analyzing data collected, and addressing issues identified is discussed in further detail with regard to Section D.4 of the Settlement Agreement.<br><br>According to data the Facility provided in response to Document Request TX-AB-1108-III.7, the numbers of abuse/neglect/exploitation allegations for the past 18 months were:<br><br>
<table>
<tr><th></th><th>1/1/10 to 12/31/10 (12 months)</th><th>1/1/11 to 6/30/11 (6 months)</th></tr>
<tr><td>Total Abuse allegations</td><td>390</td><td>151</td></tr>
<tr><td>Abuse substantiated</td><td>50</td><td>50</td></tr>
<tr><td>Neglect allegations</td><td>167</td><td>45</td></tr>
<tr><td>Neglect substantiated</td><td>99</td><td>46</td></tr>
<tr><td>Exploitation allegations</td><td>0</td><td>2</td></tr>
<tr><td>Exploitation substantiated</td><td>0</td><td>0</td></tr>
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According to Facility data provided in response to Document Request TX-AB-1108-III.7, the numbers of Unusual Incidents investigated over the past 18 months included:<br><br>
<table>
<tr><th></th><th>1/1/10 to 12/31/10 (12 months)</th><th>1/1/11 to 6/30/11 (6 months)</th></tr>
<tr><td>Deaths</td><td>18</td><td>5</td></tr>
<tr><td>Serious Injuries</td><td>77</td><td>41</td></tr>
<tr><td>Sexual Incidents</td><td>8</td><td>4</td></tr>
<tr><td>Suicide Threat (credible)</td><td>9</td><td>16</td></tr>
<tr><td>Unauthorized Departure</td><td>18</td><td>14</td></tr>
<tr><td>Choking</td><td>7</td><td>1</td></tr>
<tr><td>Other</td><td>4</td><td>1</td></tr>
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Based on an interview of 12 staff responsible for the provision of supports to individuals, 12 (100%) 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 all interviewed staff were wearing their identification badges.<br><br>Based on an interview of 12 staff responsible for the provision of supports to individuals, all appeared to understand that unusual incidents needed to be reported, and identified their supervisor as the person to whom they would report. Some indicated they would call the switchboard. The policy requires reporting to the Director or Designee, but the</td><td></td></tr>
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| | | "Procedure for Timely Reporting," dated March 23, 2005, required reporting by calling the switchboard. It appeared logical for a Direct Support Professional to notify the next person in their chain of command or the switchboard in an effort to ensure the incident was reported to the Director. However, based on the Settlement Agreement requirements that the Director be notified, the required reporting route for Direct Support Professionals should be set forth in policy, and any related procedures.<br><br>Two samples of investigations were selected for review. Sample #D.1 included 36 reports DFPS completed (19% of the 186 reports listed as having been completed between 2/1/11 and 7/19/11), and the associated Facility Unusual Incident Reports. Sample #D.2 included seven Facility reports of investigations (20% of the 35 Facility Investigations between 3/1/11 and 6/7/11). The Documents Reviewed section above contains a complete listing of each sample. The samples were drawn from the lists supplied by the Facility together with the documents requested prior to the Monitoring Team's site visit.<br><br>Based on a review of the 36 investigation reports included in Sample #D.1:<br>▪ Seventeen (47%) included evidence that allegations of abuse, neglect, and/or exploitation were reported within the timeframes required by Facility policy. In 12 of the remaining cases, it could not be determined whether the report had been made timely because the time of the alleged incident was not reported. In seven others, the report was later than the one hour allowed. However, many of the reports in this sample were most likely made by individuals themselves, and there was no requirement that they report timely, nor was there any way to ascertain that it was the individual and not someone else who was making the allegation. The identity of reporters was protected, precluding any inquiry into who made reports.<br>▪ All (100%) included evidence that allegations of abuse, neglect, and/or exploitation were reported to the appropriate party as required by Facility policy. Whether the reporter contacted both DFPS and the Director could not be determined. But any report that went to DFPS was immediately shared with the Facility, and when the Facility received the first report, they sent it on to DFPS. The result was that both the Facility and DFPS had the report.<br><br>Based on a review of seven incident reports included in Sample D.2:<br>▪ Seven (100%) showed evidence that serious incidents were reported within the timeframes Facility policy required. In case #11-04-03 the report of possible neglect was made after the individual's death when it was learned that a possible cause of death was improper positioning.<br>▪ Seven (100%) showed evidence that serious incidents were reported to the appropriate party as required by Facility policy. | |

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| | | Both DFPS and the Facility relied on reports of unusual incidents and allegations to be phoned in 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 was standard. However, the initial call information was then entered into the DFPS or Facility computer as part of the investigation information. In interviews with staff, it was reported that sometimes it was difficult to get a call through to the switchboard, potentially resulting in a delay in reporting. This function should be monitored to assure that there is reasonable access to callers who need to make reports.<br><br>The Monitoring Team noted that a quiz of basic reporting rules was developed and implemented to help keep staff's reporting skills sharp. This appeared to be a useful tool, and it should continue to be employed periodically to maintain that skill level<br><br>The Facility noted in the POI that the Director was still not being consistently notified of serious incidents. In interviews with direct support professionals, the Monitoring Team found that staff said they would call their supervisor or the switchboard, rather than the Director to report serious incidents. In interview, the IMC indicated that staff were being trained to call the Director and that trainers explained the need for the Director to have immediate knowledge of serious incidents so that protections for the individual could be put in place quickly. The IMC asked for further ideas on how to assure that staff report to the Director. The Monitoring Team recommends adding reminders to staff at their annual training on abuse/neglect, raising the subject at staff meetings, providing examples of instances where the Director was not notified immediately and what could have happened differently, and interviewing staff when visiting residences or day programs about any reluctance to report to the Director.<br><br>The Facility had made progress on this provision. However, the Facility had identified issues with regard to the staff not notifying the Facility Director of serious incidents and allegation. There was a need to clarify in policy the role of the switchboard in the notification process, and if the switchboard was going to play a role, to assure that switchboard calls were responded to promptly. Additional supervisory efforts were needed to encourage staff to take the proper steps in notifying the Facility Director. Consequently, the Monitoring Team concurred with the Facility that it was 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 | 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, a staff member alleged to have been the perpetrator of an allegation of abuse would be placed on temporary work duty reassignment. | Noncompliance |

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| | immediate and appropriate action to protect the individuals involved, including removing alleged perpetrators, if any, from direct contact with individuals pending either the investigation's outcome or at least a well- supported, preliminary assessment that the employee poses no risk to individuals or the integrity of the investigation. | Based on a review of 36 investigation reports included in Sample #D.1, the alleged perpetrator was removed in 29. In five of the remaining, the perpetrator was unknown and/or the case was being handled as "streamlined." In one case, the allegation of verbal abuse was against an entire Personal Support Team, and the team members were not removed from duty. In the final case, supervision was added to the residence. In all cases, the actions appeared to be appropriate.<br><br>The Facility provided a list of individuals (Individual #48 and Individual #94) for whom it had been agreed with DFPS that their allegations would be treated as "streamlined" investigations. These individuals appeared as alleged victims in a total of ten cases in Sample #D.1, and appeared to have had their cases handled as spurious allegations in seven of those cases. With both individuals, the evidence supporting their making false allegations was strong. Often they recanted a few hours or days after the allegation. Often the allegations involved staff not on duty or not on duty in their location. In all cases, an investigation was conducted, documents were gathered and staff were interviewed. However, witness statements were usually not taken, and the alleged victim was not interviewed to avoid reinforcing the behavior by providing attention, resulting in a somewhat abbreviated report. For both individuals, DFPS had informed the Facility of its intent to treat their allegations using the streamlined process. DFPS sought input from the individuals' PSTs to confirm that they agreed with the plan to shorten the process and agreed that the investigative process was likely reinforcing the behavior. Thus it appeared that DFPS had fulfilled the requirements of the MH & MR Investigations Streamline Policy.<br><br>Based on a review of 36 investigation files included in Sample #D.1, a total of six cases were confirmed as abuse or neglect, and four were confirmed in part. Documented disciplinary action was as follows:<br>▪ Case #39535248: Confirmed with two employees terminated and one resigned;<br>▪ Case #39601471: Confirmed against unknown perpetrator;<br>▪ Case #39753527: Confirmed against unknown perpetrator, unconfirmed against named employees;<br>▪ Case #39893147: Confirmed, and report indicated disciplinary action ordered; not cleared to return;<br>▪ Case #39942789: Confirmed against unknown perpetrator, employee cleared to return;<br>▪ Case #39290509: Confirmed against unknown perpetrator, employees were not on the reassignment list; retraining in abuse and lifting scheduled; noted that disciplinary action would be taken;<br>▪ Case #39290847: Confirmed with disciplinary action taken, cleared to return;<br>▪ Case #39335387: Confirmed with disciplinary action, retraining on restraints, | |

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| | | cleared to return;<br>▪ Case #39361247: Confirmed against unknown perpetrator, employee cleared to return;<br>▪ Case #39434048: Confirmed against supervisor, terminated supervisor.<br><br>In cases where the allegation was confirmed, but the employee returned to work (as in Case #39290847), it was not clear what retraining was provided, or what other actions were taken to ensure that the employee posed no threat.<br><br>It was difficult to follow the hand-written reassignment records to ascertain the dates an employee was placed on temporary reassignment, returned to work, disciplined and/or retrained.<br><br>Based on a review of the 36 investigations, it was documented that adequate additional action was taken to protect individuals in 35 cases (97%). For example:<br>▪ Additional monitoring of the home by supervisors from other homes was ordered;<br>▪ Staffing levels were increased for the alleged victim; or<br>▪ Staff were moved to another assignment when an allegation was made that met the requirements for a streamlined investigation.<br>In one case (#39855487), the staff member who reported seeing another staff member slap an individual left the individual with the alleged abuser. Proper procedure required that she stop the abuse and protect the individual first.<br><br>While it appeared that staff alleged to have neglected or abused individuals were being removed from direct contact at the outset of an investigation and not returned until the investigation was complete, the condition of the reassignment records did not allow confirmation that the reassignment was timely or the exact date of return to work. Nor was it possible to verify that returning staff had been retrained to assure they no longer presented a threat to safety. The Facility should improve their tracking of reassignments to temporary work to clarify when the reassignment starts, ends and what retraining and or discipline has been completed. The Monitoring Team concurs with the Facility that it was not yet in compliance with this provision. | |
| | (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 | 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.<br><br>The Facility provided a copy of a 2006 version of the training, which appeared from the context to have been updated some time in 2008. However an undated copy of the | Substantial Compliance |

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| | completion of such training. | training with color formatting also was made available. Both contained essentially the same information.<br><br>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:<br>▪ 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.<br>▪ The training did provide adequate training regarding recognizing and reporting signs and symptoms of abuse, neglect, and exploitation.<br><br>Review of a list of staff who were delinquent in training (DADTX Course delinquency list for Abuse/Neglect/Exploitation Training) showed that 1357 of 1381 staff (98%) were up-to-date in training on abuse and neglect.<br><br>Based on interviews with 12 staff:<br>▪ Twelve (100%) were able to list signs and symptoms of abuse, neglect, and/or exploitation;<br>▪ Twelve (100%) were able to describe the reporting procedures for abuse, neglect, and/or exploitation, including where to find the number for DFPS, which was on the back of their badges.<br><br>The Facility's monitoring had been showing this provision to be in compliance, a quiz for staff was being used to keep working knowledge of the reporting system sharp, and training for staff was up-to-date. The Facility was found to be in compliance with this provision of the Settlement Agreement. | |
| | (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 | 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.<br><br>A sample of 25 staff (Sample #C.2) was randomly selected to determine if acknowledgements had been signed. Of the 25, 12 (48%) had signed annual acknowledgments. Three had forms on file, but they were out-of-date and the remaining 10 were not provided. Inquiry indicated that there was some problem with how these forms were stored electronically. | Noncompliance |

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| | 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. | The files presented in response to Document Request TX-AB-0018-III.11 were examined to determine if all listed newly hired staff had signed acknowledgments. All had done so.<br><br>The Facility has been found out of compliance with this provision based on the lack of availability of staff acknowledgement forms of their responsibility to report allegations of abuse and neglect. | |
| | (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. The QDDPs had received training on it in January 2011.<br><br>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.<br><br>Based on a review of 12 individuals' PSPs (Individual #84, Individual #370, Individual #515, Individual #269, Individual #102, Individual #451, Individual #411, Individual #415, Individual #535, Individual #300, Individual #319, and Individual #442), 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 annual PSP meetings observed for this review.<br><br>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 an individual residing at ABSSLC. Examples included cases #40009307, #40124348, #40046447, and #39950187. In these cases, it was clear that staff had facilitated access to the phone and DFPS phone number.<br><br>While the Facility had a resource guide in place, no evidence was found to show that the guide was being shared at PSP meetings. It also was not clear how the guide was being shared with family members outside of the PSP meeting, if at all. The Facility remained out of compliance with this provision. | Noncompliance |

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| | (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.<br><br>The Monitoring Team's observations of nine residences on campus showed that nine (100%) of those reviewed had postings of individuals' rights in an area to which individuals regularly had access. Observations in day programs and offices showed that the poster was displayed widely throughout the Facility. 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.<br><br>Although not directly related to compliance, 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. Attendance at the meeting observed by members of the Monitoring Team had over 50 participants. The discussion for the evening was communication, which is very much a part of self-advocacy. The Facility is encouraged to continue its efforts to support this group, and particularly to expand their understanding of their rights and responsibilities.<br><br>The Facility had complied with the requirement to post an easily understood statement of rights and how to exercise those rights in living units and day programs. The Monitoring Team concurred with the Facility and found this provision to be in substantial compliance. | 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.<br><br>Based on a review of 36 allegation investigations completed by DFPS (Sample #D.1), in 17 for which a referral to law enforcement was necessary/appropriate, DFPS had made referrals in 17 (100%).<br><br>Based on a review of five investigations completed by the Facility (Sample #D.2), referral to law enforcement was neither needed nor made. Of the two Facility investigations that were concurrent with DFPS investigations, law enforcement referrals were made by DFPS. 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 | Substantial Compliance |

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| | | the Inspector General.<br><br>Since DFPS had routinely referred cases that could have criminal implications to both local law enforcement and to the Office of the Inspector General, ABSSLC was in compliance with this provision of the Settlement Agreement. | |
| | (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.<br><br>Based on interviews with the Facility Director, the Assistant Director of Programs, and the Incident Management Coordinator, there had been no reports of possible retaliation in the past six months.<br><br>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, and they knew that failure to report could leave an individual at risk and they could lose their jobs. They knew that they could report acts of retaliation, and most knew there were special numbers to call, but said they would tell their supervisors.<br><br>Based on interviews and observations of individuals in nine residences and over 50 individuals who attended the self-advocates meeting, it was clear than some individuals could report abuse and many did not have the communication skills to do so. As noted in D.2.e above, some individuals represented in sample#D.1 could and did make reports of abuse and likely would not have done so if they feared retaliation.<br><br>Based on a review of investigation records (Sample #D.1 and Sample #D.2), there was one concern noted related to retaliation. In DFPS case #39950187, the alleged perpetrator indicated in his interview that there were staff that did not like him and might retaliate against him. He named the staff, but they were not the ones who reported him for abuse and, since the allegation of abuse was confirmed, it did not appear to have been a form of retaliation against him.<br><br>The Facility was asked for a list of staff who had alleged that they had been retaliated against as a result of their good faith reporting of an allegation of abuse/neglect/exploitation and no names were submitted.<br><br>The Facility reported that their self-monitoring scores on this provision showed 100% compliance with this provision. While the Monitoring Team has some reservations about | Substantial Compliance |

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| | | the reliability of the Facility's data, the results coincided with the findings of the Monitoring Team. This provision was found to be in 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.<br><br>The purpose of a semi-annual audit of injuries is to assure that serious injuries are reported for investigation, and to ensure that non-serious injuries that raise suspicions of abuse because of the nature or location of the injury (for example bruises on the inner thigh may suggest sexual abuse), or the frequency of injury also are reported for investigation.<br><br>Trend Monitoring Reports of injuries identified numbers, types, and locations of reported injuries both serious and non-serious. However, it was not clear that the Trend Report was used to trigger investigations into the causes of repeated injuries, or to explore whether some patterns of injuries might be signs of abuse or neglect.<br><br>A cursory review of the list of all injuries provided in response to Document Request TX-AB-1108-III.16c revealed names of individuals that have sustained a number of non-serious injuries that should be considered for investigation. For example, Individual #540 was reported to have a non-serious injury due to a slip/trip/fall 17 times since January 1, 2011. Individual #442 had 28 slip/trip/falls in the past year. In a good audit, these patterns would be surfaced and investigated.<br><br>A review of the documentation regarding peer-caused injuries (TX-AB-1108-20) revealed that over 325 individuals between January and June of 2011 were involved in usually non-serious injuries caused by peers. These reports should be audited to determine which or which patterns raise concerns that would benefit from investigation.<br><br>An Action Plan should be developed to indicate how the Facility intends to review all injuries every six months, and report for investigation those injuries that due to frequency or other criteria raise suspicions of possible abuse or neglect, if reports have not already been made.<br><br>The Monitoring Team concurred with the Facility that it was not in substantial compliance with this provision. | Noncompliance |
| D3 | Commencing within six months of the Effective Date hereof and with full implementation within one | | |

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| | 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 #002.2.II.B, within one month of employment and before completing an Unusual Incident Investigation, Facility investigators were required to complete "Comprehensive Investigator Training" (CIT100) and "People with MR" (MEN0300). According to the same policy at II.C, within six months of employment, 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. While it was clear that the investigators were required to complete all four courses, it was not clear whether the IMC and the Campus Administrators were required to complete the CIT 100 course on basic investigation process and the MEN0300 course on people with developmental disabilities. There were no requirements in the policy for updates or retraining for investigators. The policy:<br>▪ Described in a comprehensive fashion the conduct of all such investigations in section VI of the policy;<br>▪ Required that investigators be qualified;<br>▪ Required that investigators have training in working with people with developmental disabilities, including persons with mental retardation; and<br>▪ Required that investigators be outside the direct line of supervision of the alleged perpetrator in Section I.H.<br><br>The CIT0100 training curriculum was reviewed. It included basic instruction in the conduct of an investigation, the types of investigations conducted by Facility investigators, and some basic information about interviewing and report writing. CSI0100 was reviewed and included information about how to conduct an investigation, practice exercises, and problems to solve. This course was conducted by Labor Relations Associates (LRA), and was a well-regarded course for investigators. What was not clear for either course was whether there was any standard of performance, and whether the student was required to demonstrate competence in accordance with that standard. LRA offered an opportunity to test on the skills learned in the course, and to receive an investigator's certificate showing that those skills had been satisfactorily demonstrated, but it was not clear that any of the investigators had done that.<br><br>Training curricula was reviewed for the Department of Family and Protective Services and | Noncompliance |

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| | | Facility investigators. This review was described in detail in the last monitoring report. The curricula for the Facility and the DFPS investigators were generally determined to be adequate. As indicated in previous reports, with regard to the DFPS training, 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. Although the training covered the basics of investigations, ongoing training should cover additional topics, such as these listed.<br><br>Six of the eight DFPS investigators assigned to complete ABSSLC investigations had conducted one or more of the investigations in Sample #D.1, which consisted of 36 files. The training records for these investigators were reviewed with the following results:<br>▪ Four out of six DFPS investigators (67%) had completed the requirements for investigations training. An investigator whose name appeared on the APS Training Transcript Crosswalk – Abilene with an indication of no training in MR&MH Investigations ILSD and ILASD conducted two of the investigations in the sample (Case #3937347 and Case #39335387). Another recent transfer had completed only the ILSD portion of the investigator training, but had conducted two investigations (Case # 40111347 and Case # 40228868).<br>▪ All six DFPS investigators (100%) had completed the requirements for training regarding individuals with developmental disabilities.<br><br>The following chart provides an overview of ABSSLC staff responsible for conducting or assisting in the conduct of investigations. Records provided showed that one investigator had taken the four required courses and one investigator had taken three. The provided records showed that all staff involved in investigations had completed CSI0100. Going forward, all investigative staff should complete the required training, documented in their training records, and documentation of such provided at the Monitoring Team's next site visit. | |

| Investigator | Comprehensive Investigator Training | Conducting Serious Investigations | People with Mental Retardation | Root Cause Analysis |
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| IMC (L.M.) | May not be needed | Yes | May not be needed | Yes |
| Investigator (T. J.) | Yes | Yes | Yes | Yes |
| Investigator (T.W.) | Yes | Yes | Yes | No |
| Campus | May not be | Yes | May not be | No |

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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>Administrator (C.R.)</td><td>needed</td><td></td><td>needed</td><td></td></tr>
<tr><td>Campus Administrator (S.S.)</td><td>May not be needed</td><td>Yes</td><td>May not be needed</td><td>Yes</td></tr>
<tr><td>Campus Administrator (K.W.)</td><td>May not be needed</td><td>Yes</td><td>May not be needed</td><td>Yes</td></tr>
<tr><td>Campus Administrator (T.T.)</td><td>May not be needed</td><td>Yes</td><td>May not be needed</td><td>Yes</td></tr>
<tr><td>QA Nurse (M.W.)</td><td>May not be needed</td><td>No</td><td>May not be needed</td><td>No</td></tr>
<tr><td>Director of Residential Services (L.J.)</td><td>May not be needed</td><td>Yes</td><td>May not be needed</td><td>No</td></tr>
<tr><td>Totals</td><td>2</td><td>8</td><td>2</td><td>5</td></tr>
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<br>The policy was unclear about whether the IMC and Campus Administrators were required to take two of the four investigative courses. The documents provided did not substantiate that all staff involved in investigations had completed the training required. As a result, the Facility remained out of compliance with this provision. In its POI, the Facility was in agreement with this determination.</td><td></td></tr>
<tr><td></td><td>(b) Provide for the cooperation of Facility staff with outside entities that are conducting investigations of abuse, neglect, and exploitation.</td><td>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.<br><br>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. In the reports included in these samples it appeared that there was good cooperation between Facility staff and DFPS investigators.</td><td>Substantial Compliance</td></tr>
<tr><td></td><td>(c) Ensure that investigations are coordinated with any investigations completed by law enforcement agencies so as not to interfere with such</td><td>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</td><td>Substantial Compliance</td></tr>
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| | investigations. | 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."<br><br>Based on a review of the investigations completed by DFPS and the Facility, the following was found:<br>▪ Of the 36 the investigation records from DFPS (Sample #D.1), 17 had been referred to law enforcement agencies. For 17 out of these (100%), there was adequate coordination to ensure that there was no interference with law enforcement's investigations.<br>▪ Of the seven investigation records from the Facility (Sample #D.2), the two that were concurrent with DFPS investigations had been referred to law enforcement agencies.<br><br>The Facility found substantial compliance with this provision based on its self-monitoring activities, and its continuing regular meetings with DFPS and OIG to address and coordinate issues amongst the agencies. In its review, the Monitoring Team did not find any instances of noncompliance, and therefore, it concurred with the Facility and 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.<br><br>Physical evidence was rarely a factor in investigations as illustrated by the fact that none of the cases 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.<br><br>Based on a review of the investigations completed by DFPS (Sample #D.1) and the Facility (Sample #D.2):<br>▪ Evidence that needed to be safeguarded was in 36 out of 36 (100%) DFPS investigations; and | Substantial Compliance |

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| | | ▪ Evidence that needed to be safeguarded was in seven out of seven (100%) Facility investigations.<br><br>Video surveillance was in place throughout the ABSSLC campus and investigators were using it regularly as part of their investigations.<br><br>The Facility found itself in substantial compliance with this provision based on its self-monitoring process. However, from the reference in the POI, the Facility did not include recent monitoring data to substantiate this finding. The most recent was dated January 2011. That said, the Monitoring Team's finding of substantial compliance with this provision was consistent with that of the Facility. | |
| | (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:<br>▪ Were to commence within 24 hours or sooner, if necessary;<br>▪ Were be completed within 10 calendar days of the incident;<br>▪ 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<br>▪ Were to result in a written report that included a summary of the investigation findings, and, as appropriate, recommendations for corrective action.<br><br>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.<br><br><u>DFPS Investigations</u><br>The following summarizes the results of the review of 36 DFPS investigations:<br>▪ Thirty out of 36 (83%) commenced within 24 hours or sooner, if necessary. This was determined by reviewing information included in the investigation that described the steps taken to assign 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: #40111347, #40228868, #39888747, #39942789, #39403707, and #39434048. 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.<br>▪ Thirty-five out of 36 (97%) were completed within 10 calendar days of the | Noncompliance |

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| | | incident, or the investigator requested and received an extension. For the one remaining case, #39836488, there was no notation of a request for extension either in the DFPS report or in the concurrent Facility report.<br>▪ Thirty-six (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.<br>▪ In nine of the DFPS investigations reviewed, recommendations for corrective action were included or concerns were expressed. In eight of these nine investigations (89%), the recommendations or concerns were adequate to address the findings of the investigation. In case #39434048, a supervisor apparently tried to teach a staff member about how to do her job by leaving her to struggle with transferring an individual from a recliner to an armchair. The investigator indicated two concerns, including that the staff be retrained on what constitutes a dangerous situation and when to ignore a direct order; and that the home supervisor did not inquire further when she encountered the situation. While the supervisor was appropriately found negligent and subsequently terminated, the investigator did not offer recommendations to address the issue that training of staff should never compromise the safety of an individual. A recommendation to retrain supervisory staff on the requirement to give priority to the safety of individuals over the need for training a staff member would have been an important recommendation to prevent possible recurrence.<br>▪ Seven cases, involving two alleged victims were handled as "streamlined." One of these cases included a recommendation to restrict off-campus activities while the Personal Support Team and the behavioral specialists strategized about how to deal with behavior that included running through the mall with no pants, yelling "rape."<br>▪ In the remaining cases, where recommendations were needed they were made in the recommendations section of the concurrent Facility investigation, and implemented during the investigation. For example in case #39896387, where an individual not known to ingest foreign objects, swallowed a glove, the DFPS report noted that the Facility had immediately put pica precautions in place. The concurrent Facility report documented the pica precautions as an immediate action, and added in-service training for staff on proper storage of gloves.<br><br><u>Facility Investigations</u><br>The following summarizes the results of the review of Facility investigations:<br>▪ Seven out of seven (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 | |

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| | | the Facility being notified of the serious incident.<br>▪ Three out of seven (43%) were completed within 10 calendar days of the incident, including sign-off by the supervisor. There were Cases: #2839, #2843 and #2840.<br>▪ Three of the seven were copied for review by the Monitoring Team with the signature page, but without the signatures and dates of review. This may have resulted from how documents were copied for review, since it was true for nearly all of the Facility investigations, including those that were concurrent with the DFPS investigations. But since the end dates of the investigations could not be established, these cases were not in compliance.<br>▪ For the remaining (Case #2648) that was not completed within 10 days, the signature of the IMC was dated after the signature of the Director, which put the report beyond the 10-day period and there was no extension noted.<br>▪ Seven (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.<br>▪ In the seven investigations reviewed, recommendations for corrective action were included in five. In all five investigations (100%), the recommendations were adequate to address the findings of the investigation. For the following investigations, no recommendations were made:<br>o Case #2843 involved an injury to an individual who did not fasten the chinstrap on her helmet, so that when she fell, she cut her chin and tongue. Immediate corrective actions were taken and recorded in the report leaving nothing to be added.<br>o In Case #2648 involving a departure without escort, the identified issues of not having a cigarette lighter available to light the individual's cigarette were resolved through immediate actions. Nothing further was needed as recommendations.<br><br>Based on issues related to investigations not 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 sufficient to provide a clear basis for its conclusion. The report shall set forth explicitly and separately, in a | Based on a review of ABSSLC Policy #002.2, the policy required that:<br>▪ The contents of the investigation report be sufficient to provide a clear basis for its conclusion;<br>▪ The report utilize a standardized format that set forth explicitly and separately:<br>o Each serious incident or allegations of wrongdoing;<br>o The name(s) of all witnesses;<br>o The name(s) of all alleged victims and perpetrators; | Substantial Compliance |

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| | 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. | o The names of all persons interviewed during the investigation;<br>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;<br>o All documents reviewed during the investigation;<br>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;<br>o The investigator's findings; and<br>o The investigator's reasons for his/her conclusions.<br><br>The Facility investigation files were accessible and arranged to provide easy access to key information.<br><br>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.<br><br><u>DFPS Investigations</u><br>The following summarizes the results of the review of DFPS investigations:<br>▪ In 36 out of 36 investigations reviewed (100%), the contents of the investigation report were sufficient to provide a clear basis for its conclusion.<br>▪ The reports utilized a standardized format that set forth explicitly and separately:<br>o In 36 (100%), each serious incident or allegation of wrongdoing;<br>o In 36 (100%), the name(s) of all witnesses;<br>o In 36 (100%), the name(s) of all alleged victims and perpetrators;<br>o In 36 (100%), the names of all persons interviewed during the investigation;<br>o In 36 (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;<br>o In 36 (100%), all documents reviewed during the investigation;<br>o In 33 (92%), all sources of evidence considered, including previous investigations of serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency. 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 | |

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| | | of these reviews in future investigations. That appeared to have been done since all reports in the sample, processed after May 2011, had references to prior investigations.<br>o In 36 (100%), the investigator's findings; and<br>o In 36 (100%), the investigator's reasons for his/her conclusions.<br><br><u>Facility Investigations</u><br>The following summarizes the results of the review of Facility investigations:<br>▪ In seven out of seven investigations reviewed (100%), the contents of the investigation report were sufficient to provide a clear basis for its conclusion.<br>▪ The report utilized a standardized format that set forth explicitly and separately:<br>o In seven (100%), each serious incident or allegations of wrongdoing;<br>o In seven (100%), the name(s) of all witnesses;<br>o In seven (100%), the name(s) of all alleged victims and perpetrators;<br>o In seven (100%), the names of all persons interviewed during the investigation;<br>o In seven (100%), the names of all persons interviewed during the investigation;<br>o In seven (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 was included in the investigation file. The investigation reports did not always include an explicit summary of the witness statements (as DFPS reports do), but statements were referenced or summarized when needed to explain findings. For example in case #2648, summaries of witness statements were included to explain how the individual managed to leave the residence without being noticed.<br>o In seven (100%), all documents reviewed during the investigation;<br>o In seven (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<br>o In seven (100%), the investigator's findings; and<br>o In seven (100%), the investigator's reasons for his/her conclusions.<br><br>There had been decided progress in assuring review of previous investigations, and in maintaining consistency in the use of the format for reporting. The Facility monitoring indicated 100% compliance for the third quarter of 2011 for this provision, although as discussed elsewhere in this report, it was not clear whether the scoring had been tested for reliability. The Facility did not find itself to be in compliance with this provision, but the Monitoring Team does find substantial compliance. | |

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| | (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.<br><br>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.<br><br><u>DFPS Investigations</u><br>The following summarizes the results of the review of DFPS investigations:<br>▪ In 36 of the 36, reports there was a notation that a supervisor had reviewed the report. There was nothing in the record to provide detail on the nature of the supervision, or how many errors were corrected due to that supervision. However the reports appeared reasonably thorough, complete and accurate.<br>▪ In 0 (0%), there was evidence of any changes being recommended by the supervisor as to the quality and completeness of the report.<br><br>The ABSSLC companion reports included supervisory reviews, but no documentation of any changes that were made as a result appeared in the reports. ABSSLC had added a page to its file system to collect supervisory comments, and it was noted to be present in a subsample of the reports reviewed on site. However, that form did not accompany the copies of reports submitted for review. It would be helpful if that were submitted for the next monitoring visit.<br><br><u>Facility Investigations</u><br>▪ Since copies of the supervisory review sheets were not submitted by the Facility with the investigation reports, and since supervisory signatures were not on many of the documents provided (as discussed with regard to Section D.3.e), it was not possible to verify that the supervisory reviews were being conducted as required.<br><br>A finding of noncompliance has been made based on the lack of documentation of supervisory review for Facility investigations, and follow-up activity. This was consistent with the Facility's self-assessment. | Noncompliance |
| | (h) Require that each Facility shall also prepare a written report, subject to the provisions of subparagraph g, for each | The findings from the Monitoring Team's review of the Facility's investigation of Unusual Incident Reports are discussed in (f) above. | Substantial Compliance |

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| | unusual incident. | | |
| | (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 entitled "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.<br><br>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. The following summarizes the results of this review:<br>▪ For seven out of the seven (100%), investigations reviewed, where disciplinary action should have been considered, prompt and adequate disciplinary action had been taken and documented. For example, the following disciplinary actions had been taken:<br>o In report #39535248, three staff members were found to have neglected an individual when they left her in a potty chair on the toilet for over two hours. Two were terminated and one resigned.<br>o In report #39290509, three staff members were involved in an allegation of physical abuse and neglect when one dragged an individual across the floor and then lifted him improperly. Two other staff were nearby, but did not assist, or stop the abuse or report it. The staff member found to be physically abusing the individual was terminated. One staff member resigned, and another was returned to work.<br>o In report #39434048, a supervisor was terminated when she attempted to teach a new Direct Support Staff to transfer an individual from a wheelchair by instructing other staff not to help her thereby putting the individual at risk.<br>▪ For seven out of eight of the investigations reviewed (88%), where programmatic action to prevent recurrence should have been considered, prompt and thorough development of programmatic action was planned and the plan documented. In three out of seven (43%), where plans were in place, there was documentation to support the implementation of the plan. In the remaining four it was not clear whether the plan had been implemented. For example:<br>o Facility case #1264 involved an individual in a wheelchair who was bumped by a vehicle while moving about the campus. The case was initially reported as possible abuse/neglect, but was returned to the Facility as an administrative referral. The Facility proceeded to | Noncompliance |

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| | | investigate and determined that the individual was being supervised within the assigned level of service, that he often traveled about in his wheelchair, and that he sometimes rode down the roads. He was supposed to have a flag to improve visibility, but it was broken that day. The Personal Support Team met to determine how to create a safer environment for this individual without restricting his freedom of movement. They determined that a telescoping rod for his flag would work better and might not break as easily, and the van should have a backup camera to eliminate blind spots among other ideas. In addition there was a plan to restructure the driveway by his residence so that vehicles would not have to back up in the future. What was not clear was whether these plans were implemented.<br><br>While there was progress in documenting disciplinary actions and programmatic actions were developed, it was not clear that the programmatic changes were made and whether they worked to protect the individual. Therefore, 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.<br><br>At the Facility, DFPS records were maintained in a record room near the investigators and the Incident Management Coordinator. The Facility Investigations of Unusual Incidents were maintained in the office of the Director across the hall. 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.<br><br>When personnel other than investigators needed to access the files, they had to request them in writing, explaining their need, and log them out.<br><br>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.<br><br>DFPS files were 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. However, DFPS was in the process of making their reports available electronically to the Facility.<br><br>Files were maintained in a manner that allowed access to appropriate personnel. The | Substantial Compliance |

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| | | third quarter monitoring of 30 records by the Facility indicated 100% compliance with the appropriate indicators. The Monitoring Team found substantial compliance with this provision. | |
| 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:<br>▪ Type of incident;<br>▪ Staff alleged to have caused the incident;<br>▪ Individuals directly involved;<br>▪ Location of incident;<br>▪ Date and time of incident;<br>▪ Cause(s) of incident; and<br>▪ Outcome of investigation.<br><br>Separate trend reports were produced for allegations of abuse/neglect/exploitation, unusual incidents, and injuries. Monthly 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 location, by day of the week, by hour, by shift, by cause, and by outcome. Trending by staff involved and by individual involved was not included in the trend reports. However, the June Trend Analysis Report for Abuse/Neglect/Exploitation did include the names of staff involved, but did not give an indication of whether they were alleged perpetrators, witnesses, or played some other role, and did not indicate whether some staff had been involved in more than one allegation. Trending by location was not done by residence, but only by the physical location (bathroom, living room, patio) at the time of the allegation. This limited the usefulness of the report in identifying whether incidents or allegations occurred in some residences more frequently than in others.<br><br>Trend reports were available to managers in the Incident Management Committee meetings where they were reviewed. Steps had been taken to remedy the living situation in the residence for young men that surfaced in Facility reviews and in previous Monitoring Team reviews. This included a change of building to allow for more space, and use of a team of consultants to try to resolve some of the long-standing behavioral issues. Since the trend reports did not track incidents or allegations by home, it was not possible to determine whether the interventions in the young men's home had resulted in a reduction of incidents. 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.<br><br>The trend reports collected and displayed the required data, except for the staff alleged to have caused the incident and the location at the facility (i.e. building number, outdoors | Noncompliance |

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| | | location, off-campus). 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 had begun with the inclusion of a recommendations tracking section in the report.<br><br>Because of the absence of tracking by building, by individual, and by staff involved, and the consequent lack of usefulness of the report to monitor where incidents and allegation occur and who was involved, the Facility remained out of compliance with this provision. | |
| 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 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. | 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 Living Center, and former employees who re-applied for a position also had to undergo these background checks.<br><br>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 25 employees confirmed that their background checks were completed. The information obtained about volunteers was discussed and confirmed with the Facility Director.<br><br>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 to be conducted annually by comparison of the employee database with that of the Registry.<br><br>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 no one had been terminated for failure to self-report since the last review.<br><br>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 | Substantial Compliance |

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| | | responsibility to safeguard the individuals and staff of the Facility.<br><br>As a result, the Facility was found to be in substantial compliance with this provision. | |

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

1. Based on the Settlement Agreement requirements that the Facility Director be notified of incidents and allegations, the required reporting route for direct support professionals and others should be set forth in policy, and any related procedures. (Section D.2.a)
2. 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. (Section D.2.a)
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, including notification of the Director. (Section D.2.a)
4. The Facility should monitor switchboard response times to assure calls are answered promptly, and if problems are noted, appropriate actions should be taken to correct the issues. (Section D.2.a)
5. The Facility should maintain easy-to-understand tracking information that includes when an employee is reassigned, when he/she returns to work, what disciplinary action was taken, and what counseling or training was provided prior to return to work. (Section D.2.b)
6. The Facility should add questions to supervisory quizzes to reinforce the requirement to protect the individual when abuse is suspected. (Section D.2.b and D.2.d)
7. The Facility should include the Resource Guide in the PSP development process, so that individuals and those closest to him/her will be provided education to be able to identify and report unusual incidents, including allegations of abuse, neglect, and exploitation. (Section D.2.e)
8. 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. (Section D.2.i)
9. The Facility should develop an action plan to audit injuries twice yearly and report for investigation those that due to frequency or other criteria raise suspicion of possible abuse or neglect. (Section D.2.i)
10. The Facility should ensure that all investigators are trained as required by policy. (Section D.3.a)
11. 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. (Section D.3.e)
12. DFPS should finalize the system for documenting the activities related to the commencement of the investigation. (Section D.3.e)
13. 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. (Section D.3.g)
14. The Facility should document the follow-up on disciplinary actions and programmatic recommendations on the Unusual Incident Report. (Section D.3.i)
15. The Trend Reports for Abuse/Neglect should track data on unusual incidents and injuries by building, by individual, and by staff involved to allow determinations to be made about where incidents, allegations and injuries are happening most frequently, and so that conclusions can be

drawn when interventions are introduced as to whether the desired outcomes are reached. (Section D.4)

16. 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. (Section D.4)

| SECTION E: Quality Assurance | |
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| 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:<br>▪ **Review of Following Documents**:<br>o DADS Policy #003: Quality Enhancement, dated 11/13/09;<br>o ABSSLC Policy #003: Quality Assurance, dated 11/13/09 (note that this was not adopted until 7/11/11);<br>o ABSSLC Participating in Quality Assurance/Quality Improvement Council (QA/QI), dated 7/11/11;<br>o ABSSLC – Review Processes: Quality Assurance Process/Plan, dated 9/8/09, revised 6/17/10, revised 7/18/11;<br>o ABSSLC FY 2010: Quality Enhancement Plan, undated;<br>o ABSSLC Plan of Improvement, dated 8/12/11;<br>o ABSSLC Trend Analysis Report: Allegations of Abuse/Neglect/Exploitation, for March, April, May and June 2011;<br>o ABSSLC Trend Analysis Report: Injuries, March, April and June 2011;<br>o ABSSLC Unusual Incidents Trend Report, March, April, May and June 2011;<br>o ABSSLC Restraints Trend Analysis, March, April, May, June and July 2011;<br>o ABSSLC Leadership Council/Quality Assurance/Quality Improvement Council meeting minutes, dated 3/21/11, 4/11/11, 5/16/11, 6/20/11, and 6/22/11;<br>o Monitoring tools associated with the Quality Enhancement Plan; and<br>o Personal Support Plans for: Individual #84, Individual #370, Individual #515, Individual #269, Individual #102, Individual #451, Individual #411, Individual #415, Individual #535, Individual #300, Individual #319, and Individual #442.<br>▪ **Interviews with**:<br>o Patricia Smith, Director of Quality Assurance;<br>o Tracyl Gandee, Settlement Agreement Coordinator;<br>o Program Compliance Monitors; and<br>o Physicians, nurses, and other staff involved in monitoring of medical sections.<br>▪ **Observations of**:<br>o Quality Assurance/Quality Improvement Meeting, on 8/22/11;<br>o Nine residences including: #6330, #6350, #6360, #6390, #6400, #6500, #6730, #6750, and #6760; and<br>o PSP annual meeting for Individual #30. |
| | **Facility Self-Assessment:** Based on a review of the Facility's POI, with regard to Section E of the Settlement Agreement, the Facility found that it remained out of compliance with all of the indicators. This was consistent with the Monitoring Team's findings.<br><br>The Facility based its assessment on updates in the development of quality assurance policies and procedures, progress in the use of monitoring tools, and to a lesser degree, monitoring results from use of the monitoring tool for Section E. The monitoring tool for Section E was noted to be in draft, but had been |

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| | applied with results registering 0% compliance for four of the five provisions in Section E. For provision #E.1 the results were 46% in January, falling to 0% in February. Scores were not provided past February. However, it was unclear what this percentage measured. The POI contained no analysis or indication of which indicator(s) were included in this number.<br><br>The Facility should 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 tool, and providing specific, written instructions on the implementation of the tool; 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. |
| | **Summary of Monitor's Assessment:** There had been some progress since the last monitoring visit, including:<br>▪ Use of quality monitoring tools to self-assess Facility performance was underway for all sections of the Settlement Agreement and some data was available;<br>▪ The Performance Improvement Council had been incorporated into the Quality Assurance/Quality Improvement Council to review Facility-wide quality management efforts, and to strategize solutions to identified issues; and<br>▪ Trend Analysis Reports for Abuse/neglect/Exploitation had begun to include some analyses by individual and staff member involved in abuse, neglect, and exploitation allegations.<br>▪ Program Compliance Monitors had been reassigned so that each PCM had a specific tool or tools to apply, allowing the PCMs to learn their specific sections in depth.<br><br>Monitoring tools had been adopted based on the tools used by the Monitoring Teams. At the time of the review, the State had issued tools for all of the sections of the Settlement Agreement. The Facility had begun to use the tools, and had made revisions to some of them. Guidelines for the use of the revised tools were available for many of the tools. However, improved instruction sheets or guidelines will be important to:<br>▪ 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 the validity of the results; and<br>▪ Provide adequate guidance to reviewers who do not have specific subject-matter expertise to ensure accurate rating of the tools.<br><br>If the data from the monitoring tools will 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.<br><br>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 |

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| | 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.<br><br>The Facility had identified a residence for young men that emerged from trend reports as needing focused attention. Over the past year, the Facility moved the young men to a new location, involved consultants in designing behavioral programs, trained behavioral support staff in new approaches, and trained direct support staff. However, the Facility did not create a corrective action plan (CAP), or a method for evaluating the results of those efforts. To fairly assess the Facility's progress with the implementation of innovative programs and strategies, it will be essential to track the outcomes so that there will be objective data to determine the success or failure of the approach.<br><br>The next step will need to be responding to trends identified with analyses of potential causes, and the development of action plans to address issues identified. Follow-up also will need to occur to ensure that actions are taken that addresses effectively 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. | In order for the Facility to be in compliance with this component of the Settlement Agreement, a tracking system needs to be in place to allow identification of issues across the many components of protections, supports, and services provided to individuals residing at the Facility. This will require not only review of monitoring data, but also collection and analysis of key indicators or outcome measures. Although the Facility had begun to collect some data, for example, related to incidents and allegations, it had not yet developed a set of key indicators. This is important for a few reasons, including providing the Facility with the ability to identify objectively the individuals who require additional attention to ensure they are safe and are receiving the supports and services they require, as well as to identify proactively homes, day programs, and/or departments that require improvement, as well as to identify a wide array of potential systemic issues. Throughout this report, references are 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; and outcomes 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 type of indicators or outcome measures that should be included in such a system.<br><br>At the time of the review, the Facility did not have a complete system such as this in | Noncompliance |

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| | | place. However it did have certain critical elements, including:<br>▪ Monthly, quarterly, and annual Trend Reports that displayed data on unusual incidents, allegations, investigations, and results of investigations of abuse, neglect and exploitation, as well as data on injuries, and restraints.<br>▪ These reports displayed data by type, location, hour, shift, and day of week, but not always by individual and staff involved, or by building (residence, day program, etc.). These reports should include data by building, by staff and by individual to assist in determining where issues are present that require focused attention and resources. A related issue involved how to track data involving staff members and individuals without displaying their names in reports, such as the Monthly and Quarterly Trend Reports for Abuse/Neglect/Exploitation, Unusual Incidents, Injuries, Restraints and Risks. The Facility had begun to include staff names in the A/N/E Trend Report in June 2011, but only in the form of a list that did not tie names to types of allegations, homes, or frequency. This type of listing was not useful. Names of the four individuals with the most restraints were included in the Restraint Trend Report for June 2011, and data for those four individuals was analyzed in some depth. ABSSLC still needs to decide the best way to display names or identifiers of individuals and staff so that related data can be comprehensively analyzed.<br>▪ The Facility adopted procedures in July 2011, "Participating in the QA/QI Council", which subsumed the former Program Improvement Council, to coordinate all quality assurance activities and functions of the various disciplines and departments. As of the August 2011 meeting, the QA/QI was moving to twice monthly meetings to focus on both systemic issues, progress on the POI-related initiatives, as well as other Facility requirements, such as ICF/MR certification.<br>▪ Monitoring data were emerging from the use of the Settlement Agreement monitoring tools to assess compliance with the Settlement Agreement. The available data were presented in bar graphs, showing the overall level of compliance with indicators on the tools. These data that had been collected thus far 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.<br>▪ A database was under development to track performance on the Plan of Improvement, and it reportedly was scheduled to be available in September 2011.<br><br>With regard to monitoring activities, the Facility had an Action Plan as part of its POI that included steps to develop and adopt a Quality Assurance Policy and Plan based on a | |

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| | | matrix of the monitoring tools. The Facility had revised its procedures related to the Quality Assurance Plan/Process, dated 7/18/11. This revised procedure outlined the steps in the quality assurance process, including use of standardized monitoring tools, specific steps for selection of samples, some rules for analyzing and reporting the collected data, and a corrective action plan process that required any area reporting a score of less than 70% to consider a corrective action plan. The revised procedures and Quality Assurance Plan represented a good start toward development of a quality assurance program. However, the Facility should consider adding:<br>▪ An explanation of how to formulate score percentages. Depending on the tool, a composite or average of all the tools applied will not afford a clear representation of performance;<br>▪ An explanation of how to weight scores to assure that areas of most concern are fairly reflected in any composite score;<br>▪ Definitions of terms such as "reliability, validity, integrity" of data as used in this procedure.<br><br>Most of the monitoring tools had been in use for six months or longer. However, the Facility recently developed an Internal QA Medical Provider Review process based on the External QA Medical Provider Review process. Four Program Compliance Monitors and the two quality assurance nurses, who reported to the Director of Quality Assurance, were conducting audits. The four Program Auditors divided the POI sections according to their experience, so that each Program Auditor had a specific set of tools and responsibilities. Each month a specific sample was drawn and the monitoring tools were applied and recorded. The discipline head was supplied with the sample and asked to apply the monitoring tools to the same sample. The two quality assurance nurses did not monitor the physicians' performance. This was being done by the physicians on staff, each applying the tools to a different physician, as well as by external physicians from other facilities who completed a sample of monitoring tools on a quarterly basis.<br><br>Upon interview, the Program Compliance Monitors and Quality Assurance Nurses could identify where some tools were beginning to work, and where some of the issues were still unresolved. As examples, they pointed to the Section F tools as having good State Office instructions (the Monitoring Team did not necessarily agree) and rising inter-rater reliability. They indicated that the tools for Sections C and D worked, but there were some issues with double negatives that needed to be worked out. It was noted that the discipline head was not yet completing the tool for Section D, and that when the tool was being used for Facility investigations (not DFPS investigations), it needed some adjustments. One big problem was dealing with terminology in the tools such as "sufficient trials," "strengths" versus "skills," and "adequate array of skills and programs." These and other difficulties will need to be addressed in future revisions to the tools and guidelines to promote inter-rater reliability and accuracy. Asked how long they spend on | |

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| | | reviews, their replies were in the range of one to two hours.<br><br>From the Monitoring Team's perspective, work still needed to be done to refine these tools for the Facility's use and their implementation, including improving the guidelines or instructions associated with each tool, ensuring inter-rater reliability and accuracy of monitoring, ensuring that quality was measured as opposed to the mere presence or absence of items, as well as identifying the priorities for the tools' implementation so as to not overwhelm the system with data that could not be used effectively. The Facility was producing overall scores of compliance based on the implementation of the monitoring tools. The tools were not weighted, and were not designed to produce overall scores. 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.<br><br>As indicated in the Facility's POI, the Facility was not in substantial compliance with this subsection. However, there was definite progress in the auditing of performance and the development of additional trend reports. Much work remained, however, in developing an adequate auditing system, as well as in the collection and analysis of key indicators or outcome measures. | |
| E2 | Analyze data regularly and, whenever appropriate, require the development and implementation of corrective action plans to address problems identified through the quality assurance process. Such 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. | Based on the QA/QI Council policy, all CAPs were reviewed by the QA/QI Council. This group also was charged with discussing the status of improvements and making recommendations to modify CAPs, as needed. The August meeting of the QA/QI Council included presentations on progress on existing CAPs, as well as plans to address issues identified through use of monitoring tools, such as the need to ensure that individuals and their primary correspondents were trained in recognizing and reporting abuse. These discussions provided an opportunity for the Council to offer ideas or to challenge the priority of the proposed CAP.<br><br>The Council planned to meet once a month to review progress on the results of the implementation of the monitoring tools, and to discuss and approve CAPs related to the Settlement Agreement requirements. At the August meeting, a second monthly meeting was approved to hear from Program Improvement Teams, and to discuss systemic CAPs that might be generated.<br><br>Corrective action plans included in the POI had focused outcomes and specific steps to achieve those outcomes. For example, a Corrective Action Plan was provided in relation to Section F.1.a of the Settlement Agreement to have each PST facilitated by one person from the team to ensure participation in developing, monitoring and revising treatments, services, and supports. The CAP included specific steps to achieve that outcome, people responsible, start dates, evidence of success, and projected completion dates for each | Noncompliance |

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| | | step. Another CAP provided in Section C of the POI to develop desensitization plans for individuals who needed restraint for or declined dental procedures likewise contained specific steps, responsible people and dates, and the evidence needed to determine completion of the step.<br><br>During the last two monitoring visits, 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 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 rooms with fewer individuals. 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 was not clear how these remedies, some of which were discussed as having been successful, were documented. If the QA/QI had asked for a CAP for this project that included measurable outcomes (e.g., decreased injuries, or increased active engagement), and documented results along the way, it would be possible to determine if the desired outcomes were achieved. Or, in the absence of a CAP with such documentation, indicators of success could be derived from data on restraints (more/fewer being used in the home), injuries, unusual incidents, etc. 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.<br><br>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 Assurance Plan Process outlined the basic CAP requirements. One corrective action plan was submitted in response to Document Request TX-AB-1108-IV.7, which included a request for "any corrective action plans, including information related to follow-up and modification of corrective actions plans." The one CAP submitted was assigned to the Quality Assurance Director, and involved adopting the state quality assurance plan and Facility procedures to implement it. Due dates were established for the nine action steps and performance was tracked, showing seven of the nine steps completed and the | Noncompliance |

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| | | remaining two due October 1, 2011. This plan was shared with the members of the QA/QI Council and progress was reported at their meetings, so entities responsible for implementing the action plan had the necessary information.<br><br>Each section of the POI had at least one and sometimes more action plans in process, which were updated and shared with the QA/QI Council. These action plans addressed issues raised in conjunction with the Settlement Agreement Monitoring.<br><br>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 the data generated by the Facility as part of their internal monitoring processes. ABSSLC was still at an early stage of the process and had not yet developed to a point where CAPs from a wide variety of sources could be reviewed, approved and distributed to all responsible entities to address the identified issues, nor was there a tracking system in place to efficiently monitor progress. As a result, the Facility was not in substantial compliance with this provision. | |
| 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.<br><br>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 QA/QI Council would discuss the status of improvements monthly and recommend modifications to CAPs that were not working.<br><br>This will continue to be assessed as CAPs are developed and implemented. The Monitoring Team concurred with the Facility that it was not in compliance with this provision. | Noncompliance |

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

1. With regard to the Quality Assurance Plan, the Facility should consider adding:
    a. An explanation of how to formulate score percentages. Depending on the tool, a composite or average of all the tools applied will not afford a clear representation of performance;
    b. An explanation of how to weight scores to assure that areas of most concern are fairly reflected in any composite score;

c. Definitions of terms such as "reliability, validity, integrity" of data as used in this procedure. (Section E.1)

2. ABSSLC should revise its monitoring tools to meet the needs of the Facility. As is detailed above with regard to Section E.1 of the SA, this should include, but not be limited to: revisions to indicators as appropriate, the enhancement of instructions and/or guidelines, availability of training and technical assistance from subject-matter experts on substantive issues, ensuring inter-rater reliability and accuracy of monitoring, ensuring that quality was measured as opposed to the mere presence or absence of items, as well as identifying the priorities for the tools' implementation so as to not overwhelm the system with data that could not be used effectively. If the tools will be scored overall, consideration should be given to weighting the factors that go into producing an overall score. (Section E.1)
3. As recommended in previous reports, 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, references are 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. (Section E.1)
4. The data referenced in Recommendation #3 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. (Section E.2)
5. As recommended in previous reports, data currently being collected and analyzed should be used to identify areas in which improvements are needed. These data should be used to identify problematic trends and/or individual issues, and the Facility should develop, implement, and monitor corrective action plans to address them. (Section E.2)
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. (Section E.2)
7. 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 residence. 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 E.2)
8. CAPs should include measurable outcomes (e.g., decreased injuries, or increased active engagement), and results should be documented along the way in order to determine if the desired outcomes are achieved. Indicators of success could be derived from existing data, such as on restraints (more/fewer being used in the home), injuries, unusual incidents, etc. (Sections E.2 and E.4)

| **SECTION F: Integrated Protections, Services, Treatments, and Supports** | |
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| 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:<br>▪ **Review of Following Documents**:<br>o DADS Policy Number 004: Personal Support Plan Process (Integrated Protections, Services, Treatments, and Supports) with attachments, 7/30/10;<br>o ABSSLC Plan of Improvement for Section F, dated 8/12/11;<br>o Supporting Visions Lesson Plan and Content, dated 9/10;<br>o Supporting Visions: Personal Support Planning PowerPoint presentation, dated 7/10;<br>o Supporting Visions Tier 2 and 3: Personal Support Planning Workbook, dated 7/10;<br>o Supporting Visions Tier 2 and 3: Personal Support Planning Assessment, undated;<br>o Living options shell, undated;<br>o Interview questions/guidelines when selecting providers, undated;<br>o AVATAR Screens for Community Placement Preference and Obstacles to Moving to a Community Setting, undated;<br>o Community Living Discharge Plan (CLDP) shell, undated;<br>o In response to request for last 10 monitoring tools completed by the: a) QMRP Coordinator; and b) Quality Assurance Department staff, the following statement: "No information for TX-AB-1108-V.4.a";<br>o Audit tools completed by QA Department staff (10) on the Settlement Agreement Cross Referenced with ICF/MR Standards Section F: Integrated Protections, Services, Treatments, and Support review tool, various dates in May and June 2011;<br>o Q Construction: Facilitating for Success – Qualified Mental Retardation Professional (QMRP) Facilitation Skills Performance Tool, with instructions, dated 6/7/11;<br>o In response to request for any tools to measure competency with the writing of PSP documents, the following statement: "No information for TX-AB-1108-V.7.b. No Tool for QMRP competency with writing of PSP document";<br>o In response to document request TX-AB-1108-V.8, the following statement: "No list of QMRP's (sic) deemed competent for facilitation of PSP. QMRP's (sic) are currently being evaluated for Facilitation Competency";<br>o An alphabetical list of each individual at the Facility, with the most recent PSP meeting date, the date on which the PSP document was completed/filed, and the date of the previous PSP meeting date;<br>o Personal Support Team Referral Form, dated 3/09;<br>o Qualified Developmental Disabilities Professional (QDDP) Coverage, dated 8/29/11;<br>o Attendance Database, from 6/1/11 through 8/26/11;<br>o Aggregate data related to attendance at PSP meetings, undated;<br>o Training materials used by State Office consultants related to PSPs and skill acquisition;<br>o Personal Support Plans (PSPs), Sign-in Sheets, Assessments, Personal Support Plan Addenda, (PSPAs), Personal Focus Assessments (PFAs), and skill acquisition and teaching programs for: Individual #84, Individual #187, Individual #370, Individual #538, |

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| | Individual #451, Individual #469, Individual #411, Individual #383, Individual #20, Individual #515, Individual #150, Individual #95, Individual #269, Individual #357, Individual #102, Individual #319, Individual #405, Individual #442, Individual #300, Individual #361, Individual #415, Individual #535, Individual #25, and Individual #504;<br>o Monthly reviews for the last six months, and quarterly reviews for the last two quarters, as available for: Individual #84, Individual #187, Individual #370, Individual #538, Individual #451, Individual #469, Individual #411, Individual #383, Individual #20, and Individual #515, Individual #150, Individual #95, Individual #269, Individual #357, Individual #102, Individual #319, Individual #405, Individual #442, Individual #300, Individual #361, Individual #415, Individual #535, Individual #25, and Individual #504; and<br>o Presentation Book for Section F.<br>▪ **Interviews with**:<br>o Kristin Wyrick, QDDP Coordinator;<br>o Jeff Branch, Active Treatment Coordinator;<br>o Ron Manns, Director of Behavioral Services;<br>o Haley Savage, Program Compliance Monitor;<br>o Jolene Willis, Assistant Director of Programs (ADOP);<br>o Pat Smith, Quality Assurance Director;<br>o William Davis, DADS SSLC QDDP and Programs Coordinator;<br>o Ric Savage, State Consultant;<br>o Tracyl Gandee, Settlement Agreement Coordinator; and<br>o Various staff in residences and attending PST meetings.<br>▪ **Observations of**:<br>o PSP Meeting for Individual #403, on 8/22/11;<br>o PSP Meeting for Individual #484, on 8/23/11;<br>o PSP Meeting for Individual #146, on 8/23/11;<br>o PSP Meeting for Individual #30, on 8/24/11;<br>o PST meeting with Monitoring Team to review at risk process on 8/24/11, and 8/25/11 for Individual #323, and Individual #498, respectively; and<br>o Activities in homes and day programs. |
| | **Facility Self-Assessment:** According to the Facility's POI, it had found that is was not in compliance with any of the subsections of Section F. This was consistent with the Monitoring Team's findings.<br><br>As is described in further detail with regard to Section F.2.g, the Facility had begun to engage in self-assessment activities. Specifically, the QA Department, and the QDDP Coordinator and QDDP Educator were implementing the competency checklist for QDDPs' facilitation of PSP meetings. In addition, the QA Department had completed monitoring using the Settlement Agreement Cross Referenced with ICF/MR Standards Section F: Integrated Protections, Services, Treatments, and Support review tool. As has been noted in previous reports, adequate instructions had not been completed for this tool, and inter-rater reliability had not been established. As a result, the validity and reliability of the data was questionable. |

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| | The POI included helpful narrative information regarding steps taken to achieve compliance. Although as described above, staff had completed some monitoring, the Facility had provided no data or analysis of the data in the POI. As the Facility expands its self-assessment activities, the POI should include the results of data analysis to substantiate the Facility's findings of noncompliance or substantial compliance. The POI also should indicate how the Facility has used this data to identify problematic trends, and develop corresponding corrective actions.<br><br>The POI included one action plan related to providing facilitation training to QDDPs, and assessing the results. Given the central role that adequate facilitation of meetings plays in the adequate definition of and integration of supports, these were appropriate activities on which to focus. Another area in which focused efforts should occur is in the development of comprehensive sets of adequate action plans for each individual. |
| | **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 QDDP, 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.<br><br>Since the last review, QDDPs had undergone additional training on meeting facilitation, and consultants for the State had begun to train teams on the philosophical and historical context of individual planning, as well as on some of the logistics of the development of sound plans. Both the QDDP Coordinator and the State consultants had begun to provide technical assistance to teams at ABSSLC during annual planning meetings. Based on the meetings observed while the Monitoring Team was onsite, these efforts had begun to show positive changes with regard to facilitation skills, more productive meetings, and a more person centered focus. As would be expected, significant changes had not yet occurred in the PSP documents themselves.<br><br>Some areas that required attention included:<br>▪ 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;<br>▪ Attendance of the full array of staff necessary to provide input into the interdisciplinary process was not consistently seen;<br>▪ Action plans largely addressed skill acquisition plans and regular medical appointments, but did not comprehensively target other supports, services, treatments, or strategies. Focused effort was needed to improve the scope of action plans, as well as to ensure measurable outcomes are included; and |

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| | ▪ 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.<br><br>Progress was being made in setting up the infrastructure for the quality assurance processes for the PSP process, including more formalized processes for conducting audits, and reviewing and analyzing data. At the time of the review, the Facility had not yet fully implement these processes, and/or identified and implemented appropriate corrective action plans to address deficiencies identified. |

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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 had been no changes since the last review when no Facility policies or procedures related to PSPs existed in addition to the State policy. As noted in the last report, 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 QDDP, the use of the Personal Focus Assessment, as well as 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 with measurable desired outcomes, Skill Acquisition Plans and Service Objectives so that they reflected the interdisciplinary coordination that is required.<br><br>The 24 PSPs that were reviewed were provided by the Facility in response to a document request for a sample of the most recent plans. One additional plan was selected for an individual who was expected to transition to the community soon. The sample included plans for individuals who lived in a variety of residences on campus. Therefore, a variety of QDDPs and PSTs had been responsible for the development of the plans. | |
| F1a | Be facilitated by one person from the team who shall ensure that members of the team participate in assessing each individual, and in developing, monitoring, and revising treatments, services, and supports. | Progress had been made and/or sustained with regard to the facilitation of PSPs by one person from the team who ensures that members of the team participate in assessing each individual, and in developing, monitoring, and revising treatments, services, and supports. Positive developments included:<br>▪ DADS Policy #004 at II.C.1.b continued to indicate that the QDDP would plan and facilitate the PSP meeting. The Facility's Policy F.16: Personal Support Planning, implemented 1/30/11, further defined the role of the QDDP, including activities before, during, and after the PSP meeting.<br>▪ The QDDP Coordinator confirmed that QDDPs facilitated the teams, including team meetings. Reviews of PSPs also suggested that the QDDP was the team | Noncompliance |

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| | | leader and responsible for ensuring team participation.<br>▪ With regard to staffing, in addition to the QDDP Coordinator, a QDDP Educator was in place to assist in providing QDDPs with needed oversight and training. A total of 23 QDDP positions resulted in a QDDP being assigned to each residence. Based on the current census of 443 individuals, this resulted in an average caseload to 1:19. At the time of the review, three of these positions were vacant, and an additional two were out on family/medical leave.<br>▪ The QDDP Coordinator was a certified trainer for the Q Construction Facilitating for Success training that a workgroup coordinated by State Office developed. In April 2011, certified trainers provided training to the other QDDPs at ABSSLC. At the end of the training sessions, the QDDPs took a written test. The competency-based component of the training is discussed in further detail below.<br>▪ In addition, State Office had hired consultants to provide training and technical assistance to QDDPs and teams on the PSP process. They had provided classroom training to ABSSLC teams, which is discussed in further detail with regard to Section F.2.e, and had begun to sit in on team meetings and provide technical assistance.<br>▪ During the week of the review, the Monitoring Team observed a number of team meetings, and met with two teams related to the risk rating and action plan development process. Progress definitely had begun to occur with regard to the facilitation of meetings. Based on these limited observations and review of PSPs, some of the areas in which progress had begun included:<br>o At annual PSP meetings, an agenda was clearly set forth, along with ground rules.<br>o Efforts were made to include the individual, and focus the discussion on him/her.<br>o Paper hung on the walls or white boards were used to track key components of the PSP process, such as the agenda, the individuals' preferences, and action plans that needed to be developed.<br>o More efforts were made than in the past to elicit information from all team members. However, not all team members participated to the extent they should have.<br>o During the onsite observations, discussions about individuals' optimal living vision showed improvement, with discussion being linked back to individuals' preferences. However, in reviewing PSPs, this was not consistently found to have occurred.<br><br>Based on review of PSPs as well as during observations of meetings held the week of the onsite review, facilitation of team meetings was improving, but for none of the plans reviewed or meetings observed was it resulting in the adequate assessment of | |

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| | | individuals, and the development, monitoring, and revision of adequate treatments, supports, and services. Areas in which improvements should be made in order to achieve compliance, included:<br>▪ The Q Construction: Facilitating for Success training included a competency-based component. At the time of the review, the QDDP Coordinator, QDDP Educator, and/or the Program Compliance Monitor had conducted baseline competency checks of all of the QDDPs. This process had assisted in identifying areas in which all of the QDDPs reviewed needed to improve their meeting facilitation skills. Based on the results, refresher training on facilitation had been provided to all QDDPs in July 2011. In addition, recommendations had been made individually at the conclusion of the competency checks, which were in the process of being implemented. The QDDP Coordinator recognized that this would be an ongoing process until the QDDPs had reached the necessary level of competence.<br>▪ Based on review of PSPs as well as during observations of meetings held the week of the on-site review, facilitation of team meetings was improving, but 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. Missed opportunities continued to be noted with regard to:<br>o Although all plans reviewed had preferences listed, the depth of the preferences was often limited to items, food, or activities. QDDPs should continue to challenge teams to define what it is the individual prefers about such items, foods, or activities to allow teams to offer the individual new experiences, and to expand the discussion to include preferences related to work, relationships, past experiences, etc.<br>o As is discussed below, PSPs did not consistently show adequate incorporation of preferences into action plans.<br>o During onsite observations, as well as in PSPs reviewed, a significant lack of adequate integration of supports, and services was noted. QDDPs should continue to challenge team members to offer their expertise in problem-solving or developing action plans, even when the action plan does not fall squarely within their domain (e.g., psychologists should assist with addressing mealtime issues, such as fast eating pace, as well as toileting issues, and dental refusals; nursing staff, habilitation therapies staff, and dental staff should discuss strategies related to physical and nutritional management supports to ensure adequate coordination; speech/communication staff should provide expertise, including, for example, replacement behaviors for PBSPs, integration of communication devices throughout an individual's | |

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| | | programing, choice-making, etc.);<br>o Although some minimal improvements were seen, QDDPs should seek data from various team members to assist in decision-making, and justify the teams' conclusions. For example, in PSPs reviewed, data was not cited consistently, such as test/lab results, or data from PBSPs and skill acquisition programs. In addition, historical information or causation was not always investigated fully enough by teams (e.g., causes for falls or fractures, history of issues related to previous failed community placements, etc.). This is essential information to inform planning for future training, treatment, supports, and services.<br>o Little discussion occurred or was documented regarding prevention, particularly with regard to health risks/issues. Much of team's focus on these areas appeared to be reactive, once an issue occurred (e.g., constipation, weight, skin integrity, infections, etc.).<br>o Teams discussion of action plans was limited. Problems were noted with regard to the scope and number of action plans discussed, as well as detail with which teams discussed action plans. More specifically, sufficient action plans were not discussed/developed to ensure the integration in PSPs of all protections, services and supports, treatment plans, clinical care plans, and other interventions provided for the individual, as required by Section F.2.a.3 of the Settlement Agreement.<br>o Likewise, teams generally did not discuss measurable, functional objectives during team meetings, and, as a result, they often were not included in PSPs.<br>o Teams continued to struggle with articulating meaningful outcomes for individuals. Often the outcome was expressed as a process (e.g., individual will participate in vocational center), rather than as a change in the individual's life (e.g., individual will obtain a job for at least 10 hours per week in one of her stated areas of preference).<br>o With more cross-disciplinary discussion and participation by the individual, it was sometimes difficult for the QDDP to control the length of the meeting. One way to address that would be to establish estimated time boundaries for each topic at the outset. Another way is for much more preparation to be done before team meetings.<br><br>Progress had been made. However, 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. | |

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| 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 QDDP, 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.<br><br>Some progress had been made with regard to tracking attendance at PSP meetings. Specifically, a database had been set up, and beginning in June 2011, was being populated with information related to team members' attendance at meetings. However, this process was at the beginning stages of implementation, and it was unclear if the data was reliable. It was unclear how a determination was made regarding whether a team member's attendance was required or not. In addition, for the aggregate data provided, it was unclear what the total number of the population included in the sample (N) was. Based on the Monitoring Team's review of PSPs, the data provided appeared to be overly optimistic. The criteria for determining when a team member's attendance at a PSP meeting is required should be defined, and incorporated into the attendance database to ensure its reliability. The total number of meetings also should be identified on the aggregate printout.<br><br>In an effort to increase participation of team members at meetings, the QDDP Educator had rescheduled PSPs, so that no more than two or three were held per day. This schedule had been sent out through the end of 2011. Reportedly, accommodations were being made to ensure the participation of individuals, guardians, and their families.<br><br>Based on the sample of 24 PSPs the Monitoring Team reviewed, sign-in sheets were provided for 22. Of these 22, for one (5%) it appeared that a duly constituted team was in attendance (i.e., Individual #415). Often, the individual presented issues requiring the attendance of specific team members, but these team members were not in attendance. If needs were identified for which the presence of a team member was warranted, but the requisite team member was not in attendance, then the conclusion was drawn that a duly constituted team was not present. Until teams do a better job of justifying team composition, this is the methodology that will be used. Examples of concerns related to team composition have been provided in previous reports, and issues were similar during this review.<br><br>Although some progress had been made in developing a database to track attendance as well as to develop a reasonable schedule for PSP meetings, the Facility remained out of compliance with this provision. | Noncompliance |
| F1c | Conduct comprehensive assessments, routinely and in response to significant changes in | Progress had been made and/or sustained with regard to the conduct of assessments. Positive developments included:<br>▪ DADS Policy #004 defined "assessment" to include identification of the | Noncompliance |

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| | the individual's life, of sufficient quality to reliably identify the individual's strengths, preferences and needs. | individual's strengths, weaknesses, preferences and needs, as well as recommendations to achieve his/her goals, and overcome obstacles to community integration.<br>▪ At ABSSLC, some further direction had been provided to staff responsible for assessments, including that: 1) all assessments and evaluations should be tied back to the PFA; and 2) each assessment should include a statement regarding whether or not an individual could transition to the community. If not, the assessor needed to identify the reasons. The APC had trained all team members on this community transition component.<br>▪ In an effort to ensure assessment documentation was available in a timely manner, personal folders had been developed on the Facility's server in which assessments were placed. This allowed access for all team members. In addition, a new routing system was in place, as discussed in further detail with regard to Section V of the Settlement Agreement. It allowed tracking of assessments from the time disciplines submitted them until they were filed in the active record. Expected timeframes had been established.<br>▪ Based on information that State Office staff and consultants provided during the onsite review, plans were underway to develop and provide specific training for disciplines regarding assessments. This would be an important development, given the centrality of assessments to adequate planning processes.<br>▪ In addition, at the State Office level, the PFA was being reformulated to focus on some broader preferences, providing teams, for example, with more information with which to discuss where the individual wanted to work and/or live. Appropriately, the revised version would include more open-ended questions, but overall fewer and more targeted questions. The goal would be for a staff member who knew the person well to review the questions with the individual, and bring this information back to the team. It was anticipated that this new process would be rolled out in the weeks after the onsite review.<br><br>However, at the time of the review, little improvement was noted with regard to the quality of the assessments or the completeness of the assessments used in developing PSPs. Areas in which improvements should be made in order to achieve compliance, included:<br>▪ In none of 24 (0%) PSP files reviewed, adequate assessments were present. Often the narrative sections of individuals' PSPs identified issues of concerns for which assessments were not found. This was often the case with regard to individuals' vocational/day activities needs, and sometimes, their psychiatric needs, for which updated assessments did not appear to be available to the team at the time of the PSP meeting. Aspiration Pneumonia/Enteral Nutrition (APEN) evaluations often were missing. More specialized assessments, such as orientation and mobility assessments for individuals who were blind or visually | |

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| | | impaired, were not found.<br>▪ In other instances, assessments clearly did not provide the team with the information it needed to develop adequate plans for the individual. As the Facility had identified, assessments did not consistently and concisely list individuals' strengths, needs, and preferences. Examples of concerns related to assessments have been included in previous reports, and were similar for this review.<br>▪ The PSPs reviewed included a Personal Focus Assessment that gathered information on the individual's preferences. Many of the PFAs identified the assessments that the team decided during the third quarter review should be completed for the annual PSP meeting. Generally, no justification was provided regarding whether or not a particular assessment was needed. This made it difficult to determine if teams had made appropriate decisions. The Facility should consider defining in policy a key set of assessments that should be conducted regularly, and the expected timeframes for reevaluation. Teams should be required to provide a justification for veering from this schedule. Optional assessments also should be defined with criteria/guidelines to assist teams in determining if such assessments would be beneficial to the individual.<br>▪ 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 vocational, 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.<br>▪ As recommended in previous reports, one assessment that would prove useful for some individuals would be an annual review of incidents, and abuse, neglect, and exploitation allegations. This type of assessment was not found in any of the PSPs reviewed. However, a document was submitted entitled "Personal Support Team Incident Considerations," dated 7/11. Documentation also was submitted to show that most QMRPs were trained on this process in July 2011. It was unclear if this was meant to guide team's discussions as incidents occurred, or at the annual meeting. In either case, the document provided a thoughtful approach to reviewing incidents. As noted in previous reports, 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 | |

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| | | 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.<br><br>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 bring the Facility into substantial compliance. | |
| 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. | As indicated in previous reports, 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. The following summarizes concerns related to the incorporation of assessments into PSPs:<br>▪ In none of the 24 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 justified not incorporating it.<br>▪ In its POI, the Facility indicated that: "No initiatives started in this area for past 6 months."<br>▪ Often, recommendations were discussed in the narrative section of the report, and the team appeared to agree that the recommendation needed to be implemented, but a corresponding action plan was not developed to implement the recommendation.<br>▪ 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 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 Settlement Agreement.<br><br>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 | Noncompliance |

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| | | 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. | |
| 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 policy further indicated that the "PST will clearly document these priorities; document their rationale for the prioritization, and how the service will support the individual."<br><br>This provision of the Settlement Agreement address a number of specific requirements, including identification and use of individuals' preferences and strengths, prioritization of needs and explanation for any need or barrier not addressed, and identification of supports needed to encourage community integration. Each of these is addressed separately below.<br><br><u>Identification and Use of Individuals' Preferences and Strengths</u><br>As noted in the last report, teams were making efforts to identify individuals' preferences. The 24 PSPs reviewed generally included more information regarding the individual's preferences. However, the following concerns were noted with regard to the identification and incorporation of preferences and strengths into PSPs: | Noncompliance |

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| | | ▪ Although all 24 of the PSPs reviewed included a listing of individuals' preferences, only three individuals' team (13%) had effectively incorporated their preferences into related action plans (i.e., Individual #20, Individual #411, and Individual #383). Even for these two individuals, it was unclear that their teams had reviewed their preferences to determine if they could be used to motivate changes (e.g., working more steadily) or expand individuals' horizons (e.g., additional vocational opportunities or living options).<br>▪ As noted above with regard to Section F.1.a, most of the preferences identified for individuals related to items, food, or activities. It will be important for teams to define what it is the individual prefers about such items, foods, or activities to be able to offer the individual new experiences based on this information. It also will be essential to expand the discussion to include preferences related to environments, work, relationships, past or future experiences, routines, interactions with others, etc.<br>▪ Little, if any, information about individuals' specific strengths was discussed in PSP documents. Strengths were not regularly built upon to address other need areas.<br><br><u>Prioritization of Needs and Explanation for Any Need or Barrier Not Addressed</u><br>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. More specifically, in none of the 24 PSPs reviewed (0%) were priorities clearly defined, or barriers identified and addressed.<br><br><u>Identification of Supports Needed to Encourage Community Integration</u><br>In reviewing objectives related to individuals' involvement in the community, some improvement was noted. However, many individuals' PSPs still included inadequate general community participation objectives (i.e., participating in a community activity once a month), and a limited number of skill building objectives were found to assist individuals in accessing and utilizing community offerings. One of the 24 PSPs (4%) reviewed included specific skill acquisition action plans for implementation in the community. Examples of concerns have been provided in other reports, and were similar to the concerns identified for this review.<br><br>Based on interviews with staff, it continued to be a challenge to address barriers such as transportation, and ensuring adequate staffing was available for individuals to participate in community activities in small groups. The Facility was anticipating the arrival of some new wheelchair accessible vans, which should assist in this regard.<br><br>Despite some limited progress in this area, the Facility remained out of compliance with | |

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| | | this provision. | |
| | 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; | This continued to be an area in which substantial effort was needed in order for ABSSLC to comply with the Settlement Agreement. The action plan section of the PSP was where measurable goals/objectives, the treatments or strategies to be employed, and the necessary supports were to be detailed to attain identified outcomes related to each preference, meet needs, and overcome identified barriers to living in the most integrated setting appropriate to the individual's needs. Facility staff recognized that action plans were not adequate. The Monitoring Team agrees with this assessment. The following summarizes the concerns related to action plans:<br>▪ As noted in the last monitoring report, PSPs generally included some individualized and measurable goals/objectives, treatments or strategies, and supports. At ABSSLC, these generally related to skill acquisition plans and daily activities (e.g., day/vocational program, recreation, etc.), and in some cases, medical care.<br>▪ However, none of the 24 plans reviewed (0%) included a full complement of measurable goals or objectives to address the array of supports and services the individual required. This negatively impacted the intensity of individuals' active treatment, the supports they were provided, and the teams' ability to measure progress, or lack thereof. More specifically, when such supports were identified in the action plans they often were not measurable (as a few examples, Individual #405's had objectives that read: "Psychiatry" and "BST Services"; examples for Individual #25 were objective that read: "hypertension," and "psychology"; or Individual #361 had objectives such as "walks when weather permits," and "pharmacy"). Most of the time, necessary objectives, supports, and services simply were not included in action plans [as a few examples, Individual #361 had no objectives for implementation of PNMP, or indirect OT/PT programs, and no action plans related to medium or high risk indicators; Individual #150 had no objectives for implementation of the PBSP or PNMP, and only brief reference to nursing care plans with no measurable objectives or delineation of responsibility (i.e., nursing versus direct support professionals); or Individual #469 had no objectives related to the PBSP or PNMP, and the team had developed no action plans related to the medium and high risk areas that had been identified].<br>▪ In reviewing the action plans that had been developed to address individuals' risk areas, measurable objectives generally were not included. This is discussed in further detail with regard to Section I of the Settlement Agreement.<br>▪ Individualized, measurable goals and objectives were not defined in individuals' PSPs to support the implementation of essential plans, such as nursing plans, psychiatric treatment plans, and physical and nutritional support plans. For example, in order to provide health care supports to individuals served, direct | Noncompliance |

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| | | support professionals as well as nursing staff need to provide supports to an individual. Supports such as ensuring that an individual is offered fluid throughout the day, or is repositioned every two hours should be specified in measurable ways in individuals' PSPs. In addition, PSPs should include measurable, observable objectives to determine the efficacy of these plans. In other words, objectives should be designed to allow the team to determine if the individual is doing better or worse, or remaining stable. As is discussed elsewhere in this report, deficits in plans that specific disciplines had developed prevented the team from fully identifying the full array of the measurable objectives necessary for the team to provide needed supports and services, and measure the outcomes of those supports. For example, PNMPs did not include measurable objectives, and nursing assessments often did not include individualized objectives. Even when plans, such as PBSPs, included objectives, teams did not consistently incorporate them into the overall PSP.<br>▪ In the section below that addresses Section T.1.b.1, there is extensive 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 Settlement Agreement.<br><br>The Facility remained out of compliance with this provision. | |
| | 3. Integrates all protections, services and supports, treatment plans, clinical care plans, and other interventions provided for the individual; | Numerous examples are provided throughout this report regarding how plans, supports and services were not integrated through the PSPs. PSPs appeared to integrate some, but not all protections, services and supports that individuals required, as this provision of the Settlement Agreement clearly requires.<br><br>None of the 24 plans reviewed (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 PBSP 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 to incorporate PNMPs with medication administration, and dental and psychology to develop and implement desensitization plans. There was little evidence that PBSPs were integrated with other supports, such as communication supports, or health related supports (e.g., weight reduction, medication administration, etc.). All of these are examples of coordination and integration that should be occurring as part of the individual planning process. Numerous examples of these concerns have been provided in previous reports. | Noncompliance |

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| | 4. Identifies the methods for implementation, time frames for completion, and the staff responsible; | Generally, for the action items identified by teams, timeframes and staff responsible were identified. However, as is discussed in further detail in the section of this report that addresses Section S of the Settlement Agreement, methods for implementation were not always adequate.<br><br>In addition, as is discussed with regard to Section I, PSP action plans for individuals identified as being at risk did not include adequate methodologies to reduce to the extent possible the at-risk factors. The few plans included in individuals' PSPs often repeated that plans already in place would be implemented, or set forth plans that were not sufficiently aggressive to either further evaluate and/or address individuals' high and medium risk levels. When an individual is identified as being at risk, teams should develop plans with clinical intensity that corresponds with the level of risk identified.<br><br>In addition, staff responsible often did not include direct support professionals, when they should have been identified. For example, although health management plans were infrequently mentioned in PSP action plans, when they were, the staff responsible were listed as medical and nursing staff, and the QDDP. Direct support professional often play a key role in implementing portions of health management plans, and notifying medical personnel of medical issues. Likewise, direct support professionals play a key role in the implementation of PBSPs and PNMPs, but PSP action plans generally listed the clinical staff as responsible. The role of direct support professionals in plan implementation should be set forth in the PSP action plans. | 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 | Although all of the plans included some practical and functional interventions, none of the 24 plans reviewed (0%) effectively addressed the individual's full array of needs for services and supports. Such issues are discussed elsewhere in this report with regard to plans to address conditions that placed individuals at-risk, psychiatric treatment plans, nursing care plans, PNMPs, OT/PT treatment plans, and PBSPs.<br><br>In addition, due to some of the characteristics of the Facility at the time of the review, providing training in areas that would be functional in the community, as well as at the Facility was difficult. For example, some of the goals and objectives developed for individuals appeared to be constrained by some of the physical plant and administrative structures in place. Food was generally delivered from a central kitchen, so cooking was not a part of daily life in the residential settings on campus. Likewise, because pedestrian safety skills on campus were different than those in the community due to strict speed limits and minimal traffic at ABSSLC, skills that individuals were learning or practicing daily on campus were not practical or functional in the community. In addition, many individuals at the Facility had part-time schedules for work or day activities, and teams did not appear to view timeliness and attendance issues as priorities to be resolved (i.e., in an integrated fashion with assistance from psychology staff, when appropriate). | Noncompliance |

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| | | Similarly, lengthy lunch breaks during which individuals went back to their residences did not allow opportunities for individuals to learn to either bring lunch and eat at their work sites or in the vicinity of their activity or vocational setting. These low expectations failed to provide individuals with functional skills to allow successful transition to a community setting, where regular participation in a day program or job would be expected. The different set of rules on campus coupled with individuals' limited exposure to the community could become a disadvantage for individuals who decide to transition to 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.<br><br>Generally, PSPs and the resulting skill acquisition programs contained data collection methods, frequency with which data should be collected, and identified a person(s) responsible. As is discussed above with regard to Section F.2.a.2, the overarching concern was that many goals and objectives were not specified in individuals' PSPs, or other treatment plans that should have been integrated into the PSP (e.g., risk action plans, health management plans, PNMPs, psychiatric treatment plans, etc.). As a result, appropriate data was not being collected to assist teams in decision-making. Even when plans included objectives, such as PBSPs, individuals' PSPs did not consistently identify the data to be collected, the frequency, and/or the persons responsible for such data collection.<br><br>In addition, the PSPs did not make a distinction between the person responsible for collecting the data, and the person responsible for data review. Often, it was assumed that this would be two different people. For example, with PBSPs, direct support staff often are responsible for collecting data, but psychology staff are responsible for reviewing the data. The current format of the PSP did not make this distinction, and often when two positions were listed, it was not clear what each one's responsibilities were.<br><br>None of the 24 PSPs reviewed appeared to be driven by a review of data, and the presence or lack of progress on measurable objectives and outcomes. In fact, very little, if any data was included in any of the PSPs reviewed. Data that should have been included, but was not, would relate to test/laboratory results, skill acquisition goal data, data related to the implementation of other plans (e.g., PNMPs, PBSPs, nursing care plans, weights, numbers of seizures, etc.), and information related to past events, such as causes of fractures or falls, details regarding individuals' successes or failures, etc. | Noncompliance |
| F2b | Commencing within six months of the Effective Date hereof and with | As noted in the previous reports, and based on the current review of PSPs, this was an area that required substantial improvement. As is discussed in other sections of this | Noncompliance |

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| | full implementation within two years, the Facility shall ensure that goals, objectives, anticipated outcomes, services, supports, and treatments are coordinated in the ISP. | report, the Monitoring Team found a lack of coordinated supports in a number of areas, including between nursing and habilitation therapies; nursing and medical; speech/communication and psychology; and between the disciplines responsible for the provision of physical and nutritional supports to individuals served. Review of the PSPs generally showed a multidisciplinary as opposed to interdisciplinary approach. | |
| 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.<br><br>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.<br><br>Improvements were seen in the manner in which plans were written to facilitate direct support professionals' understanding.<br><br>Another issue related to comprehensibility of the 24 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. Given the way most of the action items or objectives were written, any team member would have had difficulty determining specifically what their responsibilities were.<br><br>In addition, the PSPs continued to lack integration, and many separate plans continued to exist that were not integrated into the one document. Although it will be necessary for the separate plans to continue to exist (e.g., PBSPs, 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. | Noncompliance |
| F2d | Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that, at least monthly, and more often as needed, the responsible interdisciplinary team member(s) | DADS Policy #004 at III addressed personal support plan monitoring, including the requirements of the Settlement Agreement.<br><br>Based on interviews with Facility staff, monthly reviews were not being completed consistently. This was confirmed through document review. A subsample of 12 individuals (Individual #187, Individual #538, Individual #469, Individual #383, Individual #20, Individual #150, Individual #95, Individual #357, Individual #405, | Noncompliance |

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| | 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. | Individual #361, Individual #25, and Individual #504) was selected. Documents were requested of the last six months of monthly reviews, and the previous two quarterly reviews. For six of these individuals (50%), documentation indicated that no monthly reviews were available.<br><br>The QDDP Coordinator had explained that the quarterly reviews consisted of the review of the individuals' plans on a monthly basis. Quarterly reviews were submitted for seven of the individuals (58%). However, based on the documentation provided, it could not be determined if reviews had been completed on a monthly basis. More specifically, each quarterly review had one date, giving the impression that the information had been complied for each of the three months on one day.<br><br>Even for those individuals for whom monthly or quarterly reviews had been conducted, this was not consistently a full review of each program or support. Due to the fact that many plans, such as PNMPs, nursing care plans, psychiatric medication plans, and PBSPs, 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. According to the QDDP Coordinator, many disciplines completed their own reviews, and documented the results in the Integrated Progress Notes. As the team facilitator, it was unclear how or if the QDDP reviewed this information, incorporated it into the monthly report, and took action to call together a team meeting, as necessary.<br><br>In addition, the quality of all of these reviews was inadequate. Data was not provided for skill acquisition programs. The comments were general, such as "progressed," "objective initiated," or "regressed."<br><br>Often, quarterly or monthly reviews indicated that an individual was not progressing, or data had not been available for review. However, frequently, no information was provided about changes made to programs, investigation into causes for lack of progress, and/or follow-up to ensure programs were being implemented correctly.<br><br>Moreover, examples are provided in various sections of this report of individual experiencing changes in status and their teams not taking appropriate action to modify their plans and/or treatment. Numerous examples of this are provided with regard to nursing care. In addition, as noted below with regard to Section O.3, there were times when a team member(s) identified a need for a change, but individuals' PSPs were not consistently modified to reflect such changes. | |
| F2e | No later than 18 months from the Effective Date hereof, the Facility | As reported in previous reports, training on PSPs had been standardized across the SSLCs. Supporting Visions: Personal Support Planning was the standard training | Noncompliance |

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| | shall require all staff responsible for the development of individuals' ISPs to successfully complete related competency-based training. Once this initial training is completed, the Facility shall require such staff to successfully complete related competency-based training, commensurate with their duties. Such training shall occur upon staff's initial employment, on an as-needed basis, and on a refresher basis at least every 12 months thereafter. Staff responsible for implementing ISPs shall receive competency-based training on the implementation of the individuals' plans for which they are responsible and staff shall receive updated competency- based training when the plans are revised. | curriculum for personal supports planning. As indicated above, since the last review, additional training sessions and resources had been initiated. These included:<br>▪ The current QDDP Coordinator participated on the statewide workgroup and was a certified trainer for the Q Construction: Facilitating for Success training. All QDDPs had participated in the initial training. This training included a written test that each participant completed at the end of the classroom training. It also included a competency checklist. The competency checklist generally provided a good format for reviewing a number of planning and facilitation skills. As is discussed further below, as the checklist is implemented, changes likely will need to be made to further define certain competencies, and to ensure reliability across reviewers. However, its implementation already was providing some valuable information to assist QDDPs in refining their skills. At the time of the review, initial checklists had been completed for all QDDPs. Based on interview with the QDDP Coordinator and review of the completed forms, all of the QDDPs had areas in which work was needed. In July, based on concerns found through the competency-checks, refresher training was provided.<br>▪ The State had hired consultants to provide training, and work hands-on with teams on the PSP process. The consultants had provided some basic training to ABSSLC PSTs. It included an overview of the philosophical and historical context of individual planning, a discussion about differences in ICF/MR and Settlement Agreement requirements related to individual planning, and some of the logistics of planning. The specific planning topics included preferences, strengths, and needs; the cycle of planning, including assessment, planning, implementation, re-evaluation, and more planning; developing action plans; the Integrated Risk Rating form; community referrals; and barriers to implementation. The consultants also provided some training to staff responsible for writing skill acquisition plans. In addition, they had begun to sit in on PSP meetings, and provide technical assistance to QDDPs and teams. They had begun to develop a number of resources for teams to use, such as lists of questions to ask when reviewing risk categories, a description of what the third quarterly meeting should include, hints about identifying individuals' preferences, the Supreme Court's *Olmstead* decision, and lists of acronyms and definitions of frequently used terminology. During an onsite review at another Facility, the Monitoring Team discussed with the consultants their plans for additional training, and ongoing technical assistance to teams.<br>▪ The Admissions Placement Coordinator (APC) had provided teams with training on the State Office's categories for obstacles to an individual transitioning to the community, and the action plans that needed to be developed for each obstacle identified.<br>▪ As noted previously, based on a limited number of observations of PSP meetings while onsite, improvements had begun to be seen with regard to the team | |

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| | | process. As would be expected, the results of this training were not yet reflected in the PSP documents that the Monitoring Team reviewed.<br><br>Areas in which additional work was needed to reach compliance with the Settlement Agreement included:<br>▪ As indicated in previous reports, QDDPs 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. As noted above, work was underway to address the facilitation component of competency-based training. At the time of the review, the Facility reported that none of the QDDPs had yet successfully completed the competency check-off. As the QDDP Coordinator recognized, this would be an ongoing process until each QDDP demonstrated competency in this area. In an effort to ensure inter-rater reliability, the QDDP Coordinator and/or the QDDP Educator were observing the same PSP meetings with the QA Program Compliance Monitor, who was completing the competency check-off forms as well. As is discussed in further detail below with regard to Section F.2.g, the establishment of inter-rater reliability is essential. Based on review of a sample of completed checklists, further instructions also might be necessary. For example:<br>o The criteria used to make decisions regarding whether to rate an indicator "yes," "needs work," or "N/A" was sometimes unclear. Reviewers would sometimes identify problems with the way in which a QDDP had met the intent of the indicator, but then give a "yes" rating.<br>o Sometimes the evidence listed did not appear to be related directly to the indicator. It was unclear if this was a training issue, or if the meaning of the indicators were not clear to the reviewer(s).<br>o Two areas of quality that the checklist did not appear to capture adequately included the QDDPs' ability to solicit discussion of the individual's comprehensive set of strengths, preferences, needs, and supports; and/or to facilitate the adequate integration of the various disciplines to problem-solve, where appropriate.<br>▪ Based on documentation provided, the Facility recognized that it had not yet begun to implement competency-based measures for the writing of PSPs. According to the Facility's POI, the statewide workgroup was in the process of revising the tool that would be used to monitor the PSP documentation.<br>▪ Competency measures for other team members had not yet been identified. Such measures should be identified and used to evaluate whether additional training is needed.<br>▪ As recommended in the previous report, there should be additional training on how to the develop integrated action plans, including how to draw together the | |

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| | | information gathered in assessments, analyze that information, incorporate the individual's preferences, set priorities, provide clear directions to those working with the individual, and develop measurable objectives to track progress or lack thereof. It will be important to provide teams with the tools necessary to focus on individual's interests, priorities and vision for his/her living arrangements, while reconciling these with the individuals' medical and safety needs. This was an area that the State consultants had identified as a priority.<br>▪ As is discussed in further detail with regard to Section S of the Settlement Agreement, additional training on the development of skill acquisition programs continued to be an area of need.<br>▪ As noted above, the State consultants as well as the QDDP Coordinator had begun to sit in on team meetings and provide technical assistance in real time. These efforts should continue, because they likely will have the greatest impact on improving the process.<br>▪ As noted in several other sections of this report (e.g., Sections K, O, P, R, and S) adequate processes were not in place to ensure that staff had successfully completed competency-based training on the implementation of components of the PSPs, such as behavior support plans, physical and nutritional management plans, indirect therapy plans, use of alternative and augmentative communication, and/or skill acquisition plans.<br><br>Progress was being made on training staff, but the Facility remained out of compliance with this provision. In addition to focusing efforts on providing additional training and technical assistance to improve the team process during team meetings, competency measures needed to be developed and implemented for the development of the PSP documents, and the Facility needed to ensure that staff responsible for the implementation of the plans successfully completed competency-based training. | |
| 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, 433 out of 445 plans (97%) were completed within one year. The 12 plans that had been overdue were late on average by 14 days, ranging between one and 59 days late. While it is possible that extensions were granted for some of the 12 plans, this was not evident on the provided list.<br><br>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. At the time of the review, the Facility just recently had put a process in place for tracking when a PSP was filed. The Records Department had developed the Policy for Routing Reports/Documents, dated 6/15/11. Based on the Facility's POI, QDDPs had completed training on 7/8/11, and implementation of this policy would allow dates to be tracked to ensure the PSP was in the record within the 30-day time limit. | Noncompliance |

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| | | However, the Facility provided information that indicated 43 PSPs (10%) were filed in charts more than 30 days after the PSP meeting.<br><br>As is noted in other sections of this report, PSTs did not consistently meet to make changes to PSPs for individuals who experienced changes in status, or whose circumstances should have resulted in modifications being made (e.g., multiple restraints, requiring modifications to PBSPs; hospitalizations resulting in changes to status, etc.). | |
| 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. | Progress had been made and/or sustained with regard to the implementation of quality assurance processes that identify and remediate problems to ensure that PSPs are developed consistent with this section of the Settlement Agreement. Positive developments included:<br>▪ DADS Policy #004.V continued to address quality assurance processes to ensure PSPs were developed and implemented consistent with the provisions of the Settlement Agreement.<br>▪ ABSSLC's QA Department was conducting a number of reviews/audits of PSPs, including audits using:<br>o The Settlement Agreement Cross Referenced with ICF/MR Standards Section F: Integrated Protections, Services, Treatments and Supports audit tool; and<br>o The Q Construction: Facilitating for Success – Qualified Mental Retardation Professional Facilitation Skills Performance Tool.<br>Due to other priorities, the QDDP Coordinator had been conducting reviews using the Q Construction tool to measure QDDPs competency, but not the Settlement Agreement tool. Starting in September 2011, the plan was for the QA office to identify a sample of records. Initially, the Program Compliance Monitor and QDDP Coordinator would review the same subsample, until inter-rater reliability was established, and then each would review different records.<br>▪ Using the Q Construction: Facilitating for success tool, the Program Compliance Monitor and either the QDDP Coordinator or the QDDP Educator had sat in on the same PSP meetings and completed the tool. They then met with the QDDP to review the results. This provided the QDDP with some immediate feedback. At the time of the review seven such reviews had been completed.<br>▪ The Program Compliance Monitor, who recently had been assigned to monitor Section F, had previous experience as a QDDP, and had attended much of the same training that QDDPs had attended, such as the Supporting Visions Training, the Facilitation training, and training that State Office consultants recently had provided. | Noncompliance |

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| | | Areas in which improvements should continue to be made in order to achieve compliance, included:<br>▪ One of the monitoring tools included in the Supporting Visions training materials was the Personal Support Plan Meeting/Documentation Monitoring Checklist. At the time of the review, it did not appear it was being used.<br>▪ For the various monitoring/audit tools, inter-rater reliability needed to be established with the QA and programmatic staff (i.e., QDDP Coordinator and QDDP Educator) responsible for conducting audits. The Facility had recognized this need based on the varied results of the auditing that had been completed thus far. As is discussed with regard to Section E, the procedures being used to establish inter-rater reliability needed modification. It was positive, however, that the QA Department had begun to meet monthly with the Department staff with one goal being to attempt to resolve discrepancies in monitoring.<br>▪ As discussed in previous reports, the guidelines/instructions for the audit tools required modification. This will be essential to improve the accuracy of the monitoring results (validity), as well as the congruence between various auditors (reliability). Instructions also need to clearly direct auditors to review the quality of the PSPs, assessments, objectives, etc., and not just their presence or absences. For example, the review tool entitled Settlement Agreement Cross Referenced with ICF-MR Standards Section F: Integrated Protections Services, Treatments and Supports 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 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 to these guidelines, as necessary.<br>▪ As a result of inadequate instructions or criteria for auditing, many of the completed review tools that the Facility submitted for review did not appear to | |

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| | | have captured relevant issues with PSPs. Many of them found compliance with close to 100 percent of the indicators, which was inconsistent with the Monitoring Team's findings related to PSPs it reviewed. It is important to note that some of the more recent review tools that the Program Compliance Monitor recently assigned to Section F had completed identified a number of problem areas in the PSPs and related records. Few comments were provided on the review tools, which made it difficult to determine the exact concerns the reviewer had noted. However, this more critical review was promising.<br>▪ The Facility was not yet at the stage of analyzing the data collected to identify areas in need of remediation, and to develop action plans to address them. At the time of the review, the QDDP Educator and the Program Compliance Monitor had plans to begin meeting monthly to review and analyze the data collected. The QDDP Educator would discuss problematic trends with the QDDP Coordinator. On a quarterly basis, the QA Department as well as the QDDP Department would analyze the cumulative data, and reports would be provided to the QA/QI Council. This group would make decisions about the need for formal corrective action plans to be developed and implemented. As this process progresses, the extensive data being collected through the auditing activities should be distilled down to a format(s) that would be usable to the QDDP Coordinator, as well as the QA/QI Council.<br><br>In its POI the Facility recognized that it remained out of compliance with this provision, which was consistent with the Monitoring Team's findings. Progress was being made in setting up the infrastructure for the quality assurance processes, including more formalized processes for conducting audits, and reviewing and analyzing data. In order for compliance to be achieved, the Facility will need to fully implement these processes, and identify and implement appropriate corrective action plans to address deficiencies identified. | |

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

1. As appropriate, the Facility should develop facility-specific policies and procedures to assist in ensuring full and consistent implementation of the State policy on the Personal Support Plan process. (Section F.1)
2. Based on the ongoing competency checks for all QDDPs, as necessary and appropriate, the QDDP Coordinator should provide QDDPs with additional technical assistance or training on group facilitation, particularly as is relates to the interdisciplinary team process. (Section F.1.a)
3. The criteria for determining when a team member's attendance at a PSP meeting is required should be defined, and incorporated into the attendance database to ensure its reliability. The total number of meetings also should be identified on the aggregate printout. (Section F.1.b)
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. (Section F.1.c)
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. (Section F.1.c)

6. The Facility should consider defining in policy a key set of assessments that should be conducted regularly, and the expected timeframes for reevaluation. Teams should be required to provide a justification for veering from this schedule. Optional assessments also should be defined with criteria/guidelines to assist teams in determining if such assessments would be beneficial to the individual. (Section F.1.c)
7. 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. (Section F.1.d, F.2.a.1, F.2.a.2, and F.2.a.3)
8. PSPs should integrate the recommendations from assessments, not just reference them, and make the health care, therapeutic, and behavior support plans a part of the PSP, rather than stand-alone documents. (Sections F.1.d, F.2.a.2, and F.2.a.3)
9. Team members should be provided ongoing training and technical assistance on the interdisciplinary process, including the integration of information and development of strategies to address individuals' preferences, strengths, and needs, and to identify and overcome barriers. (Section F.2.a.1)
10. The Facility should address barriers such as transportation, and ensuring adequate staffing is available to enable individuals to participate in community activities in small groups. Individuals' PSPs should identify these clearly, if they are barriers to providing the individual with adequate supports and services. (Section F.2.a.1)
11. Additional training should be provided on how to 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 can be translated into clear directions for those working with the individual. (Sections F.2.a.2, F.2.a.3, F.2.a.4, F.2.a.5, and F.2.a.6)
12. Individualized, measurable goals and objectives should be defined in individuals' PSPs to support the implementation of essential plans, such as behavior support plans, nursing care/health management plans, psychiatric treatment plans, and physical and nutritional support plans. For example, in order to provide health care supports to individuals served, measurable goals and objectives should be included to define the roles of direct support professionals as well as nursing staff. In addition, PSPs should include measurable, observable objectives to determine the efficacy of these plans. In other words, objectives should be designed to allow the team to determine if the individual is doing better or worse, or remaining stable. (Section F.2.a.2)
13. 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. (Section F.2.a.3)
14. The Facility should be creative in ensuring that skills that are functional in community settings, but are not regularly taught or practiced at the Facility, such as cooking, cleaning, and realistic community safety skills, become a regular part of training programs for individuals served. (Section F.2.a.5)
15. PSPs should delineate clearly: 1) persons responsible for data collection; and b) persons responsible for data review. (Section F.2.a.6)
16. With regard to the completion of monthly reviews:
    a. If the quarterly review format continues to be used to document monthly reviews, it should be modified to include the dates on which each of the monthly reviews was completed;
    b. The process for ensuring that each team member conducts monthly reviews of the programs which he/she is responsible should be formalized, and it should result in easy access to all team members to the information;
    c. Monthly reviews should incorporate data, as appropriate, to allow the QDDP and the team to assess the efficacy of the plans and programs in place, and determine if changes are needed, staff need to be retrained, more monitoring needs to occur, etc.; and
    d. QDDPs should document clearly follow-up activity and/or changes that are made to PSPs. (Section F.2.d)
17. QDDPs 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. (Section F.2.e)

18. As the facilitation skills performance tool evolves:
    a. The criteria used to make decisions regarding whether to rate an indicator "yes," "needs work," or "N/A" should be clarified.
    b. Evidence should be related directly to the indicator, and guidelines should be provided as necessary to support the reviewers' understanding of the indicators.
    c. Two areas of quality that should be added to the checklist include: the QDDPs' ability to solicit discussion of the individual's comprehensive set of strengths, preferences, needs, and supports; and to facilitate the adequate integration of the various disciplines to problem-solve, where appropriate. (Section F.2.e)
19. Ongoing training and technical assistance should be provided to address gaps in knowledge regarding the new PSP process, as well as to enhance the various team members' skills. (Section F.2.e)
20. 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 QDDPs and teams what is expected. (Section F.2.e)
21. PSTs should completed additional training and/or be provided technical assistance on how to the develop integrated action plans, including how to draw together the information gathered in assessments, analyze that information, incorporate the individual's preferences, set priorities, provide clear directions to those working with the individual, and develop measurable objectives to track progress or lack thereof. It will be important to provide teams with the tools necessary to focus on individual's interests, priorities and vision for his/her living arrangements, while reconciling these with the individuals' medical and safety needs. (Section F.2.e)
22. As is discussed in further detail with regard to Section S of the Settlement Agreement, additional competency-based training on the development of skill acquisition programs should be provided. (Section F.2.e)
23. As has been recommended in previous reports, 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 QDDP, 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 F.2.g)
24. The guidelines/instructions for the audit tools should be modified to improve the accuracy of the monitoring results (validity), as well as the congruence between various auditors (reliability). (Section F.g.2)
25. The extensive data being collected through the auditing activities should be distilled down to a format(s) that would be usable to the QDDP Coordinator, as well as the QA/QI Council. (Section F.g.2)
26. Staff responsible for conducting monitoring activities should be provided with necessary training, adequate guidelines and criteria should be included in the audit tools, and inter-rater reliability should be established. (Section F.2.g and Facility Self-Assessment)
27. As the Facility expands its self-assessment activities, the POI should include the results of data analysis to substantiate the Facility's findings of noncompliance or substantial compliance. The POI also should indicate how the Facility has used this data to identify problematic trends, and develop corresponding corrective actions. (Facility Self-Assessment)

| SECTION G: Integrated Clinical Services | |
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| 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:<br>▪ **Review of Following Documents**:<br>o For one individual from each residence for the past month, copies of all consultant reports (medicine and surgery, inclusive of subspecialties) since the last monitoring visit, and all integrated progress notes (IPNs) commenting on consultant reports with agreement or reason not agreeing, and any PSP addendum related to the consultant report for the following individuals and consultations: Individual #418 Gastroenterology on 2/24/11, and Gastroenterology on 4/8/11; Individual #87 Optometry on 3/16/11; Individual #267 Internal Medicine on 4/27/11, Optometry on 3/30/11, and Psychiatry on 2/16/11; Individual #20 Gastroenterology on 5/31/11; Individual #451 Pap clinic; Individual #263 Cardiology on 2/25/11, Cardiology on 3/22/11, Cardiology on 4/11/11, Cardiology on 4/19/11, and Radiology on 5/19/11; Individual #115 Hematology on 4/19/11; Individual #60 Neurology on 4/11/11; Individual #543 Neurology on 2/28/11, and Neurology on 5/23/11; Individual #517 Psychiatry on 3/23/11, Neurology on 6/13/11, Podiatry on 2/15/11, and Ophthalmology on 4/6/11; Individual #328 Gastroenterology on 2/24/11, Psychiatry on 6/23/11, Neurology on 5/23/11, Endocrinology on 5/25/11, and Endocrinology on 4/6/11; Individual #242 Neurology on 7/26/10; Individual #75 Neurology on 2/14/11; Individual #227 Cardiology on 5/19/11, and Optometry on 4/18/11; Individual #196 Endocrinology on 4/11/11, Neurology on 6/27/11, Gastroenterology on 4/20/11, Psychiatry on 6/22/11, ENT on 3/8/11, Podiatry on 5/18/11, and Hematology on 5/16/11; Individual #505 Gastroenterology on 6/9/11, and Neurology on 5/23/11; Individual #201 Otolaryngology on 4/12/11; Individual #252 Dermatology on 6/22/11, Podiatry on 5/17/11, and Podiatry on 6/21/11; Individual #370 Optometry on 5/12/11, and Neurology 6/27/11; Individual #525 Urology on 5/6/11, and Urology on 7/1/11; Individual #1 Hematology on 7/6/11, Neurology on 5/23/11, Wound Care clinic on 5/26/11, Dermatology on 5/25/11, and Dermatology on 2/16/11; Individual #377 Neurology on 5/9/11, and Dermatology on 4/20/11; Individual #150 Psychiatry on 4/6/11, and Psychiatry on 6/22/11; and<br>o Presentation Book for Section G.<br>▪ **Interviews with**:<br>o Richard Chengson, MD, Medical Director. |
| | **Facility Self-Assessment:** The Facility determined it was noncompliant with either of the subsections of Section G. This was consistent with the Monitoring Team's findings.<br><br>The POI contained some helpful narrative information related to efforts to comply with this section. For example, the Facility noted that daily medical meetings were being held with minutes recorded, and a medical liaison had been appointed to the PNMT. In addition, a monthly self-monitoring process had begun using the State Office medical Quality Assurance checklist. Information had been entered into a database |

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| | for trend analysis once sufficient months had passed to allow review of accumulated information. The goal was to complete a five percent sample each quarter. Several of the questions on the QA checklist addressed Sections G.1 and G.2.<br><br>By the time of the Monitoring Team's visit, the monthly self-monitoring had included a review of several records. One physician was assigned as the lead physician in providing medical peer review, and used the same tool as the external reviewers. However, to date, there had been no attempts at inter-rater reliability. It will be important for that lead physician to review one or more of the same records at the same time as the visit as the external reviewers to begin the process of ensuring inter-rater reliability. Additionally, since all the primary care practitioners (PCPs) participate in the peer review process, once the inter-rater reliability is assured for the lead physician, the other PCPs will have to undergo similar evaluation in their ratings to ensure quality data. Some of the questions relied too heavily on the experience and practice pattern of the reviewer, and some of the questions and/or instructions provided will need to be revised to improve inter-rater reliability. This is an area that the State Office will need to resolve.<br><br>In its POI, the Facility provided no action plan(s) for Section G. Although the POI indicated sufficient data had not been collected, at the time of the Monitoring Team's visit, considerable preliminary data was available that appeared to be consistent from month to month in completeness. The need for improved compliance in certain areas for each PCP appeared to have face validity, and was instructive in creating a corrective action plan. It was anticipated that specific questions within the State Office Medical Quality Assurance checklist would be used to monitor progress for both Sections G.1 and G.2. However, the medical QA checklist was focused on PCP quality of documentation and clinical care, and Section G additionally focuses on integration of clinical care, areas which were not sufficiently reflected in the checklist for the PCP. |
| | **Summary of Monitor's Assessment:** This section addresses both integration of clinical services that are part of the organizational structure of ABSSLC, as well as integration of consultant recommendations and clinical services that are independent of ABSSLC.<br><br>The Facility had continued to take steps toward integration. The revised PST format and risk discussions with all disciplines contributed to an integrated clinical approach to the care of the individual. Another focus of integrated care was the morning rounds. The rounds now had recorded minutes. A liaison physician was appointed to the PNMT to assist in integrating medical care.<br><br>The morning medical meeting was potentially a forum for integration of all clinical services. Meetings had been held regularly over the prior six months, and minutes were maintained that documented the case reviews, and occasional important issues. However, based on observation of the morning meetings, the discussions of the clinical cases needed further integration across disciplines, each clinical discipline should be represented, and the meetings should not merely focus on inpatients in the Infirmary, although rounding is important on these complex individuals. The minutes reflected that nursing provided an update of clinical information provided for that day for those individuals in the Infirmary, and a brief discussion of the next step(s). Psychiatry brought important information to the discussions, but nursing |

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| | case management, clinical pharmacy, psychology, habilitation services, and the PNMT made few, if any contributions.<br><br>There was no "round table" or conference room discussions of the individuals in the hospital, or discussion demonstrating an integrated approach in planning individuals' return to the Facility once discharged, or critical thinking about preventing further acute illness. A conference meeting was needed in which members begin to focus on prevention of recurrence of the individual's illness, expanding the differential diagnosis to other considerations impacting the health of the individual, asking critical questions, and assigning tasks of gathering further information or developing an action plan. When follow-up is due, then further discussion should occur with the morning meeting staff. This should all be reflected in the minutes, including evidence of closure for all questions.<br><br>Additionally, improvement was needed with regard to PCPs documenting their review of consultant reports and recommendations, especially if they agree or not with the findings, and, if there was disagreement, providing a rationale and alternate action plan. The Facility was not in compliance with either of the subsections of Section G. |

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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. | As indicated in the previous report, an overall Facility plan was not in place to address this item, although some 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.<br><br>The Facility had continued to take steps toward integration. The revised PST format and risk discussions with all disciplines contributed to an integrated clinical approach to the care of the individual. A liaison physician was appointed to the PNMT to assist in integrating medical care.<br><br>The morning medical meeting had the potential to be one of the most important clinical forums for integrating clinical services. This meeting is discussed further with regard to Section L.1. Focus appeared to be on the individuals in the Infirmary, and there was no in-depth conference room discussion of those individuals in the hospital, or individuals in the residences who continued to have serious illness, complex medical needs, or ongoing behavioral challenges. For many of the individuals discussed, rounds meant | Noncompliance |

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| | | providing brief updates of the progress of the individual in the prior 24 hours. However, this is the forum to discuss whether all appropriate diagnoses had been considered, and all appropriate evaluations had been completed, as well as options for treatment, with additional dialogue as to steps to be taken to prevent a recurrence of the same illness or event. The PCPs, psychiatry staff, and Infirmary nursing staff offered the most discussion, but additional critical probing and questions as well as sharing of information/expertise was needed from the PNMT, clinical pharmacy, dentistry, RN case management, the hospital liaison nurse, habilitation services, psychology, etc., in order to provide an integrated approach to clinical care of the most critically ill individuals on the campus.<br><br>Consistent with the last three reviews, a lack of collaboration continued to exist between Habilitation Therapies and the Nursing Department. Nurses still did not understand the importance of checking the Physical and Nutritional Management Plans (PMNPs) prior to administering medications, or ensuring individuals were in the correct positions after administering medications and throughout the day.<br><br>On a positive note, progress was noted in the area of ABSSLC's medical emergency systems. A Medical Emergency Response Committee was initiated, based on the work of the Medical Emergency Response Workgroup, and a process of reviewing the emergency drills and systems had begun. From the minutes of the Workgroup, there was significant collaboration between QA, Nursing, and Medical in the discussions and inquires regarding medical emergency drills. This formation of a committee was a positive step forward in the integration of disciplines for reviewing the Facility's medical emergency systems. | |
| 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. | The Facility submitted consultant reports (medicine and surgery, inclusive of subspecialties) for one individual from each residence since the Monitoring Team's last visit. A total of 56 consultation reports were reviewed. The following are the results:<br>▪ Of these 53 out of 56 (95%) had evidence that the PCP reviewed them by documentation of initials on the report.<br>▪ The PCPs also had dated the consultation reports in 50 out of 56 (89%) consultation reports.<br>▪ IPNs related to the consultation reports were reviewed to determine whether the PCP wrote an IPN summarizing the reports, and indicated agreement with recommendations, or if there was a lack of agreement with recommendations, the justification, along with alternative steps to be taken. For 28 out of 56 (50%) of the consultation reports, the PCP had written an IPN documenting review of the report. | Noncompliance |

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| | | In summary, for this section, there was demonstration that the PCPs were reviewing the various consultant reports. However, the PCP documentation in the IPNs of the interpretation and integration of recommendations into the care of the individual continued to need improvement and remained the main gap in achieving compliance in this section. | |

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

1. With regard to the morning medical meetings:
    a. Attendance should include every clinical discipline and all should be active participants, asking probing questions and sharing expertise in relevant clinical areas being discussed.
    b. Morning medical meetings should include a discussion of individuals currently admitted to outside facilities, individuals in the Infirmary, 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.
    c. Each day, formal meeting minutes should document discussion related to planning, and the next steps decided upon in the meeting. Due dates and persons responsible should be identified in the minutes. Updates should be brought back to the morning meeting. Subsequent meeting minutes should document the follow-up until resolution, with the closure date and outcome documented for each item in a closure column or section.
    d. Critical thinking should be recorded in minutes addressing such issues as transition back to the residence of individuals hospitalized or in the Infirmary, additional evaluation or monitoring needed, a review of other diagnostic possibilities contributing to the illness, and prevention of recurrence (especially hospitalizations and ER visits). (Section G.1)
2. The PCPs should ensure they are documenting a review of consultation reports, with notation of agreement with the recommendations, or an alternative plan with rationale. (Section G.2)
3. The lead physician should review one or more of the same records at the same time as the visit as the external reviewers to begin the process of ensuring inter-rater reliability. Additionally, since all the primary care practitioners (PCPs) participate in the peer review process, once the inter-rater reliability is assured for the lead physician, the other PCPs should undergo similar evaluation in their ratings to ensure quality data. (Facility Self-Assessment)
4. In addition, the State Office, in conjunction with the Facilities, should modify existing monitoring tools to ensure that they adequately measure the Facilities' compliance with Section G. (Facility Self-Assessment)

| SECTION H: Minimum Common Elements of Clinical Care | |
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| 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:<br>▪ **Review of Following Documents**:<br>o Copy of any in-service for PCP training on International Classification of Diseases (ICD) and Diagnostic and Statistical Manual (DSM) diagnostic criteria in last six months;<br>o ABSSLC draft guideline: Guidelines for ensuring appropriate positioning before, during, and after x-rays, scans, etc., for patients without guardians and with an identified medium to high aspiration pneumonia risk; and<br>o Presentation Book for Section H.<br>▪ **Interviews with**:<br>o Richard Chengson, MD, Medical Director. |
| | **Facility Self-Assessment:** The Facility determined it was noncompliant with all sections of H. This was consistent with the Monitoring Team's findings.<br><br>The Facility relied on the State Office Quality Assurance checklist to address areas of this section. Approximately eight medical records, or five percent per month, were reviewed and the results were entered into a database for future analysis. Several questions were to be used to monitor various subsections of Section H. At the time of the Monitoring Team's visit, data was available. This consisted of both external medical peer review data, and internal data, both utilizing the same questionnaire. As mentioned with regard to Section G, verification of inter-rater reliability had not occurred, and steps were being considered to address this issue. Although the questionnaire tool did assist in monitoring some aspects of Section H, it did not cover the breadth of the Section H requirements.<br><br>The Facility was anticipating further guidance from State Office concerning clinical indicators before proceeding with planning a strategy to achieve compliance with several subsections of Section H. As a result, the Facility's POI contained no action plan(s) for this section. |
| | **Summary of Monitor's Assessment:** Section H requires focus on appropriate and timely routine assessments, as a as well for acute problems and changes in health status; identifying the diagnosis with the most accurate and complete ICD and DSM codes; providing timely treatment and intervention; and monitoring response using clinical indicators. The Facility was anticipating the clinical guidelines to be completed in the near future, and clinical indicators should be part of the structure of the guidelines. However, the guidelines are not the only source for clinical indicators, and many could be chosen from the literature and clinical experience of the PCPs. Until the clinical guidelines are finalized, one or more clinical indicators on a common diagnosis should be piloted in order to create a process. In this way, when clinical indicators are available from the clinical guidelines, a system for their use already will be in place. Additionally, initial information will have potentially been collected for review of one or more diagnoses, which would assist in choosing the clinical indicators to be used. A database or system for collecting and |

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| | analyzing this information will need to be developed.<br><br>The Facility remained out of compliance with Section H. Little progress had been made in this area. |

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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. | As indicated in the previous report, 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.<br><br>The annual medical assessments, physical examinations, and quarterly notes are discussed in detail with regard to Section L.1. However, the need remained for improvement in timeliness of completion of the annual assessments, because the compliance rate remained low. The Presentation Book for Section H provided information that a new section had been added for the 2011 annual medical assessments focusing on suitability for community placement. However, of the 15 medical records reviewed for Section L, none of the annual medical assessments completed in 2011 (as late as July 2011), included this section in the document. Evaluation of individuals' transition needs will be an ongoing area of importance for the PCP. Quarterly medical reviews were not currently being done at the Facility, but should be.<br><br>There had been focus on preventing aspiration pneumonia, beginning with a campus-wide educational program starting in January 2011. Additionally, the PNMT had added members. A physician liaison had been assigned to this team as well. Part of the emphasis of this program was training of direct support professionals, and clinical as well as nonclinical staff to recognize early warning signs of aspiration and changes in health status. As discussed with regard to Section L.1, the number of pneumonias and aspiration pneumonias had decreased over the past months, since the inception of the program. It cannot be determined at this time the significance of this improvement, but | Noncompliance |

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| | | the Facility is encouraged to keep accurate and complete data in this area to determine if this is a sustainable improvement.<br><br>Based on a review of records of individuals who had been admitted to the Infirmary, sent to an emergency room, and/or hospitalized for an acute illness, assessments were not conducted by nursing on a regular basis or in response to changes in individuals' status. This was a consistent finding since the initial baseline review, and no progress related to these issues during the current review.<br><br>During the morning medical reports, it was noted that one individual had been refusing medications, with resultant sequelae requiring care in the Infirmary. There appeared to be no system to catch such ongoing concerns, and this problem was not detected in a timely manner. Once alerted to a problem, the PCPs provided appropriate response, but identification of early change in health status remained a challenge for nursing and direct support professionals.<br><br>As is illustrated throughout other sections of this report, issues remained with regard to assessments and evaluations being completed regularly, and in response to development or changes in an individual's status, as well as being of adequate quality. Some examples of this included nursing assessments, particularly with regard to individuals who experienced acute illness, psychiatric assessments, psychological assessments, PNMT evaluations, individuals who might benefit from communication systems; and individuals being considered for enteral nutrition. | |
| H2 | Commencing within six months of the Effective Date hereof and with full implementation within one year, diagnoses shall clinically fit the corresponding assessments or evaluations and shall be consistent with the current version of the Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems. | The DADS Draft Policy #005 also set forth expectations for Facility clinical staff, specifically stating "Diagnoses must clinically fit the corresponding assessments or 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."<br><br>The Facility indicated that in the last six months, PCPs had had no in-service training on the ICD and DSM diagnostic criteria. Coding by the medical records department depends on accurate diagnoses provided by the PCPs. The more definitive the diagnosis, the more accurate the ICD code. A basic knowledge of the ICD codes would enhance the accuracy and completeness of state forms, such as the active problem list and the DG-1. The more accurate the detail in the diagnosis made, the more accurate the database and ability to act on this information.<br><br>Similar to the state in-service training concerning the types of pneumonia, a brief periodic in-service would enhance PCPs knowledge in providing more detailed diagnoses listed in the ICD nomenclature. At this point, no systematic review of this nomenclature | Noncompliance |

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| | | was occurring, which focused on the common conditions found at ABSSLC.<br><br>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. Although some progress had been seen in this area, the Facility remained out of compliance. | |
| 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. At the time of the review, the State Office was developing and finalizing clinical guidelines for some of the common clinical conditions. It was anticipated that incorporated into these guidelines would be recommended diagnostic testing, as well as options for timely treatment. According to the POI, at this point, the Facility was doing no monitoring of this area, and no data collection, until these guidelines were finalized. | Noncompliance |
| 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. | As the clinical guidelines are finalized, clinical indicators can be determined and used to monitor success with treatment. However, these had not been finalized at the time of the Monitoring Team's visit, and no data collection had started.<br><br>However, the guidelines are not the only source for clinical indicators, and many could be chosen from the literature and clinical experience of the PCPs. Until the clinical guidelines are finalized, one or more clinical indicators on a common diagnosis should be piloted in order to create a process. In this way, when clinical indicators are available from the clinical guidelines, a system for their use already will be in place. Additionally, initial information will have potentially been collected for review of one or more diagnoses, which would assist in choosing the clinical indicators to be used. A database, or system for collecting and analyzing this information, will need to be developed.<br><br>Clinical indicators also need to be developed for disciplines other than medicine. 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 clinical indicators | Noncompliance |

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| | | or 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. | As indicated in the last report, 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. During the most recent review, it appeared that the Facility required additional guidance from the State Office for a standardized monitoring approach in ensuring health status of individuals.<br><br>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.<br><br>Additionally, at the Monitoring Team's last visit, there was discussion about "short notice PST meetings" to address changes in health status rapidly. However, there was little discussion about this team approach in transitioning individuals from the Infirmary back to the residence. As indicated in the previous report, 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. | Noncompliance |
| 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."<br><br>As mentioned with regard to Section H.4, clinical indicators are expected to be determined based on the final clinical guideline for specific diagnoses and health concerns. The Facility was awaiting these series of guidelines. Once established, 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 |

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| H7 | Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall establish and implement integrated clinical services policies, procedures, and guidelines to implement the provisions of Section H. | No new policies reflecting integration had been utilized by the Medical Department. On 7/15/11, one draft guideline was developed in an interdisciplinary fashion, and provided guidance to several departments, entitled: "ABSSLC Guidelines for Ensuring Appropriate Positioning Before, During, and After X-rays, Scans, etc., for Patients without Guardians and with an Identified medium to High Aspiration Pneumonia Risk." This guideline required the collaborative efforts of the Records Coordinator, Director of Habilitation Services, Nursing Administration, and Medical Administration.<br><br>The Facility should begin to organize the various interdisciplinary committees, policies, and programs, to develop an organizational chart for this structure. This would allow development of additional structure where there are gaps, and strengthen existing processes to ensure integrated clinical services are complete and continuous. | Noncompliance |

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

1. When finalizing the annual medical assessments, the Medical Department should ensure the section on transition needs is completed. (Section H.1)
1. As recommended previously, 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. (Section H.1)
2. The medical staff should meet periodically to review ICD codes that are relevant to the IDD population, with the goal of improved precise diagnoses in the active problem list and DG-1. (Section H.2)
3. Until the clinical guidelines are finalized, one or more clinical indicators on a common diagnosis should be piloted in order to create a process. In this way, when clinical indicators are available from the clinical guidelines, a system for their use already will be in place. Additionally, initial information will have potentially been collected for review of one or more diagnoses, which would assist in choosing the clinical indicators to be used. A database, or system for collecting and analyzing this information, will need to be developed. (Section H.4)
4. As recommended previously, 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 H.5)
5. The Facility should begin to map out how the several different interdisciplinary committees, as well programs, and policies interface and interact, and, as appropriate fill in the gaps of needed processes, and ensure integrated clinical services are complete and continuous. (Section H.7)

| SECTION I: At-Risk Individuals | |
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| 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:<br>▪ **Review of Following Documents**:<br>o DADS SSLC "Risk Guidelines" laminated record;<br>o ABSSLC Presentation Book for Section I;<br>o ABSSLC POI and Action Plan for Section I;<br>o ABSSLC At-Risk lists of individuals;<br>o Presentation for Settlement Agreement Monitoring Team Visit for Section I, undated;<br>o DADS SSLC Policy #006: At Risk Individuals, dated 10/28/10;<br>o ABSSLC Risk Level of High, dated 8/24/11;<br>o ABSSLC Risk Level of Medium, dated 8/24/11;<br>o ABSSLC Individuals Seen in Community Hospital for Past Year;<br>o The following documents: Occupational Therapy (OT)/Physical Therapy (PT)/Speech Language Pathology (SLP) and Registered Dietician (RD) Evaluations, Aspiration Pneumonia/Enteral Nutrition (APEN) Evaluation, OT/PT/SLP consultations for the last year, Personal Support Plan and PSP Addendums for the last year, including PSPA for Integrated Risk Rating Form and Risk Action Plan, Physical and Nutritional Management Plan (PNMP) with pictures, PST Integrated Risk Rating Form, PST Action Plan for Risk Assessment, person-specific monitoring for past two months, competency-based training for staff, supporting documentation for implementation of PST Risk Assessment and Action Plan, Health Management Plan/Nursing Care Plan, and Daily Schedule for Individual #162;<br>o The following documents: APEN Evaluation, Head of Bed Elevation (HOBE) Evaluation, Physical and Nutritional Management Team (PNMT) Evaluation, PNMT Action Plan, PSP and PSP Addendums including integration of PNMT Evaluation and Action Plan, PNMP with pictures, Integrated Risk Rating Form, PST Risk Action Plan, competency-based staff training for staff related to PNMT Action Plan, individual-specific monitoring for PNMT Action Plan, supporting documentation for implementation of PNMT Evaluation and Action Plan, PNMT Discharge Plan/Summary, PNMT Review Log, Daily Schedule, and Health Management Plans/Nursing Care Plans for the following: Individual #452, Individual #337, Individual #407, Individual #117, Individual #498, and Individual #103; and<br>o The following documents: APEN Evaluation, Head of Bed Elevation (HOBE) Evaluation, Physical and Nutritional Management Team Evaluation, PNMT Action Plan, PSP and PSP Addendums including integration of PNMT Evaluation and Action Plan, PNMP with pictures, Integrated Risk Rating Form, PST Risk Action Plan, competency-based staff training for staff related to PNMT Action Plan, individual-specific monitoring for PNMT Action Plan, supporting documentation for implementation of PNMT Evaluation and Action Plan, PNMT Discharge Plan/Summary, PNMT Review Log, Daily Schedule, and Health Management Plans/Nursing Care Plans: Individual #250 and Individual #527;<br>o The following documents: Integrated Risk Tracking Forms, Action Plans for Risk |

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| | Assessments, Aspiration Pneumonia Enteral Nutrition Evaluations (APENs), PSPs and/or PSP Addendums, Comprehensive Nursing Assessments, and Health Management Plans for the following 27 individuals: Individual #418, Individual #87, Individual #387, Individual #23, Individual #267, Individual #20, Individual #119, Individual #25, Individual #138, Individual #199, Individual #126, Individual #429, Individual #311, Individual #19, Individual #393, Individual #123, Individual #362, Individual #162, Individual #328, Individual #7, Individual #319, Individual #184, Individual #216, Individual #26, Individual #417, Individual #437, and Individual #158;<br>o Integrated risk rating form, risk action plan, sign-in sheet for risk rating meeting, and sign-in sheet for risk action plan meeting, physician orders from July 2010 to present, most recent BSP, most recent PSP, and PSP addendums, most recent annual medical assessment and physical exam, and most recent nursing assessment for the following: Individual #267, Individual #60, Individual #151, Individual #174, Individual #218, Individual #279, Individual #212, Individual #97, Individual #523, Individual #405, Individual #40, Individual #348, Individual #54, Individual #468, and Individual #284;<br>o Integrated risk rating form, risk action plan, most recent PSP, and BSP for Individual #323, and Individual #498;<br>▪ **Interviews with**:<br>o Frank J. Kluza, RN, Chief Nurse Executive (CNE);<br>o Bobbie Holden, OT, Director of Rehabilitative Services and PNMT member;<br>o Debbie Sessions, MS, CCC/SLP, PNMT Coordinator;<br>o Tammy Siegfried, RN, PNMT member;<br>o Karen Mayfield, PT and PNMT member;<br>o Lindsey Tierce, PT and PNMT member;<br>o Nicole Spalding, RD and PNMT member; and<br>o Tricia Reyes, RD and PNMT member.<br>▪ **Observations of**:<br>o PSP Meeting for Individual #403, on 8/22/11;<br>o PSP Meeting for Individual #484, on 8/23/11;<br>o PSP Meeting for Individual #146, on 8/23/11;<br>o PSP Meeting for Individual #30, on 8/24/11;<br>o PNMT Meeting, on 8/24/11; and<br>o PST meeting with Monitoring Team to review at risk process on 8/24/11, and 8/25/11 for Individual #323, and Individual #498, respectively. |
| | **Facility Self-Assessment:** The Facility determined that it was not in compliance with any of the provisions of Section I. This was consistent with the Monitoring Team's findings.<br><br>It did not appear that the Facility had any formal self-assessment processes in place to determine its compliance with Section I. The POI provided broad statements such as "446 out of 447 individuals living at the facility have received an initial risk assessments." No qualitative analysis of the risk assessments was provided. The same was true for the other subsections of Section I. |

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| | According to the Action Plan included in the POI, the Facility was in the process of developing a system to notify the QMRP, RN, and Risk Coordinator of changes in condition that necessitated a risk assessment, including a checklist for those individuals admitted to the Infirmary, as well as for the RN Case Managers of other individuals. This was an important initiative. Many other action plans also likely are necessary in order for the Facility to comply with Section I. |
| | **Summary of Monitor's Assessment:** The State Office Consultants had assisted in mentoring the PSTs to develop quality ratings with adequate rationale to justify the rating. Based on the Monitoring Team's observations of PSPs during the onsite review, the PSTs had clearly made some progress regarding the At-Risk process. However, no improvements were found affecting the clinical outcomes for individuals designated to be at risk. Some of the concerns related to the process included:<br>▪ Teams had improved with the scoring of risk ratings. However, the PSTs did not consistently use specific clinical data when determining risk levels.<br>▪ Lack of thorough assessments needed for determination/completion of an action plan impeded the quality and outcome of the action plans. If the clinical departments do not critically review the health care of the individual, then diagnoses and comorbid conditions will be missed.<br>▪ The PSTs' discussions regarding Action Plans for high and medium risks did not include measurable, functional, outcomes and interventions.<br>▪ Most of the interventions mentioned during the PSPs addressing high/medium risks did not reflect clinical intensity in alignment with the level of risk designated by the teams.<br>▪ When discussing interventions for high-risk indicators, the PSTs did not focus on proactive measures for inclusion in the action plans.<br>▪ The PNMT was not adequately involved or integrated with the teams of individuals at highest risk.<br><br>The Facility continued to be out of compliance with Section I, but progress was being made. |

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| I1 | Commencing within six months of the Effective Date hereof and with full implementation within 18 months, each Facility shall implement a regular risk screening, assessment and management system to identify individuals whose health or well-being is at risk. | Since the last review in February 2011, ABSSLC had implemented the revised State policy addressing the At-Risk Individuals, which included Risk Guidelines consisting of specific criteria to assist the teams in determining the appropriate risk levels for each risk indicator. The Facility's POI indicated that as of June 2011, all the individuals residing at ABSSLC had received an initial risk assessment, and that teams were now completing the regularly scheduled annual PSP risk assessments, as well as risk assessments in response to significant changes in conditions. In addition, the POI indicated that those individuals who were designated with high and medium risks had Risk Action Plans in place that were reviewed at least quarterly. In July 2011, the Facility indicated that all the teams had completed training in the risk process and that an Action Plan was initiated addressing the development of a process of reassessing risk factors when an individual had a significant change in condition. At the time of the review, the Facility was in the | Noncompliance |

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| | | process of completing a number of these action steps, but had not yet built the system to address the reassessment of risk factors in response to significant changes in status. According to the Action Plan, the system addressing the reassessment of risk factors in response to changes in condition should be completed and implemented by the next review.<br><br>The Facility reported that in August 2011, State Consultants provided training regarding Quarterly Reviews, action plans, PSPs, Personal Focus assessments, and PSP facilitation to the Facility's Qualified Developmentally Disabled Professionals, Activity Center Case Managers, and Vocational Services Case Managers. In addition, a State Consultant provided coaching and assistance to six PSTs. Based on the Monitoring Team's observations of four PSPs during the onsite review, the PSTs clearly had made progress regarding the At-Risk process, as well as with regard to the process and content of the PSPs. Although this was a positive move forward compared to the findings from the previous reviews, no improvements were found affecting the clinical outcomes for individuals designated to be at risk.<br><br>To assess the Facility's risk screening process, members of the Monitoring Team observed four individuals' PSP or PSP addendum meetings (Individual #484, Individual #146, Individual #403, and Individual #30) while on site. Specifically, the observations of the PSPs indicated that:<br>▪ All appropriate disciplines were present at all (100%) of the PSP meetings.<br>▪ The staff present at the PSPs/PSP addendum meetings were the actual staff that worked with the individual, and not substitute staff sitting in for other staff members for all four (100%) of the PSPs.<br>▪ The individual was present at four (100%) of the PSPs/PSP addendum meetings.<br>▪ The PST used the Risk Level Guidelines when determining risk levels at all four (100%) of the PSPs/PSP addendum meetings.<br>▪ The PST consistently used supporting clinical data when determining risks levels for one of the PSPs observed (25%). The individuals' PSTs that did not consistently use supporting clinical data when determining risk levels included: Individual #403, Individual #146, and Individual #484. The Monitoring Team did note that there was considerable overall improvement for this indicator. However, specific supporting clinical data was not consistently used when determining risks levels. Compliance scores for this indicator reflect the consistency of the use of supporting clinical data when designating risk levels.<br>▪ Overall, the risk levels the PSTs designated were appropriate for each category for all four individuals (100%) from information and data provided by the PSTs. However, due to the inconsistent use of clinical data by the PSTs to determine risk levels, the Monitoring Team could not validate some of the risk levels that | |

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| | | these PSTs assigned.<br>▪ There was adequate and appropriate clinical discussion among appropriate team members in decisions regarding risk levels in all four (100%) of the PSPs/PSP addendum meetings observed. Although the Monitoring Team noted positive improvement for this indicator, the PSTs should continue to expand the depth and scope of the clinical discussions related to the risk indicators and risk levels. Future compliance scores will reflect the adequacy of these clinical discussions.<br>▪ Team disagreements regarding risk levels were noted in three of the PSPs, and they were appropriately resolved for Individual #146, Individual #403, and Individual #30 (100%). No team disagreements were noted in the PSP for Individual #484. For this indicator, the Monitoring Team evaluated the process of resolution based on the use of specific clinical data, the use of the Risk Guidelines, appropriate clinical judgment, and the use of a person-centered focus.<br>▪ The PSP facilitator kept the team focused for all four (100%) of the PSPs/PSP addendum meetings observed. The Monitoring Team noted significant improvement for this indicator. Areas for continued focus include time management since the PSPs observed were exceptionally lengthy.<br><br>In addition, other positive observations from the Monitoring Team included:<br>▪ The PST facilitator for Individual #403 reviewed ground rules with the PSTs at the beginning of the meeting;<br>▪ There was active and robust discussions and participation by the entire team during the PSP for Individual #30;<br>▪ A booklet of information, and agenda was provided to all the PSTs observed;<br>▪ Questions were posed to the individual first with input offered by the PST members for Individual #146.<br>▪ The PST for Individual #403 used a wall chart to track the team's information, ideas, and recommendations about the individual;<br>▪ The facilitator for Individual #403 assigned follow up tasks to team members that included completion dates;<br>▪ The Dentist for Individual #146 described ways to determine likes and dislikes during dental exams;<br>▪ The PST for Individual #403 gathered specific information regarding the individual's reactions to determine the individual's likes and preferences from a family member on the phone during the PSP;<br>▪ The PSTs for Individual #146 and Individual #403 had good discussions regarding specific community needs and preferences; and<br>▪ The Facilitators for all the PSPs observed kept the teams focused and was able to | |

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| | | bring them to consensus in many areas.<br><br>Problematic areas needing focus or improvement included:<br>▪ The PSTs should consistently use specific clinical data when determining risk levels;<br>▪ The PSP started 30 minutes late for Individual #30;<br>▪ There was no nursing care plan addressing hyperlipidemia for Individual #403;<br>▪ PSTs were uncertain whether or not to rate risk levels based on if supports were in place, or to rate the risk as if the supports were not already implemented;<br>▪ The PSTs' discussions regarding Action Plans for high and medium risks did not include measurable, functional, outcomes and interventions;<br>▪ Most of the interventions mentioned during the PSPs addressing high/medium risks did not reflect clinical intensity in alignment with the level of risk designated by the teams;<br>▪ When discussing interventions for high risk indicators, the PSTs did not focus on proactive measures for inclusion in the action plans;<br>▪ Some rating of risks was based on "institutional" standards, rather than how a community practitioner would rate the risk level (i.e., a lower standard was used, for example, with regard to fractures for Individual #403); and<br>▪ Some PSP meetings were extremely lengthy resulting in team members and/or individuals needing to leave the PSPs before they were over.<br><br>To further assess the risk rating and follow-up process, during the onsite visit, the Monitoring Team met with the PSTs for two individuals to review the completed integrated risk rating forms and the action plans. The following provides a summary of the reviews related to Individual #323 and Individual #498:<br>▪ The integrated risk rating form, as well as the risk action plan for Individual #323 was reviewed. The team appeared to over-rate the risk for aspiration, which according to the State Office guidelines should have been medium and not high risk. As his constipation medications were changed to PRN use only, his rating in this area should have been low risk. During the meeting with the Monitoring Team, the PST had described plans to move him to another residence. This would mean a change in teams and team members, which could be disruptive to the continuity of care.<br>▪ Individual #498 recently had returned from the hospital after laparoscopic surgery for possible bowel perforation, although there were no findings. He had had many PSPAs in 2011. He developed episodes of vomiting, and OT reviewed his positioning, his medication regimen had been reviewed for any medications that might aggravate vomiting (his vomiting had led to aspiration pneumonia), and consideration had been given to changes in feeding formula through his | |

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| | | feeding tube, as well as a change in rate of formula administration. An "integrated risk rating form" was distributed dated 3/23/11, which did not include his recent aspiration pneumonia of 3/30/11. Based on the more current information, his aspiration risk would have changed from medium to high risk. However, it did not appear that the team had met to review and revise his risk ratings.<br><br>An additional 15 medical records of individuals were reviewed to determine the use of the Integrated Risk Rating Form. These individuals included: Individual #267, Individual #60, Individual #151, Individual #174, Individual #218, Individual #279, Individual #212, Individual #97, Individual #523, Individual #405, Individual #40, Individual #348, Individual #54, Individual #468, and Individual #284. The following summarizes the results of this review:<br>▪ For 10 out of 15 individual (67%), it appeared that the appropriate disciplines were present at the meeting.<br>▪ For the one of 15 meetings (7%), the individual was present.<br>▪ Of the 15 records reviewed, 13 teams (87%) utilized the definitions in the Risk Guidelines developed by the State Office.<br>▪ Of the 15 records reviewed, 13 teams (87%) documented supporting clinical data in providing a rationale for the risk level.<br>▪ Out of the 15 records reviewed, seven integrated risk-rating tools (47%) were adequate in justifying the risk categorization.<br><br>The Facility indicated that it was not in compliance with the requirements of the Settlement Agreement for this area, which comports with the findings of the Monitoring Team. However, from the Monitoring Team's observations, considerable and promising progress had been made regarding the structure, and process that the PSTs used regarding the At Risk process. The Facility should continue its efforts to develop and implement a system addressing the reassessment of risk factors for individuals experiencing significant changes in status. The Facility also should continue to provide training and mentoring for the PSTs regarding the At-Risk process with an increased focus on the development and implementation of the associated Action Plans. To ensure that teams follow the State Office risk guidelines, the Facility should begin to implement a QA/monitoring process to determine which PSTs need further training and/or technical assistance. This is essential to ensure that ABSSLC identifies timely and adequately significant clinical issues and implements appropriate Action Plans that reflect the needed clinical intensity in alignment with the designated risk levels. | |
| I2 | Commencing within six months of the Effective Date hereof and with full implementation within one year, | Based on a review of records for 27 individuals determined to be at risk (Individual #418, Individual #87, Individual #387, Individual #23, Individual #267, Individual #20, Individual #119, Individual #25, Individual #138, Individual #199, Individual #126, | Noncompliance |

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| | each Facility shall perform an interdisciplinary assessment of services and supports after an individual is identified as at risk and in response to changes in an at-risk individual's condition, as measured by established at- risk criteria. In each instance, the IDT will start the assessment process as soon as possible but within five working days of the individual being identified as at risk. | Individual #429, Individual #311, Individual #19, Individual #393, Individual #123, Individual #362, Individual #162, Individual #328, Individual #7, Individual #319, Individual #184, Individual #216, Individual #26, Individual #417, Individual #437, and Individual #158), documentation showed that the PST started the assessment process as soon as possible, but within five working days of the individuals being identified as at risk for none of these individuals (0%).<br><br><u>Nursing Assessments</u><br>Based on a review of 27 individuals' records for which assessments were to be completed to address the individuals' at risk conditions, none (0%) included an adequate nursing assessment to assist the team in developing an appropriate plan. Records that did not contain documentation of this requirement included: Individual #418, Individual #87, Individual #387, Individual #23, Individual #267, Individual #20, Individual #119, Individual #25, Individual #138, Individual #199, Individual #126, Individual #429, Individual #311, Individual #19, Individual #393, Individual #123, Individual #362, Individual #162, Individual #328, Individual #7, Individual #319, Individual #184, Individual #216, Individual #26, Individual #417, Individual #437, and Individual #158. From a review of the documentation, for individuals identified at high or medium risk for aspiration, nursing staff were using the Aspiration Pneumonia Enteral Nutrition Evaluation as the required nursing assessment for risk. However, nursing's contribution to the completion of the APEN included listing the history of aspiration pneumonias, and other respiratory infections/conditions, and related hospitalizations, which did not constitute a nursing assessment. For individuals with designated risk indicators other than aspiration, nursing was using the last quarterly or annual Comprehensive Nursing Assessment to meet this requirement, even if it had been completed months prior to the meeting determining risk levels, and included little to no information or assessment of the specific risk indicator(s). Neither the APEN nor the Comprehensive Nursing Assessment forms lent themselves to the presentation of a focused assessment addressing health risk indicators.<br><br>A review of either the APENs or Comprehensive Nursing Assessments for the above 27 individuals found that none of them (0%) were adequate assessments of the specific high-risk health indicators identified by the PSTs. The following provides some examples of assessments that did not adequately address the health indicator designated as placing the individual at high risk:<br>▪ The Integrated Risk Rating forms, dated 1/27/11, and 3/17/11 indicated that Individuals #362, and Individual #162, respectively were designated as being at medium and high risk for aspiration. The APENs for both individuals noted the history of aspiration pneumonias, and respiratory issues, but included no nursing assessment addressing aspiration.<br>▪ The Integrated Risk Rating form, dated 4/27/11, indicated that Individual #387 | |

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| | | was designated as being at high risk for challenging behaviors, and fractures, and was medium risk for choking, and dental issues. The Comprehensive Nursing Assessment, dated 2/23/11, two months prior to the meeting at which health risk indicators were rated, did not address any of the high or medium risk indicators.<br>▪ The Integrated Risk Rating form, dated 5/18/11, indicated that Individual #87 was designated as being at high risk for weight, and challenging behaviors, and medium risk for choking and infections. The Comprehensive Nursing Assessment, dated 5/9/11, merely mentioned that the individual remained overweight, "but has lost weight in the last three months." Regarding challenging behaviors, the Comprehensive Nursing Assessment indicated only that the individual continued to exhibit challenging behaviors. Aside from the statement "did have MRSA [methicillin-resistant staphylococcus aureus]," there was no other mention of this issue. There was no information regarding choking or choking risks found.<br><br>Based on interviews with the Chief Nurse Executive during the review, no specific procedure addressed what nursing should do to assess risk indicators. It was apparent that nursing was unclear regarding the nursing assessment requirements related to the At-Risk process. Based on previous interviews with the State Coordinator for Specialized Services, State Office Nurse Practitioner Consultant, and the Nursing Services Coordinator, the current Comprehensive Nursing Assessment form had not been reviewed to determine if it would appropriately meet the requirements of an adequate assessment tool for addressing risk areas. It also did not appear that the Facility was aware of the need for the information contained in the assessments to be updated as a necessary component of the process. The Facility, in conjunction with the State, should specifically define the nursing assessment process regarding at-risk individuals.<br><br>Also, the areas that the At-Risk Individuals policy designated that nursing staff were to assess should be reviewed to determine which discipline is the most appropriate to conduct those assessments. For example, Speech Therapy has expertise assessing issues regarding aspiration and dysphagia that is not within the scope of nursing practice. Additionally, it is within the scope of practice for Physical Therapy to assess balance, and gait regarding the risk for falls, which also is not within nursing's scope of practice. Consequently, when these areas have been identified as being at risk and warranted a risk assessment, nursing has only provided a summary of the problematic issues related to these areas, and not a clinical assessment.<br><br><u>Physical and Nutritional Management, and/or OT/PT/SLP Assessment</u><br>Based on a review of records for five individuals determined to be at risk (Individual #452, Individual #337, Individual #407, Individual #498 and Individual #250), there was | |

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| | | documentation that the PST and/or the PNMT started the assessment process as soon as possible, but within five working days of the individuals being identified as at risk for none of these (0%) individuals. Records that did not contain documentation of this requirement included:<br>▪ Individual #452's Integrated Risk Rating Form, dated 1/12/11, identified her at high risk for respiratory compromise and dental issues. The PST referred her to the PNMT "due to recent admission to community hospital for diagnosis of respiratory distress syndrome. She was discharged from the community hospital 5/3/11 with a final diagnosis of respiratory failure." The Facility hospitalization list documented Individual #452 was discharged from the hospital on 5/3/11 with a discharge diagnosis of aspiration pneumonia. No PSPA was found documenting the referral to the PNMT and/or integrating the PNMT evaluation and action plan. The PNMT evaluation did not document the date of the PST referral to the PNMT. Individual #452's PNMT assessment date was 5/26/11, which was 23 days after her discharge from the community hospital. Neither the PNMT nor the PST revised the Integrated Risk Rating Form to reflect her diagnosis of aspiration pneumonia. Based on the documentation submitted, the Monitoring Team could not determine if the PNMT started the assessment process within five working days.<br>▪ Individual #337 was diagnosed with aspiration pneumonia on 6/26/11, as documented in his PNMT Evaluation, dated 7/25/11. His Integrated Risk Rating Form, dated 7/12/11, identified his high-risk ratings for aspiration, respiratory compromise, constipation/bowel obstruction and seizures. No PSPAs were found documenting his referral to the PNMT, and/or discussing his discharge from the hospital. The PNMT evaluation was initiated approximately a month after his diagnosis of aspiration. Again, the Monitoring Team could not determine if the PNMT initiated the assessment within five working days.<br>▪ Individual #407 was discharged from the hospital on 3/17/11 with a diagnosis of aspiration pneumonia. Her Integrated Risk Rating Form, dated 3/15/11, identified her high-risk ratings for aspiration, osteoporosis, seizures, polypharmacy/side effects, and urinary tract infections. The PNMT evaluation's reason for referral stated: "[Individual #407] to be evaluated by the Physical Nutritional Management Team due to recent placement of gastrostomy tube and history of recurrent aspiration pneumonia." No PSPA was found documenting the referral to the PNMT. A PSPA, dated 4/28/11, discussed the recommendations from the PNMT. The PSPA documented she was admitted to a community hospital with a diagnosis of aspiration pneumonia, and received a PEG tube placement on 3/14/11. The placement of a feeding tube would be defined as a significant change in status, and should have initiated an emergency referral to the PNMT. Her PNMT evaluation was not initiated until 4/26/11, which was over a month post placement of the feeding tube. | |

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| | | ▪ Individual #498's PSPA, dated 4/8/11, indicated: "risk of aspiration was changed to high due to admission to [community hospital] for aspiration pneumonia." No Integrated Risk Rating Form was submitted to reflect these changes. No PSPA was submitted showing team discussion of his referral to the PNMT. The reason for referral listed in his PNMT evaluation, dated 6/13/11, was: "[Individual #498] has been referred to the PNMT due to recent hospitalizations for vomiting episodes resulting in aspiration pneumonia." Although a referral likely should have been made in April, it was unclear when the PST determined PNMT evaluation was necessary. As a result, the Monitoring Team could not determine if the PNMT initiated their evaluation within five working days, as the Settlement Agreement requires.<br>▪ The At-Risk Individuals policy identified the responsibility of the PNMT as: "will begin assessment within 5 working days to determine possible causes for change in status, to analyze assessment findings, integrate recommendations, and propose an action plan with measurable goals and outcomes." The PNMT's caseload identified 13 individuals as receiving "informal follow-up," which was not congruent with the At Risk policy guidelines. A PNMT review log documented the PNMT initiated informal follow-up for Individual #250 for "vomiting" on 8/17/11. The review log did not document if the PST had referred her to the PNMT. Her Integrated Risk Rating Form, dated 1/25/11, did not record any high-risk indicators. The PNMT had not completed an assessment or action plan for Individual #250.<br><br>Based on a review of two individuals' records (Individual #452 and Individual #117) for whom assessments had been completed to address the individuals' at risk conditions, none (0%) included an adequate physical and nutritional management, and/or OT/PT/SLP assessment to assist the team in developing an appropriate plan. The following provides examples of assessments that were not comprehensive:<br>▪ Individual #452 was discharged from the hospital on 5/3/11 with a diagnosis of aspiration pneumonia, and the PNMT evaluated her on 5/26/11. Her Integrated Risk Rating Form, dated 1/12/11, identified high risk factors of respiratory compromise and dental issues. The PNMT evaluation did not document collaboration with her PST to revise her risk ratings as a result of her health status change. At a minimum, her risk rating for aspiration should have been high. As a result, the PNMT Action Plan was inadequate, because it did not address her current risk ratings due to a change of status.<br>▪ The PNMT evaluated Individual #117 on 6/27/11. The PNMT did not update his Integrated Risk Rating Form during the evaluation process to reflect his current risk factors. This impacted the focus of his PNMT Evaluation, because the Risk Rating form did not accurately reflect his current high and medium risk levels, which should formed the foundation of his PNMT Action Plan. | |

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| | | Medical Assessments<br>Based on a review of 15 records for individual determined to be at risk for various health domains (Individual #267, Individual #60, Individual #151, Individual #174, Individual #218, Individual #279, Individual #212, Individual #97, Individual #523, Individual #405, Individual #40, Individual #348, Individual #54, Individual #468, and Individual #284), there was documentation that the IDT started the assessment process as soon as possible but within five working days of the individual being identified as at risk for nine (60%). Records that did not contain documentation of this requirement included Individual #405, Individual #348, Individual #151, Individual #523, Individual #97, and Individual #279.<br><br>Based on a review of one individuals' records who had experienced a change in status, there was documentation that the PST started the assessment process as soon as possible, but within five working days of the individuals' changes in an at risk condition for none of individuals (0%).<br><br>Based on a review of 15 individual records for which assessments had been completed to address the individual's at risk conditions, five (33%) included an adequate medical assessment to assist the team in developing an appropriate plan. Records that did not contain documentation of this requirement included: Individual #279, Individual #97, Individual #523, Individual #151, Individual #174, Individual #348, Individual #405, Individual #468, Individual #284, and Individual #212. The following provides an example of an assessment that was not comprehensive:<br>▪ Individual #348 had several episodes of pica ingestion of liquids, including one hospitalization. Despite these events, the 8/12/11 PSPA indicated this individual's level of supervision would be reduced from enhanced to routine. The team did not address the pica habit, acknowledge the risk of the habit, or assess it properly, and did not provide a plan to address this area. Instead, the change in plan was a reduction in supervision that would allow the opportunity to increase his risk of recurrence. | |
| 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 | Based on a review of 30 records for individuals determined to be at risk (Individual #103, Individual #162, Individual #527, Individual #418, Individual #87, Individual #387, Individual #23, Individual #267, Individual #20, Individual #119, Individual #25, Individual #138, Individual #199, Individual #126, Individual #429, Individual #311, Individual #19, Individual #393, Individual #123, Individual #362, Individual #162, Individual #328, Individual #7, Individual #319, Individual #184, Individual #216, Individual #26, Individual #417, Individual #437, and Individual #158), there was documentation that the Facility: | Noncompliance |

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| | 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. | ▪ Established and implemented a plan within fourteen days of the plan's finalization, for each individual, as appropriate, in none of the (0%) cases.<br>▪ Implemented a plan that met the needs identified by the PST assessment in none of these cases (0%).<br>▪ Included preventative interventions in the plan to minimize the condition of risk in none of the cases (0%).<br>▪ When the risk to the individual warranted, took immediate action in none of the cases (0%).<br>▪ Integrated the plans into the PSPs in none of the cases (0%).<br>▪ None (0%) of the plans showed adequate integration between all of the appropriate disciplines, as dictated by the individual's needs.<br>▪ For none of the plans (0%) were appropriate, functional, and measurable objectives incorporated into the PSP to allow the team to measure the efficacy of the plan.<br>▪ Plans included the clinical indicators to be monitored and the frequency of monitoring for none of the individuals (0%).<br><br>The following are examples of plans that were inadequate to address the at-risk factors identified for the individuals:<br>▪ Individual #103 was evaluated by the PNMT on 8/3/11. The results of his Integrated Risk Rating Form, dated 8/8/11, were not discussed and/or or adequately evaluated in his PNMT evaluation. As a result, his PNMT Action Plan did not reflect interventions to address his high and medium risk indicators and was not adequate.<br>▪ Individual #162's Integrated Risk Rating Form, dated 3/17/11, identified him as being at high risk for aspiration and gastrointestinal (GI) problems. His Risk Action Plan was inadequate to address his high risk for aspiration and GI problems. His action plan had two action steps: 1) implement Simethicone [oral anti-foaming agent used to reduce bloating, discomfort and pain caused by excess gas in the stomach or intestinal tract]; and 2) purchase new neck (buck pillow) for positioning. The timeline for the first action step to initiate a new drug was three months. This was not an acceptable timeframe for an individual identified at high risk. The second action step did not identify a completion date. The pillow was to be monitored for continued fullness and usefulness, but no timelines were identified for how often the monitoring would occur, who would complete the monitoring, how it was to be documented, would staff training be required, etc. The action plan did not recommend an evaluation of his PNMP to determine if strategies were sufficient to minimize his risk of aspiration. The Risk Action Plan did not support integration across disciplines, nor did it identify clinical indicators for wellness and/or the onset of illness. It was unclear how | |

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| | | these two action steps would address minimizing and/or reducing his high risk factors aggressively.<br>▪ Individual #527's Integrated Risk Rating Form, dated 8/19/11, acknowledged high-risk ratings for aspiration, and respiratory compromise. He was followed informally by the PNMT. The PNMT had not completed an evaluation, risk action plan, nor did this individual have a PNMP.<br><br>As noted above, to further assess the risk rating and follow-up process, during the onsite visit, the Monitoring Team met with the PSTs for two individuals to review the completed integrated risk rating forms and the action plans. The following provides a summary of the reviews related to Individual #323 and Individual #498:<br>▪ For Individual #323, the risk action plan was reviewed. The action steps appeared to be focused on paper compliance (e.g., completion of data sheets, the PNMT evaluation, a nursing care plan). The PST is encouraged to focus on the development of action steps that interface with the individual, and ensure translation of the paper compliance into daily actions that will improve the quality of life of the individual. In the risk action plan, there was little focus or clarity on what was to be measured to determine success in risk reduction.<br>▪ For Individual #498, the risk action plan did not offer objectives for his pulmonary or gastrointestinal concerns. Medium risk areas also need to be addressed in the risk action plan. The role of PNMT was not clear, although they were represented at the meeting. Some PST members were going to be changing, including the nurse on the team. During the PST's meeting with the Monitoring Team, it also was recommended that a pulse oximetry reading be completed before and after dental cleaning to ensure that he does not become hypoxic during the procedure.<br><br>The Facility should focus its efforts in the next six months on the process of developing specific and clinically appropriate risk action plans for each individual. Updated and complete assessment information should be available to the teams in attempting to create risk action plans. Incorporation of the action plans into individuals' PSPs with measurable goals, and review of each goal's achievement with modification to plans, as needed are essential requirements for compliance in this area. | |

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

1. To ensure that teams follow the State Office risk guidelines, the Facility should begin to implement a QA/monitoring process to determine which PSTs need further training. (Section I.1)
2. The State Office should consider the need for an additional high-risk category, a "stable high risk" category for those chronic conditions meeting the criteria of high risk. However, teams should focus on the "active" high-risk categories needing further discussion and intervention.

Separating the two would allow teams to prioritize their attention, yet not lose track of the other high-risk categories. (Section I.1)

3. The State Office should consider expanding the "infection" category to provide additional options to provide guidance to the PSTs. Currently, the description of high risk for infection requires two or more multiple drug resistant organism (MDRO) infections, or an open wound. It would be helpful to expand this to any hospitalization for an infection (e.g., sepsis, UTI, diverticular abscess, empyema, meningitis, etc.), because infections requiring hospitalization indicate the need for intense review for risk reduction, not only those with MDRO or a surgical wound. (Section I.1)
4. As detailed in the Monitoring Team's Austin report, the risk guidelines should be reviewed to determine if further subcategories are needed to address the diverse topic of challenging behavior. (Section I.1)
5. Additional training on the at-risk process should be provided to the PSTs. This is necessary to ensure that the at-risk process adequately identifies the critical issues, and that appropriate and clinically sound action plans are developed to address the risks identified. (Sections I.1, I.2, and I.3)
6. When the team convenes about an individual, the departments responsible for background information concerning a risk category should be sufficiently knowledgeable about that category to explain the risk to the remainder of the team. (Section I.1)
7. Each PST member should obtain all relevant information ahead of the meeting, especially information on which the team will base a risk rating. (Section I.1)
8. There should be evidence to confirm the team's rationale for each category of risk reviewed. (Section I.1)
9. When there is a change in health status, the PST should reconvene to rate the categories of risk, and incorporate any changes in health into the risk categories and into a risk action plan. Particularly, when an individual is hospitalized and subsequently discharged home, the PST should meet promptly address any changes in health and functional status. (Sections I.1, I.2, and I.3)
10. The PCPs should ensure complete and timely assessments are ordered, and results incorporated into the individual's treatment and care. The risk action plan requires critical clinical thinking on how to prevent recurrences such as ER visits or hospitalizations to improve the quality of life by improving the health of the individual. (Sections I.2 and I.3)
11. The areas that the At Risk Individuals policy designates that nursing is to assess should be reviewed to determine which discipline is the most appropriate to conduct those assessments. (Section I.2)
12. The Facility, in conjunction with the State, should define specifically the assessment process regarding at-risk individuals for all disciplines. (Section I.2)
13. Given that PSTs, at times, do not realize when more assessment is indicated, and department heads should review PST findings relevant to their department to ensure appropriate guidance is provided to the teams in determining needed assessments. (Section I.1, and I.2)
14. The PNMT should formalize their procedures to ensure compliance with the DADS At-Risk Individuals policy, including the initiation of evaluations and action plans within policy timeframes. (Sections I.2 and I.3)
15. The PNMT, in collaboration with Facility Administration, should define the criteria for referral, including defining what would constitute an emergency referral. (Section I.2)
16. As individuals' risks are identified, and risk action plans are developed, teams should ensure that measurable objectives or indicators are established to allow the team to measure whether or not the individual is better or worse, and if his/her risk level is reduced. If a plan is not working, the team needs to reevaluate it, and potentially revise it. (Section I.3)
17. The Facility should monitor the PSPs to ensure the risk ratings and action plans are integrated into individuals' PSPs. (Sections I.1, I.2, and I.3)
18. As the Facility's self-assessment processes evolve, data should be collected, and analyzed, addressed, and included in the POI to substantiate compliance or noncompliance with the Settlement Agreement. Such data could come from a variety of sources, including audits, as well as other data sources, such as databases or outcome indicators. (Facility Self-Assessment)

| SECTION J: Psychiatric Care and Services | |
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| 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:<br>▪ **Review of Following Documents**:<br>o The State Supported Living Centers: Nursing Protocol for Pre-Treatment and Post-Sedation Monitoring, dated February 2011;<br>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;<br>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;<br>o List of individuals prescribed benzodiazepines;<br>o List of individuals prescribed anticholinergic medications that included the name of the medication(s) prescribed;<br>o List of individuals prescribed intra-class polypharmacy that included the names of medications prescribed;<br>o Facility-wide data regarding polypharmacy;<br>o List of individuals with tardive dyskinesia;<br>o The draft policy of the Human Rights Committee (HRC) review of psychotropic medications separate from the Behavioral Plan;<br>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;<br>o The MOSES and DISCUS assessments for the past year for seven individuals who were prescribed Reglan;<br>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;<br>o List of new admissions since January 1, 2010, and whether a Reiss screen was obtained;<br>o Spreadsheet of all individuals who had had a Reiss screen completed, including the dates of completion, and a copy of the Reiss Scoring Sheet for 20 percent of the individuals identified on the spreadsheet;<br>o List of individuals who have been referred for a Psychiatric Evaluation as a result of an elevated score on the Reiss screen, inclusive of the Reiss Scoring Sheet, and the results of any evaluation that was performed pursuant to the Reiss Screening results;<br>o List of all psychiatrists, including board status;<br>o Curricula Vitae (CVs) of all psychiatrists; |

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| | o List of individuals selected for Desensitization Plans;<br>o For the past six months, minutes from the committee that addresses polypharmacy;<br>o Ten recently completed Comprehensive Psychiatric Evaluations (CPEs);<br>o Chemical Restraint Trend Analysis;<br>o Twenty of the most recently completed Chemical Restraint Checklists, including the restraint forms for the following individuals on the corresponding dates: Individual #59 on 5/10/11, and 6/15/11; Individual #150 on 6/15/11; Individual #95 on 5/26/11 times three, 5/27/11, and 5/21/11; Individual #287 on 5/31/11; Individual #48 on 6/16/11 times two; Individual # 87 on 6/18/11, 6/30/11, 7/8/11 and 8/10/11; Individual #323 on 6/20/11; Individual #332 on 7/7/11 times two; Individual #313 on 7/12/11; and Individual #304 on 8/19/11;<br>o List of all individuals age 18 or younger who were receiving psychotropic medication;<br>o Twenty of the Dental Restraint Checklists for the last six months;<br>o Restraint Checklist for failed/Unsuccessful episodes of pre-treatment sedation for the last six months;<br>o The following sections of the active records: a) Data Record; b) Social History Evaluation; c) Personal Support Plan section; d) PBSP, including addendums; e) Annual Medical Summary; f) Active Problem List; g) Inactive Problem List; h) Psychiatric Problem List; i) Hospital Admission(s); 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 four samples of individuals who were receiving psychotropic medication:<br>1. The records of the following individuals were requested in the pre-review document request: Individual #376, Individual #544, Individual #50, Individual #315, Individual #228, Individual #136, Individual #348, Individual #235, Individual #103, and Individual #51;<br>2. The records of the following individuals were chosen as the individuals who had been admitted to ABSSLC in the calendar year 2011: Individual #87, Individual #95, Individual #107, Individual #121, Individual #125, Individual #133, and Individual #135;<br>3. The records of the following individuals were selected as they were less than 18 years of age: Individual #387, Individual #274, Individual #81, Individual #163, Individual #455, and Individual #160; and<br>4. The following individuals were selected because of their psychiatric acuity: Individual #323, Individual #505, Individual #303, Individual #313, Individual #102, Individual #231, Individual #510, and Individual #74.<br>▪ **Interviews with**:<br>o Toni Wilson, R.N., Psychiatric Nurse, and Amy Hodge, Psychiatric Assistant, on 8/22/11; |

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| | ○ Michael Murray, M.D., Staff Psychiatrist, on 8/22/11, 8/23/11, 8/24/11, and 8/25/11;<br>○ Toni Wilson, R.N., Psychiatric Nurse, Amy Hodge, Psychiatric Assistant, and Marcos Perez, Psychiatric Assistant, on 8/25/11;<br>○ Richard Chengson, M.D., Medical Director, on 8/22/11;<br>○ Jerry Griffen, D.D.S., Director of Dental Services, on 8/23/11;<br>○ Marla Knight, Pharm. D., Clinical Pharmacist, on 8/24/11;<br>○ Ron Manns, Director of Behavioral Services, on 8/23/11;<br>○ Shay Butts, Human Rights Officer, on 8/23/11;<br>○ Tracyl Gandee, Settlement Agreement Coordinator, on 8/25/11; and<br>○ William Whittaker and Mr. Bryan Luster, Program Compliance Monitors, on 8/25/11.<br>▪ **Observations of**:<br>○ Neurology Clinic, conducted by the Consulting Neurologist, Dr. Rex Anderson, on 8/22/11;<br>○ Psychiatric Clinic for home 6390, on 8/25/11;<br>○ Psychiatric Clinics for 6400 Plum Street, on 8/23/11 and 8/24/11;<br>○ Human Rights Committee Meeting, on 8/23/11;<br>○ Behavioral Support Committee Meeting, on 8/24/11;<br>○ Meeting with Personal Support Team members and Monitoring Team regarding Individual #323, on 8/24/11;<br>○ Meeting with PST members and Monitoring Team regarding Individual #498, on 8/25/11;<br>○ Observation of the following individuals: Individual #513, Individual #254, Individual #527, Individual #301, Individual #26, Individual #348, Individual #523, Individual #24, Individual #439, Individual #502, Individual #293, Individual #308, Individual #280, Individual #383, Individual #504, Individual #170, Individual #199, Individual #510, Individual #447, Individual #467, Individual #76, Individual #241, Individual #268, Individual #478, Individual #231, Individual #327, Individual #347, Individual #373, Individual #33, Individual #235, Individual #376, Individual #395, Individual #370, Individual #194, Individual #3, Individual #32, Individual #156, Individual #414, Individual #476, Individual #390, Individual #546, Individual #11, Individual #246, Individual #178, Individual #321, Individual #209, Individual #105, Individual #51, Individual #533, Individual #342, Individual #440, Individual #272, Individual #154, Individual #168, Individual #276, Individual #198, Individual #507, Individual #189, Individual #384, Individual #160, Individual #81, Individual #274, Individual #455, Individual #387, Individual #450, Individual #227, and Individual #135. |
| | **Facility Self-Assessment:** Based on the Facility's POI, it found it was in compliance with only one of the provisions of Section J, specifically Section J.1 that addresses the qualifications of the psychiatrists. This was consistent with the Monitoring Team's findings.<br><br>The Facility recently had redesigned its quality assurance process as it related to the Psychiatry Department. A member of the Monitoring Team reviewed this process with two of the Program Compliance Monitors who work in conjunction with the Settlement Agreement Coordinator, and the staff of the Psychiatry Department. |

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| | According to staff, the current plan was to consist of a review of 16 individual records each month by members of the Psychiatry Department. The Psychiatric Nurse and the Psychiatric Assistants would complete the reviews. The Psychiatrist would then additionally review four of these records (25%) without knowing the results of the initial review. Results of this review would be utilized to assess inter-rater reliability. In addition, a Program Compliance Monitor also would review two of these records to further contribute to the assessment of inter-rater reliability.<br><br>During the interview with the Settlement Agreement Coordinator, it was noted that a new aspect of the revised system would involve reporting out a completion percentage for each sub-item within a provision of the Settlement Agreement, instead of reporting an overall compliance percentage for each provision or section of the Settlement Agreement. This would be an improvement, and should assist the Facility to better identify specific areas in which improvements are needed.<br><br>The discussion with the Program Compliance Monitors indicated that there could still be some items where they would only be able to provide dichotomous yes/no ratings as to whether or not the item was present, as opposed to assessing the validity of the clinical parameters in question. For example, with regard to the issue of an appropriate psychiatric diagnosis, their process had involved checking to see if the individual's psychiatric diagnosis was consistent across different documents (i.e., the listed psychiatric diagnosis was the same in the CPE, the Psychiatric Clinic Notes, and the Psychology section of the record, etc.). They had not assessed whether the psychiatric diagnosis could be justified based on the symptoms with which the individual presented. This was a reasonable approach, as they did not have specific training in this area. However, if the Program Compliance Monitors simply do not rate those items for which they feel they do not have the necessary clinical expertise and rely on the ratings of the clinical staff for those particular items, it might make the results of the QA surveys less confusing. The inclusion of a large number of reviews completed by staff members of the Psychiatry Department (as well as 25 percent of the monthly sample also being reviewed by the Psychiatrist) should make it possible to also address the clinical quality of different factors, as well as their presence or absence.<br><br>As the plans for the new quality assurance review process had only recently been finalized, there were no actual results to examine at the time of this monitoring review, and the Facility's POI consisted mainly of narrative information about some of the actions taken, and some data from other sources (e.g., number of Reiss Screens completed). However, by the time of the next monitoring review, this system should be fully operational, and the Facility should use data from internal audits, as well as other data sources to justify its findings of substantial compliance or noncompliance. It also should use the data to identify and address areas in need of improvement.<br><br>The Facility's POI included one action plan related to comprehensive psychiatric evaluations. It was not a particularly detailed action plan. In addition, as illustrated in this report, a number of other issues required the development and implementation of action plans. |
| | **Summary of Monitor's Assessment:** The Psychiatry Department at ABSSLC had made a number of |

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| | changes relevant to its efforts to comply with the Settlement Agreement since the last review.<br><br>The full-time Staff Psychiatrist that was present at the time of the last review had terminated her employment with ABSSLC. However, another full-time Staff Psychiatrist had joined the Facility. The Consulting Psychiatrist also had increased slightly his consulting hours. The Facility also was continuing to actively recruit additional psychiatrists.<br><br>A member of the Monitoring Team was able to attend a number of Psychiatric Clinics, and it was clear that there was an interdisciplinary approach to the reviews. There was ample time for discussion, with no sense of time pressure.<br><br>Approximately 34 percent of the 219 individuals who were prescribed psychotropic medication were directly observed, either in the clinic setting or through visits to the residences. These observations did not reveal individuals who appeared to be overmedicated, drooling, or displaying other overt side effects of psychotropic medications.<br><br>The Facility appeared to be making progress in the area of polypharmacy. The necessity of the current medications was a topic of discussion in almost all of the Psychiatric Clinics that were observed. Many of the individuals who were reviewed had already had substantial reductions in their psychotropic medications, both in terms of the number of medications prescribed, as well as the dosages of individual medications. This was especially true for the individuals who were admitted from the community while on multiple medications. For example, an individual who was receiving seven psychiatric medications when he was admitted from the community in June of 2011 was currently receiving only two in August 2011. The small sample of newly-admitted individuals that were reviewed in order to examine this issue further had been receiving, on average, five psychiatric medications at the time of their admission. A few months later, they were receiving, on average, 2.6 medications, with ongoing tapers of the remaining medications.<br><br>The discussions that were generated during the Psychiatric Clinics also indicated that the teams were gathering valuable information on a number of individuals through their ongoing process of actively challenging the medications of those individuals who were receiving multiple medications. In those situations where the attempt to decrease a medication was unsuccessful, and the dosage had to be restored, the Facility essentially established the clinical justification of that medication. However, the problem remained that this information could be lost through record purging. Potential solutions to this problem were discussed with the Psychiatry Department and the Pharm.D. during the review, and are discussed in further detail below.<br><br>The Psychology Department, in conjunction with the Psychiatry Department, had proposed removal of the discussion of the psychiatric medications from the PBSP. The Staff Psychiatrist was considering moving this information into the PSP documentation, which seemed reasonable. However, it remained to be seen how this process would evolve. The Settlement Agreement is very clear about the need for integration between the Psychiatry and Psychology Departments regarding the individual Treatment Plans, and that will need to be kept in mind as a new system is developed. |

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| | The Staff Psychiatrist indicated that he was planning to attend the Bi-weekly Neurology Clinics that occur between 3:00 p.m. and 6:00 p.m. on alternate Mondays. During the onsite review, a member of the Monitoring Team attended the Clinic and found the interaction between the Neurologist, Psychiatrist, and Primary Care Physicians to be valuable and comprehensive in terms of coordinating the psychiatric and neurological care of individuals who were followed by both disciplines. It will also be important to ensure that these discussions are documented in the record.<br><br>The review of the individual records described below indicated that progress had been made in completing CPEs that met both the formatting and content requirements of the Settlement Agreement. The content of the CPEs is a component of many of the provisions of Section J of the Settlement Agreement. The information contained in these documents had positively affected the Facility's performance with regard to the justification of the psychiatric diagnosis, the differentiation of the behaviors that were related to the psychiatric diagnosis, as opposed to environmental factors, the efficacy of the psychotropic medications, and the discussion of the risks versus benefits considerations related to the prescribed medication. These issues will also be reviewed in further detail below.<br><br>During the onsite review, a new initiative that would significantly enhance the quality and utility of the internal Quality Assurance audits of the Psychiatry Department was reviewed. The process, as described, would not only increase the scope of the reviews, but also would include more emphasis on inter-rater reliability, which should make the data generated from those reviews more clinically relevant. |

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| J1 | Effective immediately, each Facility shall provide psychiatric services only by persons who are qualified professionals. | The findings 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; and 3) the review of the relevant sections of a sample of 31 records of individuals who received psychotropic medication. The description of the sample of individual records reviewed is detailed in the Review of Documents section above.<br><br>The Facility recently had hired a full-time Psychiatrist, Dr. Michael Murray, who was Board Certified in Adult and Adolescent Psychiatry, and had completed an accredited Residency in Child Psychiatry. Dr. Murray had extensive experience in treating individuals with intellectual disabilities and comorbid mental illness. This experience involved inpatient work at both the Austin State Hospital and the Big Springs State Hospital. His most recent clinical work had been with the County Mental Health System. Although this work primarily involved individuals with mental illness, he was also responsible for providing care to those individuals with intellectual disabilities and comorbid mental illness who were residing in community residences in his catchment area. | Substantial Compliance |

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| | | The Facility also had continued to employ Dr. John Crowley as a Consulting Psychiatrist. Dr. Crowley was Board Certified in Adult Psychiatry, as well as Child and Adolescent Psychiatry. Since the last review, Dr. Trina Cormack, who was a full-time staff Psychiatrist, and Dr. Patricia Lowermore, who served as a Consulting Psychiatrist, had left their employment with ABSSLC. The Facility continued to actively recruit for additional Psychiatrists and this effort should continue.<br><br>Based on the qualifications of the psychiatrists treating individuals at ABSSLC, the Facility was found to be in substantial compliance with this provision. | |
| 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. | The Consulting Psychiatrist's time commitment to ABSSLC was scheduled to increase from 40 to 48 hours per month in the fall of this year. This time would be divided into three eight-hour days every other week. As noted above, the Facility recently hired a full-time Staff Psychiatrist, and the former full-time staff Psychiatrist had left her employment at ABSSLC. Both Psychiatrists currently treating individuals at ABSSLC were Board Certified in Adult Psychiatry, and the Consulting Psychiatrist was also Board Certified in Child and Adolescent Psychiatry. The Staff Psychiatrist also had completed an accredited Residency in Child and Adolescent Psychiatry.<br><br>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 the Psychiatry Department staff to schedule the Psychiatry Clinics and facilitate the direct observations of individuals by the Psychiatrists.<br><br>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 review of the records of 30 individuals who were receiving psychotropic medication indicated that the goal of a monthly and quarterly review in the Psychiatry Clinic had been achieved for all of the individuals. The record of Individual #107 did not contain the section with the Psychiatric Progress Notes and, thus, this factor could not be assessed for this individual. The corresponding goal to have the Psychiatrist observe every individual at least quarterly was achieved for 24 individuals in the sample (80%). The following six individuals (and the date of the Quarterly Review for which they were not observed) were as follows: Individual #81 (4/11/11); Individual #135 (4/11/11), Individual #160 (4/11/11), Individual #455 (4/11/11), Individual #231 (4/14/11 and 5/19/11), and Individual #136 (7/8/11). As it is important from a clinical standpoint to directly observe each individual at least quarterly, it would be useful to develop a mechanism to directly observe individuals who are not available at the time of the quarterly review at another time, and then document the results of that assessment, as an addendum to the relevant Quarterly Psychiatric Review. | Noncompliance |

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| | | The review of this sample of records also indicated that there was a Comprehensive Psychiatric Evaluation completed within the last two years for 14 of the 31 individual records (45%). This completion rate was higher than it had been at the time of the prior review, when only 30 percent of the individuals in the sample had CPEs.<br><br>With regard to the quality of the evaluations, none of the CPEs contained in the sample of records that were assessed at the time of the prior review met the formatting or content requirements set forth in the Settlement Agreement. During this review, nine of the 14 CPEs (64%) inspected were found to comply with both the formatting and content requirements of the Settlement Agreement. The fourteen records that contained current CPEs were for: Individual #133, Individual #87, Individual #95, Individual #135, Individual #107, Individual #121, Individual #125, Individual #313, Individual #102, Individual #323, Individual #231, Individual #510, Individual #74, and Individual #544. The subset of these current CPEs that met the formatting and content requirements of the Settlement Agreement were for the following nine individuals (29% of the total sample of 31): Individual #133, Individual #87, Individual #95, Individual #107, Individual #121, Individual #313, Individual #231, Individual #510, and Individual #74.<br><br>At the time of the prior review, the Psychiatry Department had just begun to implement a new protocol for the CPEs, specifically designed to more closely adhere to the specifications of the Settlement Agreement. Only a small number of these documents were available for review at that time. Those that were reviewed did appear to meet the requirements of the Settlement Agreement. The primary recommendation related to those revised versions of the CPEs was that they contain more specific documentation that would justify the validity of the individual's psychiatric diagnosis. The current CPEs that are cited above as complying with the requirements of the Settlement Agreement contained extensive documentation in the section of the CPE entitled "Bio-Psycho-Social-Spiritual Formulation." These detailed discussions provided not only information necessary to justify the psychiatric diagnosis, but also provided valuable information that was necessary to address the risk versus benefit assessment of using the psychotropic medication, the efficacy of the current and past medications, as well as clarifying any overlap between the target symptoms of the psychotropic medication and the behaviors that are described in the Functional Analysis as being present on a behavioral basis.<br><br>Overall, the new format for the CPAs represented a significant improvement over the documentation that was available in prior versions of these documents. Although progress had been made, adequate CPEs were available for less than 50% of the individuals in the sample, and additional effort was needed to ensure psychiatrists observed individuals on a quarterly basis. As a result, the Facility remained out of compliance with this provision. | |

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| 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. | All of the individuals who received psychotropic medication had a treatment program and one or more psychiatric diagnoses. However, as will be discussed in more detail with regard to Section J.13, psychotropic medication was utilized for individuals whose behavioral programs were inadequate. Without adequate treatment in place, it could not be confirmed that psychotropic medication was not being used as a substitute for treatment.<br><br>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 Sections J.2 and J.13 of the Settlement Agreement.<br><br>In addition, the behaviors that were monitored to assess the efficacy of the psychotropic medications also 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 J.13 of the Settlement Agreement.<br><br>Depending on the circumstances leading up to the event and the route of administration, the use of psychotropic medication as a chemical restraint also could be construed as punishment, for the convenience of staff, or in the absence of adequate treatment. For example, the use of a medication administered by an intra-muscular (IM) injection after an aggressive act toward a staff member or peer (which the individual's history of aggressive acts indicates will not likely be repeated in the near future) could be interpreted as a punishment.<br><br>In order to ensure that emergency chemical restraint was not used as punishment, for staff convenience, or in the absence of adequate treatment at ABSSLC, the Facility had implemented a multi-layered process for both the administration and subsequent review of chemical restraints. More specifically:<br>▪ The Psychiatry Department had been asked to formulate a suggested chemical restraint for individuals, based on their history and presentation. This information was listed in the individual's Quarterly Psychiatric Review documentation and was consistently present in the sample of records reviewed.<br>▪ The actual administration of chemical restraint involved nursing staff contacting psychology staff to ascertain if behavioral interventions would suffice to de-escalate the individual's potentially dangerous behavior. If this intervention was not successful, the PCP was contacted to request an order for a chemical restraint, which was informed by the Psychiatrist's recommendation.<br>▪ Both the Psychology Department and the Pharm. D. subsequently reviewed the | Noncompliance |

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| | | documentation that was generated during the administration of the chemical restraint.<br><br>In order to assess the integrity of this process, a sample of the completed documentation for 20 recent administrations of chemical restraint was requested. The review of this documentation indicated that the internal review processes described above were followed as dictated by the protocol. However, there were concerns with the completeness of the documentation contained on the forms. On all of the 20 forms reviewed, the section that instructed: "Describe events leading to the behavior that resulted in restraint" contained only a brief description of the overt behavior that triggered the request for a chemical restraint, and did not include a description of the environmental or behavior precipitants that might have provoked the individual's aggressive response. A clear description of the antecedents to the aggressive behavior is necessary to accurately determine if the administration of the IM medication was, to some degree, a punishment and/or used in the absence of adequate treatment. Thus, although it did not appear that psychotropic medication was utilized as a punishment for noncompliant behavior at ABSSLC or for the convenience of staff, more complete documentation on the chemical restraint forms that involve the intramuscular injection of psychotropic medication against an individual's will was necessary to fully support this observation.<br><br>The Facility was found to be out of compliance with this provision. In addition to needing to improve documentation related to chemical restraint, improvements also were needed with regard to the clinical justification of diagnoses, ensuring medication was not used to suppress behaviors that were present on a learned or environmental basis, and the quality of behavioral programming. | |
| 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 | The spreadsheet prepared by the Dental Office detailed the utilization of pre-treatment sedation for dental and medical procedures from January through June 2011, including a list of the episodes of administration of pre-treatment sedation. The most common agent utilized was Ativan, in a range of 0.5 milligrams (mg) to 4 mg (with the most commonly used dosage being 2 mg). Other agents that were routinely utilized included Valium, in a range of 20 mg to 40 mg (with the most commonly used dosage being 20 mg); Halcion, 0.5 mg; and Chloral Hydrate, in the range of 1,000 mg to 2,000 mg. These are all commonly used medications for pre-treatment sedation. However, it would be unusual and potentially unsafe to administer 40 mg of Valium to an individual (Individual 304 on 6/29/11 for "MD Appt"), unless they had previously received dosages this high. It would be important for the Facility to determine if this individual's history indicated that this dosage could be safely tolerated.<br><br>Documentation of the post-treatment sedation monitoring of the individual was | Noncompliance |

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| | psychiatric, pharmacy and medical services, and shall be monitored and assessed, including for side effects. | requested for 20 of the individuals who had been administered pre-treatment sedation over the past six months. Review of this documentation indicated that the individuals were carefully monitored in the Dental Office after the procedures. During the 8/23/11 interview with the Director of Dental Services, he indicated that all of the individuals are sent from the Dental Office to the Infirmary for further monitoring before they are allowed to return to their living units. He also indicated that the pre-treatment sedation was actually administered in the dental office, so that the monitoring of the individual's vital signs took place in that controlled setting. Thus, the post-treatment monitoring of the individuals who receive pre-treatment sedation is comprehensive and should ensure that the individual safely recovers. The Director of Dental Services also indicated that there were a small number of individuals who did not receive this close monitoring after being administered pre-treatment sedation. Those are the individuals who receive the pre-treatment sedation, but then refuse to proceed with the procedure and usually leave the Dental Office unaccompanied and, perhaps, agitated. There did not appear to be any mechanism in place to monitor the physiological or medical response of those individuals to the pre-treatment sedation, due to their noncompliance. The Facility should develop a process for monitoring individuals who receive pre-treatment sedation, but do not remain at the dental/medical office, such as notifying nursing and residential/day services staff of their departure from the Dental Office. Documentation should be maintained to verify what monitoring occurred and the results.<br><br>The spreadsheet for the last six months of utilization of pre-treatment sedation also contained a column that indicated whether or not there was a "plan to minimize the need of pre-treatment sedation." This data indicated that such a plan was in place for 21 unique individuals.<br><br>Data was analyzed further for a random sample of 30 unique individuals that appeared on the spreadsheet, which in total accounted for 73 administrations of pre-treatment sedation from January through June of 2011. These thirty individuals accounted for 32 of the total of 73 administrations (44%), because one individual had two administrations for dental procedures during this time period, and another had two administrations for medical procedures. Within this sample of 30 individuals, four individuals (13%) received the pre-treatment sedation for a dental procedure, and 25 individuals (83%) received the pre-treatment sedation for a medical procedure. The column that contained this information was left blank for one individual and thus the total does not equal 100%. The spreadsheet also contained a column that indicated if a plan had been developed for behavioral desensitization. This data indicated that two of the four individuals (50%) who received pre-treatment sedation for dental procedures had such a plan, and neither a "yes" nor "no" answer for the other two. Eight individuals (32%) who had received pre-treatment sedation for a medical procedure had a desensitization plan in place. Five individuals (20%) did not have a plan in place, and for the remaining 12 individuals | |

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| | | (48%), no information was provided. The significance of the missing information for those individuals that had neither a "yes" or "no" in this column was unclear, because a legend did not accompany the spreadsheet that would clarify this point. Regardless, only a small portion of individuals requiring desensitization or other procedures to potentially reduce the need for pre-treatment sedation had plans developed.<br><br>The concerns related to the quality of the individual Desensitization Plans that had been developed for the individuals at ABSSLC who require them is discussed with regard to Section C.4 of the Settlement Agreement.<br><br>The Director of Dental Services noted that he was aware of four individuals who had gained "substantial benefit" from the efforts to desensitize them to interventions in the Dental Office, as well as an additional small number that had shown noticeable improvement in their ability to comply with dental interventions. Although those impressions are, to a certain extent subjective, they do provide valuable information regarding the success of these programs for some individuals. The Director of Dental Services also indicated that there likely will be individuals for whom desensitization programs will be helpful in enabling them to participate with dental hygiene, but not more intrusive dental work, such as treatment for cavities or extractions. The Psychology Department might want to consider this observation as they determine the success or failure of the Desensitization Plans for specific individuals.<br><br>The Facility remained out of compliance with this provision. Based on the subjective observations of the Director of Dental Services, clear progress had been made in developing effective desensitization plans. The detailed review of the spreadsheet of individuals who require pre-treatment sedation for medical and dental procedures indicated that plans had only been developed for a relatively small percentage of the individuals who will ultimately require them in order to satisfy the requirements of this provision, | |
| 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. | At the time of the August 2011 onsite review, 219 individuals were receiving psychotropic medication. This number was not significantly different from those identified in the Monitoring Team's prior reports (222 individuals in February 2011, and 225 individuals in August 2010). 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.<br><br>In December 2010, ABSSLC hired a new full-time Psychiatrist who recently terminated her employment with the Facility. However, the Facility had been able to hire another | Noncompliance |

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| | | full-time Psychiatrist, as described above. The Facility also had continued to contract with one of the prior two Consulting Psychiatrists. As indicated above, he had recently increased his consulting time from 40 hours to 48 hours per month. Thus, the total amount of psychiatric time that was available to evaluate and treat the individuals at ABSSLC remained less than 1.5 full-time equivalents. The Medical Director indicated that the Facility had additional open psychiatric positions that it had been attempting to fill.<br><br>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. However, the Facility remained out of compliance with this provision. | |
| 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. | As noted above, one full-time Psychiatrist and one part-time Psychiatrist provided the psychiatric services at ABSSLC. The primary contact that 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 have the Psychiatrist directly observe the individual every three months. The Psychiatric Nurse, Psychiatry Assistants, and the living unit Nursing Staff, working in conjunction with the members of the Psychology Staff, contributed to the execution of this schedule of Psychiatric Clinic reviews, which is discussed in detail with regard to Section J.2.<br><br>CPEs were identified in 14 out of 31 of the records reviewed (45%). Nine of these 14 (64%, or for 29% of the total number of individuals reviewed) conformed to the requirements set forth in the Settlement Agreement, including clear, explicit formatting and content of the CPEs. The strengths as well as the deficiencies related to both the documentation of the Psychiatry Clinics and the CPEs are described in more detail with regard to Sections J.2 and J.13 of the Settlement Agreement. | 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 ABSSLC was 443. Of these, 219 individuals were receiving psychotropic medication (49%).<br><br>The Reiss Screen was specifically designed to identify individuals who were not receiving psychiatric services who could benefit from a psychiatric 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 fifth individual (20%) was requested of the | 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. | individuals who were identified in the spreadsheet as having been administered the Reiss Screen. This resulted in the identification of 43 individuals who should have been administered the Reiss protocol. A copy of the actual Reiss Scoring Sheet was requested for these individuals to provide verification of the documentation contained in the spreadsheet.<br><br>The inspection of this documentation indicated that the Reiss Screen had been administered as scheduled for all but two of the individuals. However, the reason that this information was not available for individual #475 and Individual #356 was that they were deceased and the records were no longer available on site. Thus, the accuracy of the spreadsheet was verified for 100 percent of the individuals for whom the information was still available on site.<br><br>The Reiss Screen protocol also dictated that it should be administered to individuals who were newly admitted to ABSSLC and who were not receiving psychotropic medication. There had only been one recent admission to ABSSLC who was not receiving psychotropic medication, Individual #261, and a copy of the Reiss Scoring Sheet for this individual was available for verification. The Reiss total score for this individual was below the clinical cut-off score that would have necessitated a referral for a CPE.<br><br>None of the individuals identified in this sample had a Reiss Score above the clinical cut-off score of nine, which would have prompted a referral for a Psychological and Psychiatric Evaluation. However, the Reiss report spreadsheet identified seven individuals who had scores above the Reiss cut-off score of nine. The specific individuals identified were as follows: Individual #502, Individual #97, Individual #467, Individual #99, Individual #383, Individual #170, and Individual #527. Accordingly, additional documentation was requested that would substantiate that these individuals had been referred for a CPE.<br><br>The documentation that was generated in response to this request indicated that Individual #383 had been referred to the Psychiatry Clinic, but a CPE was not produced. The documentation for the other individuals consisted of an additional review by the individual's Psychologist, which discussed the results of the Reiss Screen in the context of their history and also indicated that these results would be discussed with the individuals' Personal Support Teams. A copy of CPEs that were conducted pursuant to the Reiss Screening Score was also provided for all of these individuals, with the exception of Individual #383. However, the format and content of these consultations did not conform to the standards specified for the CPEs as set forth in the Settlement Agreement. As a result, the Facility remained out of compliance with this provision of the Settlement Agreement. | |

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| | | The Facility should continue to administer the Reiss Screen to individuals who are newly admitted that are not currently receiving psychotropic medication. Those individuals whose scores are above the clinical cut-off score should be referred for a CPE that meets the formatting and content requirements of the Settlement Agreement. | |
| J8 | Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall develop and implement a system to integrate pharmacological treatments with behavioral and other interventions through combined assessment and case formulation. | During the onsite review, a member of the Monitoring Team directly observed the interactions of the Staff Psychiatrists with the clinical teams during the Psychiatric Clinics. These observations indicated that the Psychiatrist worked closely with the members of the Psychology Department. The Psychologist, who was 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.<br><br>Within the sample of 31 individual records, 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:<br>▪ In 19 of the 31 records reviewed (61%), the symptoms that were described as being "targets" of psychotropic medication also were described in the Functional Analysis as being present on an operant basis, or 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. 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 consistently present in these records. This suggested that the psychiatric evaluation process and the psychological assessment process were operating in a parallel manner and were not integrated. This dual documentation also gave the impression that the psychotropic medication was being prescribed to suppress target behaviors, such as aggression, agitation, and self-injurious behavior (SIB), rather than the symptoms of an identified psychiatric disorder. As noted with regard to Sections J.2 and J.13, the Psychiatry Department had begun to make noticeable progress in addressing this issue.<br>▪ The Treatment Plans for the use of psychotropic medications and the Behavioral Support Plans generally did not specify which of the identified behaviors were directly related to a symptom of the identified psychiatric disorder, as opposed to being related to behavioral or environmental etiologies. In those cases where the identified behavior was thought to be determined by both biological and psychological processes, this should have been clarified. These issues were discussed with the Director of Behavioral Services and the full-time Staff | Noncompliance |

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| | | Psychiatrist who were both aware of this problem.<br><br>The Psychiatry Department, working in conjunction with the Psychology Department, was developing a plan to remove the Treatment Plan for the psychotropic medications from the Behavioral Support Plan. The Staff Psychiatrist indicated that the separate psychiatric Treatment Plan might be included in the Positive Behavior Support Plan (PBSP) documentation, but the process had not yet been finalized. Both the Director of Psychological Services and the Staff Psychiatrist indicated that consideration was being given to tracking the identified symptoms of the psychiatric disorder separate from the behaviors that were a focus of the Behavioral Plan, and that often currently also were listed as target behaviors of the psychotropic medication. Both of these plans had merit. However, it will be important to keep in mind that the Settlement Agreement specifies integration of the psychological and psychiatric treatment plans and, thus, this integration should not be ignored or lost in the process of the differentiation alluded to above. | |
| J9 | Commencing within six months of the Effective Date hereof and with full implementation within two years, before a proposed PBSP for individuals receiving psychiatric care and services is implemented, the IDT, including the psychiatrist, shall determine the least intrusive and most positive interventions to treat the behavioral or psychiatric condition, and whether the 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. | This provision describes a collaborative process through which "the IDT, including the psychiatrist, shall determine the least intrusive and most positive interventions to treat the behavioral or psychiatric condition."<br><br>There was insufficient documentation in the records reviewed that this collaborative process was occurring at ABSSLC. The Psychiatric Clinics were attended by multiple disciplines, including nursing staff, direct support professionals, psychology staff, and the QDDPs. Thus, the composition of the disciplines that was in attendance at the Psychiatric 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 nursing staff's description 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 who was present during the review clearly took this information into account when making decisions.<br><br>None of the 31 records reviewed provided 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. However, there was evidence of progress in this regard. As noted with regard to Section J.2, nine of the 31 records reviewed of individuals receiving psychotropic medication contained CPEs that met both | Noncompliance |

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| | | the format and content specified in the Settlement Agreement. The Bio-Psycho-Social-Spiritual formulation of these CPEs included discussions that would relate to this provision of the Settlement Agreement, and which supported the position that the prescribed psychotropic medication represented the least intrusive approach.<br><br>However, the aspect of this provision that was not fulfilled by these discussions in the CPEs was the stipulation that there be an interdisciplinary discussion of this issue, involving the staff of the Psychology Department and other members of the interdisciplinary team. During the onsite review, the Staff Psychiatrist indicated that he was planning to attend the PSP meetings for the individuals he follows. This would provide an opportunity to involve the broader PST in the discussion as to whether the prescribed psychotropic medications represented the least invasive approach to address the individual's maladaptive behavior.<br><br>These discussions would, thus, have the potential to expand the discussions in the newly revised versions of the CPEs in a manner that will more closely comply with this provision of the Settlement Agreement. At this juncture, the Facility remained out of compliance with this provision. | |
| J10 | Commencing within six months of the Effective Date hereof and with full implementation within 18 months, before the non-emergency administration of psychotropic medication, the IDT, including the psychiatrist, primary care physician, and nurse, shall determine whether the harmful effects of the individual's mental illness outweigh the possible harmful effects of psychotropic medication and whether reasonable alternative treatment strategies are likely to be less effective or potentially more dangerous than the medications. | 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. As noted with regard to Sections J.2 and J.13, since the last review, the Facility had made progress in this regard. This primarily was due to the expanded discussions in the Bio-Psycho-Social-Spiritual sections of the newest CPEs, which met the specifications contained in the Settlement Agreement. The discussion contained in the CPEs of the following individuals provided an adequate discussion of why the benefits of the medication outweighed the risks: Individual #133, Individual #87, Individual #95, Individual #107, Individual #121, Individual #313, Individual #231, Individual #510, and Individual #74.<br><br>The efforts to actively challenge the medications of individuals for whom there was no evidence that the medications had been effective also had had a positive impact on this provision. The tapering of medications for Individual #315 and Individual #376 produced evidence that the medications were necessary based on the degree of the deterioration in the individuals' psychiatric status that occurred after the medications were removed (which exceeded the side effect profile of the medications), and the subsequent stabilization that occurred after the medications were restored. Thus, the completion of CPEs that complied with specifications of the Settlement Agreement, coupled with the efforts to empirically substantiate the efficacy of psychotropic medication, will continue to have a positive impact on the Facility's compliance with this | Noncompliance |

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| | | provision of the Settlement Agreement.<br><br>Although progress had been made, only 11 of the 31 records reviewed (35%) provided adequate current documentation that the benefits of the individual's prescribed psychotropic medication outweighed the risks they presented. | |
| J11 | Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall develop and implement a Facility- level review system to monitor at least monthly the prescriptions of two or more psychotropic medications from the same general class (e.g., two antipsychotics) to the same individual, and the prescription of three or more psychotropic medications, regardless of class, to the same individual, to ensure that the use of such medications is clinically justified, and that medications that are not clinically justified are eliminated. | ABSSLC had developed a Polypharmacy Committee that met monthly to review those individuals whose psychotropic medication profiles were consistent with the definitions of polypharmacy. The meeting was referred to as the Psychotropic Polypharmacy Review Committee Meeting. Minutes of these meetings were available from January through June 2011. The following excerpt from the minutes of the Psychotropic Polypharmacy Review Committee meeting, which was held on 6/21/11, listed the following individuals who would typically attend this meeting:<br><br>Richard Chengson, M.D., Edward Craig, M.D., Michael Murray, M.D., Marla Knight, Pharm.D., John Crowley, M.D., Toni Wilson, R.N., Ron Manns, Behavior Analyst, Tracey Cunningham, R.N., Jana Cowart, QDDP, Amy DeLeon, R.N., and Dr. Jiron, locum tenens physician.<br><br>The format for the meetings included one individual Case Study that involved a presentation of the individual's psychiatric status and their history with regard to the current and past utilization of psychotropic medications. These individual Case Studies were uniformly detailed with regard to the individual's current status and relevant past history. The Case Study was followed by additional discussions referred to as "Follow-up on previous Case Studies." The minutes suggested that these were briefer individual case-centered reviews intended to monitor the progress with regard to recommendations made during the initial Case Study.<br><br>The focus of these meetings 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.<br><br>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 PCP and the Psychiatrist.<br><br>The review of the sample of records indicated that QDRRs by the Pharm. D. were current and had been completed quarterly for all of the 31 records reviewed.<br><br>The direct observations of the Quarterly and Monthly Psychiatry Clinics, which are | Noncompliance |

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| | | described in the discussions of Sections J.2, J.9, and J.13, indicated that a frequent topic mentioned during the individual reviews was whether or not the individual's psychotropic medication could be reduced or eliminated. A number of the individuals reviewed were also in the process of having their psychotropic medications challenged.<br><br>As discussed with regard to Section J.13, in those cases where the taper of an individual's medication indicated that it was essential to their stability, this data provided the empirical evidence that justified the use of the medication, which was also a factor that was alluded to in this Provision of the Settlement Agreement. As noted in the discussion with regard to Section J.13, the Pharm. D. indicated that this documentation would be carried forward in the Pharm. D. Notes on a continual basis. As is recommended with regard to Section J.13, this information also should be carried forward in individuals' Psychiatric Quarterly Review Notes.<br><br>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 was presented in the form of bar graphs for each quarter, from the first quarter of 2010 through to the first quarter of 2011. The graph for the "Number of Psychotropic Drugs Used" for the entire ABSSLC population had declined significantly, from 748 in the first quarter of 2010, to 486 in the first quarter of 2011. A more relevant statistic for the specific issue of polypharmacy was contained in the graph that reports the average number of "Psychotropics per Person." This had declined from an average of 3.42 in the first quarter of 2010 to an average of 2.28 in the first quarter of 2011.<br><br>Although the data with regard to the average number of psychotropic medications per individual provided a broad indication of the prevalence of polypharmacy, the Facility should also develop a simple method to track the number of individuals receiving three or more psychotropic medications, as well as the concurrent use of two psychotropic medications from the same class. This information then could be distilled into aggregate data that would provide a more specific indication of the Facility's progress in reducing polypharmacy.<br><br>The Facility might also want to consider tracking this information for the individuals who are admitted from the community in a separate tracking system for the first year that they reside at ABSSLC. The rationale for this suggestion is that the individuals who were admitted from the community often were receiving large numbers of psychotropic medications that constituted unnecessary polypharmacy. Thus, the commingling of this information with the Facilities' longitudinal database would negatively skew the perception of their progress in reducing unnecessary polypharmacy. | |

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| | | This review clearly indicated that the Facility was making progress in reducing the unnecessary use of polypharmacy with psychotropic medications, and that much of this progress related to the effectiveness of this committee. The last two sentences in this provision of the Settlement Agreement indicate that for those Individuals for whom polypharmacy cannot be totally eliminated, adequate empirical justification that the prescribed medications were effective needs to be provided. This criterion had not yet been met, and thus, the Facility remained out of compliance with this provision. | |
| 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. | This provision of the Settlement Agreement stipulates a quarterly side effect monitoring for individuals receiving psychotropic medication with instruments such as the Monitoring of Side Effect Scale or Dyskinesia Identification System: Condensed User Scale. 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 was reviewed of 31 individual records who were receiving psychotropic medication at the time of the on-site review of the Facility.<br><br>The review of the records for these 31 individuals yielded documentation that a MOSES evaluation had been performed as specified over the last year, and was current for all but the following three individuals: the records of Individual #544 and Individual #274 were missing the second pages of the recent MOSES, which contained signatures and dates; and the most recent MOSES for Individual #510 was dated 1/26/11. Thus, the overall successful completion rate was 90%. This documentation, which was completed by a member of the Nursing Department, was also inspected to ascertain if it had been reviewed and signed by the prescribing physician in a timely manner (defined as within seven to 10 calendar days from completion). This analysis indicated that the individual's PCP had reviewed and signed the corresponding MOSES assessment in a timely manner for the following fifteen individuals (48%): Individual #376, Individual #50, Individual #103, Individual #133, Individual #95, Individual #135, Individual #125, Individual #455, Individual #323, Individual #303, Individual #74, Individual #235, Individual #136, Individual #218, and Individual #315. For the remaining individuals, the signature of the PCP occurred well beyond seven to 10 days after the completion of the evaluations, and for many, did not occur until almost a month later.<br><br>As noted above, the DISCUS was also to be performed on a quarterly basis for all of the individuals who received antipsychotic medication. The sample of 31 individuals who received psychotropic medication indicated that documentation of current and quarterly evaluations for the last year could be identified for 29 of the 31 individuals contained in the sample. However, Individual #235 was not receiving antipsychotic medication and, thus, monitoring with the DISCUS was not necessary. The record for Individual #74 did not contain any DISCUS forms, and the individual was receiving the antipsychotic agent Risperidone and, thus, should have been monitored with the DISCUS. Thus, overall, the | Noncompliance |

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| | | documentation was complete for 29 of the 30 individuals who required periodic monitoring (97%). The parameter of the prescriber's review and signature was also assessed utilizing the same criteria described above for the MOSES. This analysis indicated that for 13 of the 30 records reviewed (43%), the documents had been reviewed and signed in a timely manner.<br><br>The specific individuals for whom this documentation was identified were as follows: Individual #50, Individual #133, Individual #95, Individual #135, Individual #125, Individual #455, Individual #505, Individual #323, Individual #103, Individual #136, Individual #228, Individual #376, and Individual #303. For the remaining individuals, the prescribing provider's review and signature occurred well beyond seven to 10 days after the completion of the evaluation, and for many, did not appear until almost a month had past.<br><br>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 Gastroesophageal Reflux Disease (GERD), it contains 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%). This process generated a list of the following seven individuals: Individual #232, Individual #333, Individual #457, Individual #21, Individual #117, Individual #53, and Individual #409. The documentation that was provided in response to this request indicated that the MOSES had been performed every six months and was current for the following five individuals (71%): Individual #409, Individual #333, Individual #457, Individual #21, and Individual #117. The MOSES had been reviewed and signed by the prescriber in a timely manner for the following four individuals (57%): Individual #409, Individual #457, Individual #21, and Individual #117.<br><br>The review of the corresponding documentation for the DISCUS evaluations indicated that the DISCUS was current and had been performed quarterly for the following five individuals (71%): Individual #53, Individual #232, Individual #457, Individual #21, and Individual #117. The DISCUS forms had been reviewed and signed by the prescribing provider in a timely manner for the following four individuals (57%): Individual #53, Individual #457, Individual #21, and Individual #117.<br><br>These results suggested that the Facility's system for ensuring that the MOSES and DISCUS were performed as required for individuals who received psychotropic medication was functioning with a 90% (MOSES) to 97% (DISCUS) successful completion | |

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| | | rate. However, the mechanisms to ensure that the prescribing providers reviewed the results of these important clinical assessments, which members of the nursing staff performed, needed improvement, as well as systemic changes. The corresponding mechanism for assessing for 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 can be improved, so that the completion rates for the MOSES and DISCUS for individuals who received Reglan are comparable to those obtained for the population of individuals who receive traditional antipsychotic agents. The issue of the prescribing provider's timely review of these documents will also require attention. | |
| 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 intellectual disabilities/developmental disabilities (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 had been effective for the disorder for which it was prescribed.<br><br>The records of 31 individuals who were prescribed psychotropic medication were reviewed. The specific sections of these individuals' records that were requested are identified above in the section that lists documents reviewed.<br><br>A description of the specific symptoms, which supported and documented the identified diagnosis of the individuals' psychiatric disorder could be identified in 16 (52%) of the 31 records, including the following individuals: Individual #163, Individual #274, Individual #133, Individual #87, Individual #95, Individual #135, Individual #107, Individual #121, Individual #313, Individual #323, Individual #231, Individual #510, Individual #74, Individual #235, Individual #348, and Individual #228. These findings represent a slight improvement, as compared to the 46 percent completion rate that was identified in the prior report. However, the degree of improvement in the documentation was greater than that implied by the positive change in the percentage rates. As noted in the prior report, this information, when present, was often not available in an organized fashion. Therefore, the Monitoring Team member would have to search in disparate sections of the records to identify the symptoms that would support the psychiatric diagnosis. During the current review, that information was readily located in the Bio-Psycho-Social-Spiritual formulations of the newer CPEs, which complied with the formatting and content specifications of the Settlement Agreement and/or in the Comments sections of the Quarterly Psychiatric Reviews (this also is discussed with regard to Section J.2). | Noncompliance |

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| | | A related issue that was identified in the prior reviews was the lack of documentation that would link the monitored target behavior to the identified symptoms of the psychiatric disorder. The primary behaviors that were monitored to assess the efficacy of psychotropic medication were aggression, self-injurious behavior, and agitation. The documentation in the records that provided the linkage between the psychiatric diagnosis and the target behaviors was identified in 10 of the 31 records reviewed (32%). The individual records that contained this information were those of: Individual #133, Individual #87, Individual #95, Individual #107, Individual #121, Individual #313, Individual #323, Individual #231, Individual #510, and Individual #74.<br><br>At the time of the prior review, the Monitoring Team indicated that a potential remedy for this issue would be to clearly state in the diagnostic section of the CPEs how the symptoms of the diagnosis produced and/or contributed to the monitored target behaviors of the psychotropic medications in those cases where the identified target behavior was not clearly a specific symptom of the diagnosis. This issue was discussed with the full-time Psychiatrist during the prior onsite review, who indicated that an attempt would be made to distinguish between the "symptoms" of a disorder, as opposed to the "behaviors" that were related to the diagnosis. In the current review, in some of the CPEs that met the requirements of the Settlement Agreement, this documentation was located within the discussion of the relationship between the individuals' psychiatric diagnosis and the monitored target behaviors of the psychotropic medication. However, a comparison of the list of individuals whose records contained this information to the list of those who had CPEs that met the Settlement Agreement standards showed that not all of the CPEs contained this specific information. The reason for this was that an individual CPE could meet the formatting and content specifications of the Settlement Agreement without containing a detailed discussion of this factor, which could appear elsewhere in the individual's psychiatric documentation. The Monitoring Team's prior reports had suggested that the individual's CPE was a logical document within which to discuss this item.<br><br>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. 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 | |

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| | | 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 behavioral-environmental factors. In those cases, the Personal Support Team should reconsider the appropriateness of the continued use of those medications.<br><br>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 12 of the 31 records (39%), including: Individual #133 Individual #87, Individual #95, Individual #107, Individual #121, Individual #313, Individual #323, Individual #231, Individual #510, Individual #74, Individual #51, and Individual #228. These results indicated a noticeable established improvement over the comparable rate of 19% that was identified at the time of the prior review. This improvement was due to either a discussion of this specific subject in the newer CPEs, and/or the completion of the recently established section in the Psychiatric Review forms entitled: "Target Symptoms of Medication(s) (Explain why these may overlap with target behaviors of PBSP.)" This section was not uniformly completed in the psychiatric review notes. Ensuring that this section is routinely and accurately completed in each Quarterly Review would have a significant positive impact on the Facility's compliance rate with this important factor.<br><br>As noted above, another important aspect of this provision relates to the effectiveness of the psychotropic medication. At the time of the prior review, data that confirmed the efficacy of the psychotropic medication could only be identified in three of the 37 individual records reviewed (8%). The current review found that there was sufficient information to document the efficacy of the prescribed psychotropic medications in the records of 11 of the 31 individual records reviewed (35%). Specifically, the records of Individual #133, Individual #87, Individual #95, Individual #121, Individual #313, Individual #231, Individual #510, Individual #103, Individual #315, Individual #544, and Individual #376 contained sufficient data to conclude that the prescribed medications were effective.<br><br>This improvement was connected to the following three inter-related factors: 1) the inclusion of more discussion of this information in the revised CPEs; 2) the incorporation of more historical information regarding the frequency of the target behaviors in the ongoing Psychiatric Clinic Notes; and 3) the attempts to challenge psychotropic medications as part of the Facility's efforts to decrease polypharmacy. For example, two of the individuals reviewed (Individual #315 and Individual #376) had undergone recent challenges of their psychotropic medication, which resulted in a deterioration of their psychiatric status that, subsequently, were re-stabilized after the restoration of these medications. This type of evidence establishes the efficacy of the specific medication | |

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| | | involved. However, there is the risk that this important information could be lost over time through the purging of records. This potential problem was discussed during the onsite review with both the Staff Psychiatrist and the Pharm. D. The Pharm. D. indicated that she intended to carry this information forward on a continual basis in her Quarterly Reviews of the individuals' medications. It is recommended that the Psychiatry Department also develop a parallel mechanism to maintain this valuable information on a continual basis in the individuals' Psychiatric Clinic Notes and in the individuals' CPEs.<br><br>Although steady progress was being made with each of the components of this provision, the Facility's compliance rates remained low. In order to attain compliance, the Facility is encouraged to continue to implement the new procedures. | |
| 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 active record that contained the Informed Consents related to the use of psychotropic medications was reviewed for the sample of 31 individuals. This review indicated that signed consents could be identified for all but one of the individuals receiving psychotropic medication, with the exception of Individual #121, for a completion rate of 97%. This individual was newly admitted to ABSSLC. The Rights assessment described this individual's guardian status as "Adult - No Guardian (guardianship never established)." Therefore, the Facility Director or her designee would have signed the consent forms. The individuals' Legally Authorized Representative (LAR) had signed consent documentation for 13 of the 31 individuals (42%). The Facility Director or her designee had signed the Informed Consent forms for the remaining individuals, who did not have a LAR.<br><br>Based on this sample, signed consents were routinely being obtained for individuals residing at ABSSLC who were prescribed psychotropic medication. However, the risk versus benefits discussions referred to above with regard to Section J.10, generally 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.<br><br>The Facility was actively addressing these deficits through a number of initiatives. As noted in the discussion related to Sections J.2 and J.10, the Psychiatrist had added expanded risk-benefit discussions to the new CPEs. Additional material related to risk versus benefit considerations also had been added to the Quarterly Psychiatry Review Notes. The plan to separate the Treatment Plan for the individuals' psychotropic medications from their PBSPs also would result in the Human Rights Committee reviewing the Psychotropic Medication Treatment Plan separately from the PBSP. Although this would likely require additional training for the HRC, this should provide a greater focus on the specifics of the risks versus benefits of the psychotropic medications. This matter was independently discussed with the Staff Psychiatrist, | Noncompliance |

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| | | Director of Behavioral Services, and the Human Rights Officer during the onsite review, and they all shared this opinion.<br><br>An additional improvement that ABSSLC should implement to ensure that the Informed Consents for psychotropic medications are truly "informed" would consist of providing more specific side effect information that would indicate the actual percentage of the individual side effects that have been experienced by those receiving the specific medication, as based on large population studies. | |
| 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. At the time of the prior review, the Facility recently had implemented a mechanism to document the results of the most recent neurological consultation. At the time of that review, this documentation could be identified in only five of the 15 (33%) records of individuals who the Neurologist had seen in consultation during the prior year.<br><br>Within the sample of 31 records reviewed as part of the present review, a Neurology Consultation within the last year was identified in the records of 19 individuals. The Neurology Notes listed the psychotropic medications that the individual was receiving, as well as the anticonvulsant medications, and discussed any recent changes in their psychotropic medications in 18 of these 19 records (95%). The psychiatric section of these 19 records was reviewed to ascertain if there was a reference to the occurrence and content of relevant Neurological Consultations. This information was identified in the Psychiatric Quarterly Progress Notes of 18 of the 19 records (95%). The only record that was missing both the relevant neurological and psychiatric documentation was that of Individual #107. As noted in the discussion related to Section J.2, the record of Individual #107 did not contain the Psychiatric Clinic Notes, and this is where the reference to the prior Neurology Consultation appeared. Thus, the Psychiatry Department had made considerable progress in this regard. The new Staff Psychiatrist also stated that he intended to attend the bi-weekly Neurology Clinics that occurred on alternate Mondays between 3:00 p.m. and 6:00 p.m. A member of the Monitoring Team attended this Clinic on 8/22/11. The individual clinical discussions between the Consulting Neurologist, the PCP, and the Psychiatrist were detailed and clinically relevant.<br><br>At the time of the next review, it should be possible to ascertain if the Staff Psychiatrist had been able to continue to attend the Neurology Clinics on a regular basis. It also will be important to document the Psychiatrists' attendance, and provide a brief overview of | Noncompliance |

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| | | the issues discussed. The most logical place to document this would appear to be in the section of the Quarterly Psychiatric Notes that refers to the most recent Neurological Consult. In light of the increasing demands on the Staff Psychiatrist's time, the Facility might also want to consider the possibility of coordinating the Neurological Reviews of the individuals who are followed by both Psychiatry and Neurology so that their appointments are scheduled consecutively, rather than being dispersed throughout the three-hour duration of the Neurology Clinic. | |

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

1. The Facility should complete CPEs that conform to the formatting and content requirements of the Settlement Agreement for each individual prescribed psychotropic medication. (Section J.2)
2. The Psychiatry Department should develop a mechanism to ensure that an individual who cannot be observed at the time of their Quarterly Psychiatry Review is seen at another time in close proximity to that Quarterly Review. This subsequent observation should then be documented as an Addendum to the corresponding Quarterly Review. (Section J.2)
3. The documentation contained in the Chemical Restraint forms that involve the intramuscular injection of a psychotropic medication during crisis situations should be fully completed, and should include a description of the events that led up to and/or provoked the behavior that resulted in the chemical restraint. (Section J.3)
4. The Facility should develop a process for monitoring individuals who receive pre-treatment sedation, but do not remain at the dental/medical office, such as notifying nursing and residential/day services staff of their departure from the Dental Office. Documentation should be maintained to verify what monitoring occurred and the results. (Section J.4)
5. In assessing the goals for determining the success of the individual Desensitization Plans, the Facility should consider differentiating between the individual's ability to participate with dental hygiene as a separate objective from more intrusive dental procedures, and/or procedures for which the general population typically would request sedation. (Section J.4)
6. The Facility should increase the development and implementation of programs and procedures that will decrease the reliance on psychotropic medication for pre-treatment sedation of individuals for medical and dental procedures. (Section J.4)
7. ABSSLC should continue its efforts to recruit additional Board Certified Psychiatrists who have experience working with individuals with intellectual and developmental disabilities. (Sections J.5, and J.1)
8. For individuals for whom adequate CPEs have not yet been completed, the Facility should include an extensive discussion of the individual's differential psychiatric diagnosis in the CPE. This discussion should also include a thorough justification for the individual's primary psychiatric diagnosis. (Section J.6, and J.2)
9. The symptoms that support the individual's primary psychiatric diagnosis also should be listed in the Quarterly Psychiatric Review Notes. (Sections J.6, and J.2)
10. Those individuals whose Reiss Screening score is above the clinical cut-off score should be referred for a CPE that meets the formatting and content requirements of the Settlement Agreement. (Section J.7)
11. The plans to separate the Positive Behavioral Support Plan from the Treatment Plan for the Psychotropic Medications should be done in a manner that ensures that the individual documents continue to reflect the degree of integration that is required by the Settlement Agreement. (Section J.8)
12. The initiative to delineate the behaviors that are the focus of the BSP from the symptoms of the psychiatric disorder should be a priority. This should include a discussion of this issue in the CPE, as well as in the Psychiatric Review Notes. (Section J.8)

13. As additional CPEs are completed using the new format, the discussions of whether the prescribed psychotropic medication represents the least intrusive approach to the individual's problematic behavior should be included. (Section J.9)
14. The discussions of whether or not the use of psychotropic medication represented the least intrusive approach to the individual's maladaptive behaviors should be expanded to include the broader Interdisciplinary Team. These discussions should be documented clearly, including the team's deliberations. (Section J.9)
15. The discussion of the risks versus benefits of the prescribed psychotropic medication should be thoroughly addressed in the revised CPEs, and also commented on in the Quarterly Psychiatric Review Notes. (Section J.10)
16. As attempts to challenge the psychotropic medications of individuals when the benefits of those medications are not clearly apparent occur and show that symptoms are exacerbated as medications decrease, these findings should be documented in the individual's permanent record, and/or carried forward in Quarterly Psychiatric Review Notes to provide justification that the benefits outweigh the risks. (Section J.10)
17. The Psychiatry Department should develop a simple method to track the number of individuals who are receiving two or more psychotropic medications from the same class, as well as the number of individuals that are receiving three or more psychotropic medications. This information should be collected at each individual's Quarterly Review, and, subsequently, aggregated into a Facility-wide database. (Section J.11)
18. The Facility should consider tracking the polypharmacy related to those individuals who are admitted from the Facility in a separate database for the first year. (Section J.11)
19. The Facility should develop and implement systems to ensure that the MOSES and DISCUS side effect assessments, which members of the nursing staff complete, are reviewed and signed by the prescribing provider in a timely manner. (Section J.12)
20. The monitoring system for the MOSES and DISCUS of individuals receiving Reglan should be improved to increase completion rates. (Section J.12)
21. The prescribing provider should review the MOSES and DISCUS evaluations for individuals who are prescribed Reglan in a timely manner. (Section J.12)
22. The inclusion of information that would explain how the identified target behaviors of the individuals' psychotropic medications are related to their psychiatric diagnosis should be included in the individual's CPEs and also be documented in the Quarterly Psychiatric Reviews. (Section J.13)
23. The discussion of the differentiation of behaviors that are identified as targets of the prescribed medication and are also described as being present on a learned basis should be addressed in the revised CPEs. (Section J.13)
24. The Monthly Psychiatric Review forms contain a section entitled "Target Symptoms of Medication(s). (Explain why these may overlap with target behaviors of PBSP)." This section should be completed for all of those individuals receiving psychotropic medication. In those cases where this is not applicable (i.e., there is no overlap), this should be stated clearly. (Section J.13)
25. The incorporation of longitudinal historical data into the Quarterly Review documents should be expanded. (Sections J.13, and J.11)
26. The discussion of the efficacy of the currently prescribed medications should be included in the revised CPEs as they are completed for the remaining Individuals who are receiving psychotropic medication who have not yet had the benefit of such a thorough evaluation. (Sections J.13, and J.11)
27. Individuals for whom the challenge of a specific medication has provided valuable information concerning its efficacy should have this information carried forward on a continual basis in the Psychiatric Review Notes. (Section J.13)
28. The discussions of the risks versus benefits of prescribed psychotropic medications that appeared in the revised CPEs should be expanded to include more specific documentation regarding the degree to which the clinical benefits of the medication outweighed both the perceived and potential side effects of the medication. (Section J.14)
29. The side effect information that is provided to those who are giving consent for an individual's psychotropic medication should include more detailed information about the actual probability of those side effects occurring, based on the published literature. (Section J.14)
30. The Psychiatrist should attend the Neurological Reviews for those individuals that are followed jointly by Psychiatry and Neurology. (Section

J.15)

31. The attendance of the Psychiatrist at the individual's Neurological Review should be documented in the next Quarterly Psychiatric Review for that individual. (Section J.15)
32. With regard to the Facility's self-assessment, the Facility should use data from internal audits, as well as other data sources to justify its findings of substantial compliance or noncompliance. It also should use the data to identify and address areas in need of improvement, and develop and implement corrective actions plans, as appropriate. (Facility Self-Assessment)

| SECTION K: Psychological Care and Services | |
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| 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:<br>▪ **Review of Following Documents**:<br>o Section K Presentation Book, including Plan of Improvement, dated 8/12/11, Settlement Agreement Monitoring Tool, and supporting evidence;<br>o DADS Psychological and Behavioral Services Policy #008, dated 11/13/09;<br>o Vita, Ron Manns, M.S., BCBA, Director of Behavioral Services;<br>o List of psychology staff members, including information regarding completion of coursework in Applied Behavior Analysis;<br>o Minutes from meetings of Psychology Department, dated 4/13/11, 5/19/11, and 6/23/11;<br>o Minutes from meetings of the Human Rights Committee (HRC) held weekly between 2/15/11 and 7/5/11;<br>o Risk Level Rating of Medium and Risk Level Rating of High: list of individuals, dated 8/24/11;<br>o Behavior Support Committee (BSC) minutes;<br>o List of standing members of the Behavior Support Committee;<br>o Psychology procedure: Behavior Services Peer Review;<br>o External Peer Review reports following visits on 3/14/11 to 3/18/11, 4/13/11 to 4/15/11, 5/16/11 to 5/25/11, and 8/8/11 to 8/12/11, and one undated report;<br>o Scatterplot Data Sheets and Behavior Observation Notes for: Individual #25, Individual #108, Individual #201, Individual #3, Individual #215, Individual #160, Individual #397, and Individual #384;<br>o Sleep Data Sheet for: Individual #504;<br>o Description of Residence 6350 and Residence 6380 Integrity Pilot, Revised Integrity/Reliability (I/R) Probe, ABSSLC PBSP Monitoring Forms, and Instructions for PBSP I/R Monitoring;<br>o Psychology Monthly Progress Notes for: Individual #387, Individual #424, Individual #207, Individual #61, Individual #300, Individual #478, Individual #228, Individual #108, Individual #526, Individual #425, Individual #187, Individual #398, Individual #533, Individual #109, Individual #405, Individual #287, Individual #132, and Individual #376;<br>o Behavioral Assessment for: Individual #387, Individual #424, Individual #517, Individual #61, Individual #319, Individual #534, Individual #216, Individual #300, Individual #526, Individual #127, Individual #187, Individual #533, Individual #323 (draft), Individual #287, Individual #160, Individual #510, Individual #376 (short form), and Individual #246;<br>o Behavior Assessment for newly admitted individuals: Individual #95, Individual #131, and Individual #133;<br>o Outline for development of behavior supports;<br>o Template for abbreviated functional assessment; |

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| | ○ Functional Assessment Rating Scale;<br>○ Personal Support Plans for: Individual #207, Individual #505, Individual #545, Individual #526, Individual #425, Individual #187, Individual #323, Individual #469, and Individual #205;<br>○ List of individuals receiving counseling;<br>○ Individual Treatment Plan (counseling) for: Individual #163, Individual #517, Individual #319, Individual #48, Individual #231, and Individual #149;<br>○ Psychotherapy Progress Notes for: Individual #81, Individual #323, Individual #160, and Individual #106;<br>○ Treatment Plan: Group Therapy – Anger Management;<br>○ Treatment Plan: Group Therapy – Anxiety Management;<br>○ List of Individuals with Behavior Support Plans, updated 7/11;<br>○ Behavioral Assessment, BSP, PSP, BSC, HRC, Consent, In-service tracking template;<br>○ Behavior Support Plans (BSPs) for: Individual #87, Individual #387, Individual #267, Individual #163, Individual #207, Individual #123, Individual #517, Individual #61, Individual #43, Individual #319, Individual #74, Individual #534, Individual #95, Individual #216, Individual #228, Individual #530, Individual #108, Individual #303, Individual #505, Individual #545, Individual #48, Individual #526, Individual #425, Individual #313, Individual #231, Individual #533, Individual #332, Individual #444, Individual #323, Individual #160, Individual #245, Individual #132, Individual #376, and Individual #246;<br>○ Behavior Protocol for: Individual #107; and<br>○ Core Competencies for Positive Behavior Supports: Participant' Guide.<br>▪ **Interviews with**:<br>○ Psychology Department Staff, including Associate Psychologists Joseph Abeyta, Vic Aguero, Samantha Brooks, Shana Carroll, Melissa Castillo, Stacy Dow, Stacia Ellison, Jason Fry, Jenni Jamison, Kathryn Jones, Erin Lomasney, Connie Moss, Tiffany Neely, Julia Smith, Michael Smith, Adam St. Cyr, Sarah St. Cyr, and Barbara Strelow, on 8/22/11;<br>○ Ron Manns, M.S., BCBA, Director of Behavioral Services, and Jason Fry, Associate Psychologist, on 8/23/11;<br>○ Personal Support Team Members for Individual #323, on 8/24/11; and<br>○ Personal Support Team Members for Individual #498, on 8/25/11.<br>▪ **Observations of**:<br>○ 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;<br>○ Activity Center 5921, Activity Center 5922, Activity Center 5923, Activity Center 6340, and Activity Center 6700;<br>○ Workshop 657, Workshop 662, and Workshop 680;<br>○ Facility Incident Report Team, on 8/22/11; |

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| | o Unit II Daily Incident Monitoring Meeting, on 8/23/11;<br>o Personal Support Plan Meeting for Individual #146, on 8/23/11;<br>o Behavior Support Committee, on 8/24/11;<br>o Restraint Reduction Committee, on 8/25/11; and<br>o Quarterly Review Team Meeting for Individual #231, on 8/25/11. |
| | **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 was related to Section K.2, which requires the Facility to have a qualified director of psychology. This was consistent with the Monitoring Team's findings. Mr. Manns held an advanced degree in psychology, with an emphasis on Applied Behavior Analysis. He was also a Board Certified Behavior Analyst (BCBA) with many years of experience working with individuals with disabilities.<br><br>Progress towards compliance was noted in several other areas. The following provide examples of information included in the Facility's self-assessment, including in its description of the action plans it had implemented, that was consistent with the Monitoring Team's findings:<br>▪ Monthly review of progress on behavior support plans continued. Guidelines were developed that included directions to propose recommendations when a lack of progress was observed for three consecutive months.<br>▪ Behavioral assessments had been revised to include a description of observed adaptive behaviors, staff input regarding behavioral function, and review of observations in the individual's environment. Efforts had been made to complete assessments for those individuals who had a behavior support plan. Summary information was provided regarding behavioral function, setting events, and antecedent management, including preventative strategies and replacement behavior. A revised template had been developed to streamline and improve this process.<br>▪ Therapeutic support, in the form of on-campus group counseling, had been expanded to include training in anger management, social skills, and community readiness.<br>▪ Improvements in the oversight of behavior support plans had been evidenced through the work of both the Behavior Support Committee and external peer review. Staff were provided constructive feedback in improving and revising the content of these plans.<br>▪ Steps had been taken to provide competency-based training to staff regarding behavior support plan implementation.<br><br>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. One completed self-monitoring form was provided. However, without accompanying documentation, it was difficult to assess the accuracy of the report and inter-rater reliability. Compliance scores provided in the Plan for Improvement suggested an overall score, which did not assist in identifying specific areas that required additional attention and |

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| | corresponding action plans. 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:** Although the Facility had not been able to hire new staff who were Board Certified Behavior Analysts, the staff already employed within the department continued to make good progress towards certification. At the time of the visit, fifteen of 19 Associate Psychologists (79%) were scheduled to begin or continue coursework in pursuit of certification. A new BCBA Director of Behavioral Services, who met the requirements of the Settlement Agreement, was providing ongoing supervision as required for certification.<br><br>Both internal and external peer review continued. A review of minutes from the Behavior Support Committee and observation of this meeting during the visit indicated that the focus of the committee had shifted from review of medications to thoughtful feedback and recommendation regarding the content of behavioral assessments and resulting behavior support plans. Consulting BCBA professionals continued to make regularly scheduled visits to the Facility, during which time they worked directly with staff and the individuals served. Exit reports reflected very specific recommendations to apply throughout the home environment or with identified individuals.<br>Data collection remained problematic. Observations conducted during the review with follow-up review of data suggested that reported measures of problem behavior were neither accurate nor reliable. Confidence in the recorded data was lacking, yet important clinical decisions were made based on these measures. Again, professional staff should work closely with direct support professionals to ensure manageable and accurate data collection systems.<br><br>Functional behavior assessment remained a focus for the psychology staff. Staff had worked to complete these assessments for those individuals who had behavior support plans to ensure that the function of the behavior was identified, leading to teaching of more appropriate replacement behaviors and more effective treatment strategies. Revisions to the assessment process and resulting report are recommended.<br><br>Timely completion of comprehensive psychological evaluations had not been addressed. Only half of the individuals newly admitted to the Facility in the last six months had a current assessment. Formal assessment of cognitive abilities and adaptive behavior was often quite dated. The State and the Facility should develop specific guidelines for completion of psychological evaluations that will meet the requirements of the Settlement Agreement.<br><br>Therapeutic services provided to individuals, either in the form of a behavior support plan and/or counseling, remained an area in need of improvement. Programs should be comprehensive in scope, and staff should be effectively trained and supervised in implementing or supporting any treatment protocol. The Facility had made efforts to introduce competency-based training. Timely consent for new or revised treatment plans also remained a challenge. |

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| K1 | Commencing within six months of the Effective Date hereof and with full implementation in three years, each Facility shall provide individuals requiring a PBSP with individualized services and comprehensive programs developed by professionals who have a Master's degree and who are demonstrably competent in applied behavior analysis to promote the growth, development, and independence of all individuals, to minimize regression and loss of skills, and to ensure reasonable safety, security, and freedom from undue use of restraint. | As of April 1, 2011, Ron Manns M.S., BCBA, was serving as the Director of Behavioral Services (information regarding Mr. Manns' qualifications is discussed with regard to Section K.2). Although active recruitment of Board Certified Behavior Analysts had been ongoing, hiring of new credentialed staff had been unsuccessful. Importantly, however, the staff already employed within the department continued to make good progress towards certification. Through the summer 2011 semester, 15 of 19 Associate Psychologists (79%) had completed at least one course in Applied Behavior Analysis offered through the University of North Texas. Specifically, one staff member had completed four courses, eight had completed three courses, four had completed two courses, and two had completed their initial course. At the time of the visit, 15 of 19 Associate Psychologists (79%) were scheduled to begin or continue coursework in pursuit of certification. Mr. Manns provided the required supervision to those enrolled. One Associate Psychologist reportedly was not going to pursue further board certification. This Licensed Professional Counselor had been reassigned to provide individual and group counseling services to identified individuals. The State and Facility are commended for their ongoing support of staff who were pursuing certification as behavior analysts. Mr. Manns remained the only Board Certified Behavior Analyst at the time of the visit.<br><br>This provision item was rated as being in noncompliance, because the Associate Psychologists 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. | Noncompliance |
| K2 | Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall maintain a qualified director of psychology who is responsible for maintaining a consistent level of psychological care throughout the Facility. | In April of 2011, Ron Manns, M.S., BCBA, was promoted to Director of Behavioral Services following the retirement of Catherine Hennington. Mr. Manns earned a master's degree in psychology with an emphasis on Applied Behavior Analysis. He was a Board Certified Behavior Analyst. Since 1979, Mr. Manns had held a variety of clinical and/or administrative positions related to the field of developmental disabilities. He met the qualifications for the position of director as outlined in the Settlement Agreement. | 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 via its weekly meetings. Membership included the Director of Behavioral Services, Associate Psychologists (levels V and III), the Director of Speech and Language Services (or her alternate), and representatives of medical or nursing disciplines (including a QA nurse, a unit nurse manager, or the Pharmacy Director). Minutes of meetings held between 3/30/11 and 8/10/11 were reviewed. Feedback was provided to staff on behavioral assessments, behavior support plans, and safety plans. Unlike previous meetings, it was | Noncompliance |

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| | | clear that medications were no longer the focus of the review. Rather, staff were receiving thoughtful feedback and recommendations regarding the content of their assessments and plans. This included efforts to more clearly analyze the function of identified problem behaviors, identify replacement behaviors that were functionally equivalent, address expanded preventative and antecedent management strategies, and provide clearer directions to staff. Observation of the meeting held during the week of the onsite review reflected committee members' active participation with discussion focused on improvement to the assessment process and resulting supports offered to the target individual.<br><br>The BCBA level practitioners hired as external consultants continued to provide regularly scheduled visits and feedback to the Facility. Reports provided to the Monitoring Team reflected visits in March, April, May, and August of this year. One additional undated report also was provided. Each report provided a summary of recommendations that addressed general home considerations and more individual-specific strategies. Recommendations were comprehensive and clearly outlined. Specific areas addressed included: reinforcement protocols, active treatment strategies, plans for ensuring treatment integrity, a task analysis of competency-based training that focused on role play or verbal report, a plan for tracking inter-observer agreement, and feedback on data collection. Overall, these reports provided an excellent source of information for the psychology staff at ABSSLC.<br><br>The Associate Psychologist assigned to the individual or residence should participate in all training and other feedback opportunities that the BCBA consultants provide. This should provide appropriate clinical oversight and help to ensure that programs are implemented with a degree of integrity. Ongoing support and training should be provided to psychology assistants and direct support professionals, with regularly scheduled analysis of objective data to determine program efficacy or lack thereof. As questions or problems arise, these can be reviewed internally with colleagues or communicated to the consulting professionals.<br><br>The Facility clearly had established a peer-based review system for all behavior support plans. The Behavior Support Committee, chaired by the Director of Behavioral Services, provided internal peer review, and BCBA-level consultants provided regularly scheduled external peer review. The Director of Behavioral Services described plans for expanded internal peer review through the addition of monthly clinical case reviews. One suggestion would be to invite a member of the psychiatry staff to participate in internal peer review of individual cases in which medication is prescribed. Although the State policy refers to peer review, a Facility-specific policy outlining the internal and external peer review processes would result in substantial compliance with the requirements of the Settlement Agreement. | |

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| 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. | Monthly review of progress on identified problem behavior continued. A total of 55 progress notes representing 18 individuals were reviewed. Graphs depicting occurrences of targeted behaviors each month were provided. Listed below each graph was the criteria established for the year. In some cases, this information was out-of-date (e.g., in the April 2011 progress noted for Individual #387, the noted criteria was for March of 2010). This was followed by a summary that included events for the month and a review of progress. The purpose of the listing of events was unclear for a number of reasons:<br>▪ Every occurrence of the targeted behavior was not noted (e.g., Individual #387);<br>▪ A summary statement was provided that did not provide insight into the possible reasons for elevated rates of aggression and self-injury (e.g., Individual #424 "continued to struggle with being aggressive, screaming, and yell all month" – May progress note); and<br>▪ Although some behaviors might have worsened or remained elevated, no significant events were reported (e.g., Individual #207, aggression, self-injury, and sleep disturbance, April report).<br>Medications were listed with changes made in the psychiatry clinic noted. Information regarding staff training utilizing the Positive Behavior Support Monitoring Tool and Reliability Probe was reported. Lastly, recommendations were provided.<br><br>Concerns remained regarding this review of progress, because in no case were changes to the Behavior Support Plan recommended. For example, the three monthly progress notes for Individual #387 reflected worsening behavior in four of five, five of five, and one of three target behaviors, respectively. However, no changes to the behavior support plan were recommended. In fact, in none of the 55 reports reviewed were changes to the individual's behavior support plan recommended. Progress notes for 11 of the 18 individuals (61%) did indicate the need for continued monitoring of appropriate implementation of the plan and ongoing staff training. In some cases, the annual PSP meeting was scheduled to occur, and therefore, an updated BSP had been written. For 10 of the 18 individuals (56%), the progress note included a review of the Behavior Observation Notes to record emerging behaviors. Staff should provide graphic display of targeted behaviors in a manner that will allow analysis of the effects of planned (e.g., changes to the PBSP, changes in medication, etc.), and unplanned changes (e.g., sudden move in home, health problems, etc.). When improvement is not observed, or when there is a worsening in targeted behaviors, changes to the behavior support plan would be advisable. The Director of Behavioral Services had developed a Psychology Procedure (3/17/11) that included guidelines for monthly review of progress. When a lack of behavioral improvement was noted for three consecutive months, the psychologist was expected to make recommendations to address this situation. As this policy is implemented, changes to the monthly progress notes and corresponding treatment plans should be realized. | Noncompliance |

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| | | During the on-site review, the Monitoring Team observed numerous occasions of individuals engaging in problem behavior. When the data sheets and observation notes from the week of the visit were checked for eight of these individuals, clear discrepancies existed between what was observed and what was recorded. Findings are reviewed below:<br>▪ On 8/24/11, Individual #25 was observed lightly slapping her head four times at 10:52 a.m.; there was no scatterplot data and nothing was recorded in the Behavior Observation Notes.<br>▪ Individual #108 was observed screaming and spitting at 5:15 p.m. on 8/24/11; a scatterplot was not provided and nothing was recorded in the Behavior Observation Notes.<br>▪ Individual #201 was observed at 7:40 a.m. on 8/25/11 engaged in self-injurious behavior; there was no data recorded during the first shift of the day, although data was recorded for the second shift; additionally there was nothing recorded in the Behavior Observation Notes. This individual presented with a significant black eye, and staff reported: "he always hits himself."<br>▪ On 8/25/11 at 2:27 p.m., Individual #3 was observed repeatedly striking his chin; nothing was recorded on the scatterplot data sheet and a note was provided indicating that there were no Behavior Observation Notes from 8/20/11 through 8/25/11.<br>▪ Individual #215 was observed engaging in aggressive behavior on 8/22/11 at 11:52 a.m.; this behavior was not recorded.<br>▪ Individual #160 was observed displaying repeated aggression and property destruction on 8/23/11 between 7:40 a.m. and 8:15 a.m. Data was recorded on the scatterplot data sheet and in the Behavior Observation Notes. What was concerning was that the data sheet instructions indicated staff should make only one mark in the appropriate half hour block regardless of the frequency of the behavior. As the graphs for both these behaviors required measures of frequency (as noted in the Behavior Assessment), this will result in an under-reporting of occurrences of these target behaviors.<br>▪ On 8/24/11, Individual #397 was observed biting his hand twice; this information was not recorded.<br>▪ Individual #384 was observed on 8/22/11 and 8/24/11 engaged in self-injurious behavior; no data was recorded for either event either on the scatterplot data sheet or in the Behavior Observation Notes. In fact, the notes for the second shift on 8/22/11 indicated that there was "no target behavior."<br>▪ One other concern was raised when reviewing the sleep data for Individual #504 who was staying home from work while staff gained a better understanding of her sleep patterns. Staff were directed to check every 30 minutes to note whether the individual was awake or asleep. Because the data sheet was | |

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| | | missing information, it was unclear whether the individual was asleep at designated observation times or whether staff had forgotten to complete the check. Direct support professionals should make a record every time the individual is checked.<br><br>The Facility had implemented a pilot project in two residences on campus. The BCBA consultants had trained the Psychology Assistants assigned to these residences to use a monitoring tool designed to collect PLACHECK data, inter-observer agreement measures, information regarding accurate implementation of behavior support plans via either observation (preferred) or interview, and probes of staff knowledge of identified core competencies. This was a comprehensive tool that if implemented as intended should provide a wealth of important information. However, a revision to the PLACHECK section is recommended. Noting the number of individuals engaged for at least one minute during a three minute observation is a cumbersome measure that will require timing the duration of engagement for each individual in the group. It would be advisable to use a true momentary time sample as PLACHECKS were originally designed. Multiple observations could be conducted over a relatively short period of time, allowing for more constructive feedback to staff. As with other onsite training provided by the BCBA consultants, including the Associate Psychologists is recommended.<br><br>As clinical decisions are based upon the data that is collected, it is essential that data be accurate and reliable. As recommended previously, Psychology staff should work closely with direct support professionals to ensure that data collection systems are manageable, and are completed with a degree of integrity. Improved staff training and ongoing assessment of inter-observer agreement will be necessary. The data systems in place at the time of the visit did not accurately reflect an individual's engagement in problem behavior. Therefore the Facility remained out of compliance with this requirement of the Settlement Agreement. | |
| K5 | Commencing within six months of the Effective Date hereof and with full implementation in 18 months, each Facility shall develop and implement standard psychological assessment procedures that allow for the identification of medical, psychiatric, environmental, or other reasons for target behaviors, and of other psychological needs that may require intervention. | Again, it was apparent that a priority had been placed on the completion of functional behavior assessments for individuals with identified problem behaviors. The Facility should be commended for these efforts. The form that the Psychology Department provided to track the scheduling of assessments indicated that 109 assessments were scheduled for completion between 2/1/11 and 7/31/11. Nineteen Behavioral Assessments were reviewed, 18 of which had been completed since 2/1/11. The assessment for Individual #160 was written on 1/31/11. The findings and recommendations provided in the Monitoring Team's last report remained relevant and are repeated here.<br><br>The assessment reports continued to follow the standard format noted in previous Monitoring Team reports. The following summarizes the Monitoring Team's concerns | Noncompliance |

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| | | about the reports:<br>▪ 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 based upon these findings. Although 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. For example, while prenatal and early developmental history might be interesting, this information was not useful in determining the current function of identified problem behavior.<br>▪ An addition to these reports was a brief review of cognitive, adaptive, social, and affective functioning levels. As formalized assessment was not employed to determine these functioning levels, it might be more appropriate to provide a profile of the individual's observed skills across a variety of domains, with particular attention to the individual's ability to communicate.<br>▪ Detailed histories of psychotropic medication were minimally relevant to the individual's current presentation. A simple listing of current medications or identification of psychiatric disorders for which medication was prescribed would be more appropriate.<br>▪ Past variables were also quite lengthy in some cases, offering little information relevant to the individual's current needs. Significant events during the past year were also reviewed. There was no identified standard for rating a particular event as significant, and therefore it appeared that event inclusion was dependent upon staff judgment. Reports could be effectively streamlined resulting in an improved focus on determining behavioral function.<br><br>With regard to the procedures used to gather information, the assessments showed strengths as well as weaknesses. The following summarizes the results of the review of the 19 assessments in this regard:<br>▪ In every report (100%), the assessment included both indirect and direct procedures for gathering information related to behavioral function. Rating scales (Questions About Behavioral Function and/or Functional Assessment Screening Tool), interviews (Functional Assessment Interview Form), and direct observation were the methods employed.<br>▪ When information was provided regarding the assessment activities, many of the plans provided detailed information regarding the feedback staff provided.<br>▪ Greater emphasis should be placed on descriptive assessment (i.e., direct observation), rather than on indirect assessment as provided by rating scales and interview. Nine (47%) of the assessments included a description of what was observed that provided information relevant to developing a hypothesis regarding behavioral function. The other plans either noted that the target behaviors were not observed, provided incomplete descriptions of what was | |

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| | | observed, or provided a summary of a "typical" behavioral episode. 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.<br><br>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. The Director of Behavioral Services planned to introduce a revised format for functional assessment that should result in improved reporting.<br><br>Screening for psychopathology, emotional and behavioral issues continued to be completed either through the psychiatric clinic's completion of a psychiatric assessment, or through the utilization of the Reiss Screen for Maladaptive Behavior to screen for the need of a psychiatric assessment. The Reiss screenings continued to be utilized to examine individuals who were not receiving psychiatric services. The Facility's compliance with the implementation of the Reiss screening process is discussed above with regard to Section J.7 of the Settlement Agreement.<br><br>As noted with regard to Section K.6, in a sample of 27 individuals, the most recent full psychological evaluation was often quite dated. In only three of the 27 cases (26%) was the evaluation less than 10 years old. As has been recommended previously, more frequent assessment of an individual's cognitive abilities and adaptive behavior is necessary.<br><br>The Facility remained out of compliance with this provision due to issues related to the quality of behavior assessments, the timely completion of updated psychological evaluations, as well as issues related to the Reiss screening process as discussed with regard to Section J.7. | |
| K6 | Commencing within six months of the Effective Date hereof and with full implementation in one year, | Information regarding the date of an individual's most recent full psychological evaluation was found in two documents including the Personal Support Plan (PSP) or Behavior Assessment (BA). In the documents reviewed, this information was found for | Noncompliance |

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| | each Facility shall ensure that psychological assessments are based on current, accurate, and complete clinical and behavioral data. | 27 individuals. The table below indicates the individual, the document in which the date of the evaluation was located, and the date of the evaluation. | |

| Individual | PSP or BA (date) | Date of Evaluation |
|---|---|---|
| Individual #387 | BA (2/23/11) | 6/28/05 |
| Individual #424 | BA (5/25/11) | 8/19/93 |
| Individual #207 | PSP (9/13/10) | 6/18/99 |
| Individual #517 | BA (3/18/01) | 7/21/98 |
| Individual #61 | BA (4/8/11) | 9/16/85 |
| Individual #319 | BA (7/1/11) | 3/7/06 |
| Individual #534 | BA (5/20/11) | 8/31/89 |
| Individual #95 | BA (6/7/11) | 3/22/11 |
| Individual #216 | BA (7/7/11) | 12/18/89 |
| Individual #300 | BA (4/4/11) | 7/23/89 |
| Individual #505 | PSP (11/18/10) | 10/1/91 |
| Individual #545 | PSP (2/10/11) | 4/23/93 |
| Individual #526 | PSP (3/16/11) and BA (3/1/11) | 5/2/96 and 11/21/01 |
| Individual #425 | PSP (10/7/10) | 9/24/91 |
| Individual #127 | BA (3/7/11) | 4/11/88 |
| Individual #187 | PSP (4/28/11) and BA (3/28/11) | 12/11/87 |
| Individual #533 | BA (5/9/11) | 9/29/89 |
| Individual #323 | PSP (8/19/10) and BA (8/11/11) | 2/6/02 |
| Individual #287 | BA (3/3/11) | 11/3/89 |
| Individual #160 | BA (1/31/11) | 4/1/09 |
| Individual #469 | PSP (5/19/11) | 11/23/87 |
| Individual #131 | BA (4/18/11) | 6/3/81 |
| Individual #205 | PSP (2/17/11) | 9/18/89 |
| Individual #133 | BA (4/14/11) | 11/8/90 |
| Individual #510 | BA (6/21/11) | 6/10/02 |
| Individual #376 | BA (2/11/11) | 7/7/88 |
| Individual #246 | BA (6/12/11) | 11/15/90 |

The following statement or something similar was included in either the PSP or BA for 11 individuals: "Based upon behavioral observations and records, there do not appear to be any clinically significant changes in these functional levels since his/her last evaluation." As these evaluations included measures of cognitive ability and adaptive behavior skills

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| | | for these 11 individuals, this suggested that efforts at training and habilitation had been ineffective for a time period of eight to 29 years. For the remaining 16 individuals in the sample, evaluations were between two months and 22 years old.<br><br>On average for this sample of individuals, full psychological evaluations had been completed 15.97 years before the date of the PSP or BA. This did not provide current information regarding the individual's cognitive abilities or adaptive behavior. Psychological evaluations should be updated on a regular basis, with particular attention paid to school-aged individuals whose re-evaluations are required every three years (e.g., Individual #387 was overdue for an evaluation). Problems with data collection are reviewed in detail with regard to Section K.4. | |
| K7 | Within eighteen months of the Effective Date hereof or one month 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. | Six individuals newly admitted to the Facility in the past six months remained in residence at the time of the visit. A request was made for the initial psychological assessment completed for each of these individuals. Three of six assessments (50%) were provided (Individual #95, Individual #131, and Individual #133). The Facility indicated that no assessment was available for Individual #107, Individual #121, and Individual #125. Each of the completed assessments followed a standard format: a) reason for referral; b) review of diagnosis and functioning levels; c) date of last full psychological evaluation; d) background information, including brief statements regarding the individual's cognitive abilities, social functioning, adaptive behavior, and affective presentation; e) review of past behavioral support and psychiatric treatment; f) functional behavior assessment procedures; g) challenging behavior; h) significant events; and i) assessment results and conclusions.<br><br>The report for Individual #95 provided a good review of the observations that the Associate Psychologist conducted, and were considered when developing a hypothesis regarding the function of the target behaviors. This was not true in the reports for Individual #131 and Individual #133, which drew conclusions regarding behavioral function largely from rating scales and staff interview. This is less reliable information, particularly as the staff had worked with the individuals for a relatively short period of time. Although all three reports were completed within one month of the individual's admission to the Facility, it was concerning that in these last two reports, the date of the report preceded the dates of the completion of the assessment activities. In the case of Individual #133, the report was dated within 30 days of admission, but at least one rating scale and one interview had been completed after this period of time. Other concerns related to the content of these assessments can be found in the discussion related to Section K.5.<br><br>As noted with regard to Section K.6, in a sample of 27 individuals, the most recent full psychological evaluation was often quite dated. In only three of the 27 cases (26%) was | Noncompliance |

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| | | the evaluation less than 10 years old. As has been recommended previously, more frequent assessment of an individual's cognitive abilities and adaptive behavior is necessary. The Facility should conduct psychological evaluations at a minimum of once every five years. Measures of adaptive behavior are recommended annually. | |
| 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 22 individuals were scheduled to receive counseling. One Associate Psychologist, and two therapists not employed by the Facility provided these therapy sessions. Three individuals were receiving individual therapy in the community, and were participating in group sessions offered on campus. It was unclear whether there was coordination of counseling activities between therapists. If not, this would be advisable.<br><br>Individual treatment plans were provided for six individuals. Psychotherapy progress notes were provided for an additional four individuals. The following summarizes the results of this review:<br>▪ As noted in the last report, although 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.<br>▪ None of the documentation (0%) included failure criteria that would trigger a review or revision.<br>▪ Further, there were no measurable goals to ensure generalization of the skills learned in therapy to other environments (0%).<br>▪ Some individual treatment plans suggested tasks to be completed outside of therapy sessions. For example, Individual #231 was expected to chart one future plan daily, Individual #517 was to sustain his attention and concentration for longer periods of time, and Individual #48 was expected to express his anger appropriately. Similarly, the treatment plan outlines for anger and anxiety management noted homework activities, including mood monitoring, deep breathing, and muscle relaxation. No information was provided regarding the staff member responsible for monitoring these activities or the degree to which he/she had been trained.<br><br>The Facility is commended for offering counseling to individuals identified as requiring it, and for expanding the range of counseling services provided. It will be important to ensure that treatment goals are stated in objective and measurable terms to allow for clearer assessment of progress. Objective measures also will allow for a better analysis of treatment failure, ensuring timely revision to plans as necessary. It also will be important to ensure that skills learned in therapy are generalized so that they are effectively employed with other individuals and in other environments. Lastly, those individuals responsible for supporting treatment plans outside of the therapeutic setting should be trained and supervised. | Noncompliance |

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| 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 34 individuals and a Behavior Protocol for one individual, representing 14% of the 242 individuals identified with plans, were reviewed. The format was consistent across all plans and remained as described in the last report. Review of these plans resulted in similar findings as were reported previously. Therefore each section will be addressed briefly below.<br>▪ Dates of implementation were provided in 28 of the 35 plans (80%). While this was an improvement from the previous review, the date of development or implementation is essential to allow staff to discriminate current from outdated plans and to provide a historical record of interventions, both successes and failures. Two plans appeared to be outdated: Individual #267 had a plan dated 6/16/10; and while not dated, the content of the plan for Individual #123 was dated.<br>▪ Target behaviors were listed in the first section of the plan. However, 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.<br>▪ 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. Feedback regarding the integration of psychological and psychiatric treatment plans is provided with regard to Section J.8 of the Settlement Agreement.<br>▪ 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 a behavior support plan was provided in table format in 26 (74%) of the plans reviewed. This section might be better utilized if a rationale for the necessity of a plan was provided with a review of previous treatments and the reason for revision.<br>▪ The next section of the plans included a description of activities and outcomes from recent Functional Behavior Assessments (FBA), 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. Lengthy review of the actions that were taken to complete the FBA should be reserved for the FBA report. The primary purpose of describing the potential function of the targeted problem | Noncompliance |

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| | | behaviors is to ensure that functionally equivalent replacement behaviors are identified, and that appropriate treatments, including preventative strategies, antecedent management, and behavior consequences, are prescribed. Secondarily, this information can help those implementing the plan understand the relationship between the perceived purpose the target behavior has served and the proposed intervention.<br>▪ 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. As reported, psychology staff were beginning to conduct formal preference assessments with individuals. This was a very positive step that will best be in evidence if the date(s) of the assessment and resulting information are reported in the behavior support plan.<br>▪ Baseline data was clearly reported in 28 of 33 plans (85%). The Behavior Protocol was excluded as this was developed for a newly admitted individual. One Behavior Support Plan appeared to be missing pages and therefore this was not included in the analysis. Problems with five of the 33 plans included a poorly identified recording period, conflicting measures, or multiple measures.<br>▪ All of the plans reviewed included definitions of identified problem behaviors.<br>▪ Guidelines for data collection also were provided in all of the plans, although the plan for Individual #530 directed staff to write a summary in the Behavior Observation Notes at least once per shift if any target behaviors had occurred.<br>▪ 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 only seven (20%) of the plans. As noted in Cooper, Heron, and Heward (2007): "Evidence from decades of research indicates that both desirable and undesirable behaviors … are learned and maintained through interaction with the social and physical environment (p. 501). Staff should identify clearly functionally equivalent replacement behaviors that the individual can learn to perform without waiting for a question or other prompt from staff. Replacement behaviors should be operationally defined to ensure that these behaviors are observable and measurable.<br>▪ Teaching of identified replacement behaviors was often insufficient. For several individuals, they were provided one opportunity per shift to learn and/or practice their replacement behaviors. This limited training will severely impact timely acquisition of important skills.<br>▪ 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.<br>▪ Schedules of reinforcement that were sufficient to promote positive behavior change were present in very few of the plans reviewed, specifically, eight of the | |

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| | | 35 (23%). Reinforcement that is available once per shift or once per week will not be sufficient to result in improved behavior. Staff should pay particular attention to this section of the plan to ensure that dense schedules of reinforcement are employed to help the individual learn more appropriate ways of responding.<br>▪ 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 19, or 54%, 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 or move the individual to another location. Other plans included consequences that clearly could produce a strengthening of the identified problem behavior. Numerous examples of this have been provided in the Monitoring Team's previous reports.<br>▪ The author of the plan was identified in 24 of the 35 plans (69%). 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.<br><br>The Human Rights Committee maintained a regular schedule of weekly meetings. Minutes of 21 meetings held between 2/15/11 and 7/5/11 were reviewed. In the majority of the meetings (15, or 71%), members present included the human rights officer, a parent or non-affiliated member, a psychologist, and a nurse. Near the end of April, an individual served at the Facility began attending these meetings representing a positive addition to committee membership. Another positive change was evident by the presentation of behavior support plans by the psychologist who had authored the plan. During this same time period, there were four meetings held without a nurse or medical personnel in attendance. As noted previously, a member of the medical staff, preferably psychiatry, should be present when the discussion focused on medication matters.<br><br>A review of the document "Individuals with Behavior Support Plan," dated 7/11, indicated that since February 2011, the Behavior Support Committee had reviewed 127 plans. For eight of these plans, Human Rights Committee approval was not required. The BSC reviewed fourteen of the remaining 119 plans in the same month as the report, and therefore, HRC approval was noted to be "pending." Of the 105 remaining plans, 59 (56%) had been reviewed by HRC within 30 days of the BSC review. Parent or guardian consent was difficult to determine, because the tracking form with this information was not complete. It will be essential to ensure timely review is completed and consent obtained for newly developed or revised behavior support plans to ensure that the individual's needs are appropriately addressed. | |

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| | | As recommended in the last report, the Psychology Department should develop a hierarchy of treatment restrictiveness that can be used as a guide in identifying necessary consents. This could help expedite the review process ensuring that behavior support plans are implemented and amended as necessary in a timely manner. Lastly, consents for the introduction or change in medication would more appropriately be the responsibility of the prescribing psychiatrist and his/her staff.<br><br>When an individual is scheduled to move, either between residences on campus or into the community, staff should conduct a gradual and well planned transition. Current and future teams should meet to ensure familiarity with the individual and his/her needs, strengths, and preferences. Visits to the receiving site should be scheduled, first with familiar staff providing support during different daily events and for increasing periods of time. As the individual successfully adapts to the new setting, these familiar staff can be available, but not physically present. Once the transition has occurred, regularly scheduled meetings are recommended to ensure that unforeseen issues or problems are effectively and efficiently addressed. This matter was discussed during the presentation made to the Monitoring Team by the Personal Support Team for Individual #323. Staff are encouraged to follow this recommendation particularly for individuals who present with complex needs and/or significant challenging behaviors. | |
| 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. | Graphs continued to display monthly occurrences of targeted behaviors. Axes were labeled, and data points and paths were displayed. Condition change lines depicting changes in medication were included in at least one graph for Individual #207, Individual #300, and Individual 108. Other graphs included arrows with legends indicating medication changes. For Individual #228 and Individual #132, moves to new homes were also noted. As each graph depicted total frequency of the target behavior per month, it was difficult to ascertain the individual's response to these medication or environmental changes. No graphs included condition lines reflecting changes to behavior support plan strategies. Measures of inter-observer agreement or treatment integrity were also not depicted on any of the graphs.<br><br>Monthly data display 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. The Behavior Assessment for Individual #534 provided an excellent example of the inability to visually analyze effects of treatment changes (in this case, medication dosing) on the behaviors targeted for change. As recommended previously, graphing of daily measures of performance will allow for better analysis of treatment efficacy.<br><br>Although the Facility had begun collecting inter-observer agreement measures for behavior support plans, observations and review of documentation indicated that the | Noncompliance |

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| | | accuracy of the data could not be assured. As described in previous reports, the availability of data that Personal Support Teams can have confidence in is essential in ensuring that teams are making effective data-based decisions.<br><br>Although monthly review of progress was evident, there was no indication that assessment and intervention were re-evaluated and revised in a timely manner. Inter-observer agreement procedures were in the initial stages of implementation, and data remained inaccurate. In addition, graphing conventions did not allow adequate review of the data. Therefore, the Facility remained out of compliance with this provision. | |
| 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. | Psychology staff reported that finding time to train direct support professionals on behavior support plans remained a problem. Both clinical and direct support staff reported that "mandatory holdovers" remained a frequent event, requiring staff to work beyond an eight-hour shift. While direct support professionals reported that psychology staff provided appropriate support, training on plans should be a priority.<br><br>The introduction of the PBSP Monitoring Form (described with regard to Section K.12) should afford greater dialogue between psychology staff and the direct support professionals who are expected to implement the behavior support plan. The Facility is again advised to recruit the participation of direct support professionals in the weekly Behavior Support Committee meeting to encourage their input on the development of plans and to help identify potential or report observed difficulties with plan implementation. Direct support professionals who were interviewed during the onsite review indicated that plans were clearly written and understood. Observed staff response to problem behavior was often an instruction to the individual to stop as found in the majority of BSPs. | 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. | The Facility had introduced and trained staff in five core competencies designed to promote positive behavior change. These included: a) building relationships; b) use of reinforcement; c) use of a pivot response; d) simple correction; and e) engaging the individuals in active treatment. Staff should review these competencies to ensure that guidelines for performance are clear to all staff (encourage their input and feedback), and to rephrase directions in which staff should ignore or not respond to "junk" behavior.<br><br>Several documents, including behavior support plans, competency checklists, and written summaries, referenced "junk" behavior. This was usually in the context of advice to staff to use "pivot" strategies when such behavior was observed. While clearly not intended to be disrespectful to the individual, such classification has a negative connotation, particularly as these behaviors most likely serve some function for the individual. It would be advisable to guide staff to minimize or avoid any response to inappropriate and non-harmful behaviors that are not specifically targeted in the | Noncompliance |

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| | | individual's behavior support plan. Should these behaviors occur with increasing frequency or appear to be particularly problematic, staff could record their observations in the Behavior Observation Notes.<br><br>Since the last visit, monitoring of behavior support plan implementation had begun. Using the PBSP Monitoring Form, psychology staff were observing, interviewing, and providing feedback to direct support professionals. Accuracy of plan implementation was either observed or determined through interview. Interview questions addressed target behaviors, reinforcers, data collection, identification and teaching of replacement behavior, and staff response to target behaviors. Staff knowledge of core competencies was also assessed. This is certainly a good beginning to the development of a competency based training program focusing on appropriate implementation of individual behavior support plans. As noted in the State Policy (#008), competency-based training is to occur prior to staff assuming responsibility for implementation of an individual's BSP. Until a plan of training is developed that will ensure on-the-job training with demonstrated competency for all staff prior to working with specific individuals, the Facility will remain out of compliance with this requirement. Ongoing assessment of treatment integrity will also be essential. | |
| 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 visit, there were a total of 19 Associate Psychologists working under the supervision of the Director of Behavioral Services, a master's level psychologist and Board Certified Behavior Analyst. Eighteen of the 19 Associate Psychologists were assigned caseloads to ensure that services were provided to individuals as necessary and appropriate. The one staff member without a caseload was providing individual and/or group counseling services, as well as social skills groups to identified individuals. With a census of 443, this resulted in a 1:25 ratio of professional staff to individuals served. There were a total of 10 Psychology Assistants assigned to provide support to these 18 Associate Psychologists. The ratio of Psychology Assistants to Associate Psychologists adhered to the established standard of the Settlement Agreement.<br><br>A rating of noncompliance was provided 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 with regard to Section K.1, the majority (79%) actively was pursuing certification. | Noncompliance |

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

1. 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). (Section K.1).

2. The Facility should develop a policy related to internal and external peer review. (Section K.3)
3. The Associate Psychologists should participate in all training and discussion between the consulting professionals and direct support professionals. This will help ensure appropriate clinical oversight and ongoing training to staff. (Section K.4).
4. 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. (Section K.4)
5. Inter-observer agreement measures should be collected on a regular basis. (Section K.4).
6. Once a system is in place and operational for assessing the reliability of data, the Facility should make efforts to reduce the redundancy of the current system. For example, it might be possible to limit Behavior Observation Notes to those incidents that meet specific criteria or that are unusual for the individual involved. (Section K.4).
7. Staff should change the PLACHECK data collection system so that it involves shorter, but more frequent observation of individuals' engagement. A momentary time sample is recommended. (Section K.4).
8. Staff should provide graphic display of targeted behaviors in a manner that will allow analysis of the effects of planned (e.g., changes to the PBSP, changes in medication, etc.) and unplanned changes (e.g., sudden move in home, health problems, etc.). (Section K.4)
9. As recommended previously, revisions to the functional behavior assessment process and report format should be made. Greater emphasis should be placed on information gathered through direct observation, and when conducted, functional analysis. (Section K.5)
10. In addition, the report should be streamlined 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. (Section K.5).
11. The State and the Facility should develop a policy that provides clear guidelines for the completion of formal assessment of cognitive abilities and adaptive behavior. Psychological evaluations should be conducted at a minimum of once every five years. Measures of adaptive behavior are recommended annually. (Section K.6 and Section K.7).
12. 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. Plans for generalization of learned skills to other individuals and other environments should be addressed. (Section K.8).
13. With regard to the content of the Behavior Support Plans:
    a. BSPs 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 should be 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. (Section K.9).

14. 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. (Section K.9).
15. With regard to the Human Rights Committee:
    a. The individual's assigned Associate Psychologist would present all information related to the individual's behavior assessment, behavior support plan, safety plan, or desensitization plan;
    b. A member of the medical staff, preferably psychiatry, should be present when the discussion focuses 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. (Section K.9)
16. The Facility should develop a document describing both antecedent and consequence strategies, with their corresponding levels of restrictiveness, 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. (Section K.9).
17. Transitions of individuals, both on campus and into the community, should be conducted in a gradual and well-planned manner. Familiar staff, particularly staff familiar with the implementation of the individual's BSP, should accompany the individual to the new environment for increasingly longer and more varied visits. As the individual experiences success, visits without familiar staff present are advisable. Once the transition occurs, teams should meet regularly to ensure that any obstacles or problems are addressed in a timely manner. (Section K.9)
18. Efforts to assess and monitor inter-observer agreement for BSP data should be conducted across the campus. Use of the new monitoring tool should continue with changes made as problems or challenges are identified. (Section K.10)
19. With regard to the monthly review of individual progress on behavior support plans, changes should be made to the current format, including graphic display of daily data to allow for a better analysis of behavior change and contributing variables. When improvement is not observed, timely revisions to the behavior support plan should be made, as appropriate. (Section K.10)
20. Psychology staff should work closely with direct support professionals to ensure a thorough understanding of the behavior support plans with effective and accurate implementation of the same. Continued efforts to monitor and record staff performance should have a positive effect on treatment integrity. (Section K.12).
21. Training materials should be revised so that the term "junk" behavior is eliminated. (Section K.12)

| SECTION L: Medical Care | |
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| | **Steps Taken to Assess Compliance:** The following activities occurred to assess compliance:<br>▪ **Review of Following Documents**:<br>o List of staff in the Medical Services Department;<br>o Names and degrees of all primary care providers new to the Facility since January 2011;<br>o Name and degrees of all primary care providers that are new to Facility since last monitoring;<br>o Number of individuals on each physician's caseload;<br>o Employees in Medical Department Completing Cardiopulmonary Resuscitation (CPR) training certification with date of completion July 2011;<br>o Continuing Medical Education (CME) for each primary care provider over last six months, including list of CME credits according to topics reviewed;<br>o Total number of CME hours for each primary care provider over last six months;<br>o Minutes of Infection Control Committee Meetings during the prior six months;<br>o Clinical guidelines developed and implemented since January 2011;<br>o Skin integrity meeting information;<br>o "Questions with Multiple No. Audits for Round 2";<br>o Morning Medical Meetings, copy of all minutes, logs from Infirmary, hospitalizations and 24-hour reports discussed for 30 days prior to Monitoring Team's visit: Infirmary Rounds Minutes 6/1/11to 7/11/11, shift report 6/1/11 to 7/11/11;<br>o Shift reports, dated 8/23/11, 8/24/11, 8/25/11;<br>o Most recent results - reports of the Facility wide medical review system including copy of any non-Facility physician review reports or data since last monitoring visit;<br>o List of individuals who died since the last compliance visit and for each individual, date of death, death certificate, whether autopsy was done (and if so, copy of autopsy report), medical problem list current at time of death, and for seven days prior to death or hospitalization, all clinical documentation, including nursing and physician notes, and all diagnostic studies including radiologic and laboratory. The following individuals were included in the packet: Individual #271, Individual #96, Individual #10, Individual #316, and Individual #310;<br>o Mortality Reviews (Clinical, administrative and nursing reports) since last visit;<br>o Individuals whose Do Not Resuscitate (DNR) order has been rescinded as of July 13, 2011;<br>o List of individuals with DNR orders, including medical/legal justification for DNR;<br>o List of death reports that remain incomplete/outstanding;<br>o Twenty most recent annual medical assessments and physical examinations and prior annual assessment and examination for the following: Individual #305, dated 6/2/10, 6/15/11; Individual #518, dated 6/8/10, 4/28/11; Individual #375, dated 5/3/10, 6/20/11; Individual #13, dated 6/1/10, 6/20/11; Individual #85, dated 6/23/10, 6/7/11; Individual #262, dated 5/19/10, 4/13/11; Individual #459, dated 5/12/10, 6/1/11; Individual #232, dated 6/16/10, 6/30/11; Individual #42, dated 6/21/10, 6/22/11; Individual #502, dated 6/8/10, 6/2/11; Individual #247, dated 5/25/10, 6/14/11; |

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| | Individual #462, dated 6/7/10, 5/31/11; Individual #532, dated 6/4/10, 6/23/11; Individual #486, dated 6/10/10, 6/23/11; Individual #3, dated 4/26/10, 6/21/11; Individual #458, dated 5/18/10, 4/25/11; Individual #363, dated 5/24/10, 6/24/11; Individual #511, dated 6/2/10, 4/29/11; Individual #304, dated 5/26/10, 6/7/11; Individual #392, dated 6/16/10, 5/4/11; and Individual #103, dated 4/19/10, 5/4/11;<br>o Specialty Clinic Schedule per month for past six months as of July 2011;<br>o In-Town Consultations by Specialty 1/1/2011 to 6/30/11;<br>o List of individuals with Vagus Nerve Stimulator (VNS) and date of VNS placement, if applicable, replacement date;<br>o List of individuals with fractures, date of fracture, type of fracture, and bone fractured;<br>o List of individuals with injuries requiring visit to ER or hospitalization since the last site review;<br>o List of individuals engaging in pica in the last 180 days;<br>o Policies or procedures for medical screening and routine evaluations: Section 3: Medical Services 03.01.01, revised 2/15/10; ABSSLC Preventive Care Flow Sheet POR-MR-9, dated 7/08; Annual medical summary and physical examination, updated 9/2010;<br>o List of individuals for those over 50, date of last colonoscopy, and list reason for colonoscopy (preventive versus evaluation of active problem) with reason if not up-to-date;<br>o For those women over 40, date of last mammogram and reason listed if not up to date (guardian refusal, etc.);<br>o Current list of all those with osteopenia/osteoporosis with medications and dosage per persons;<br>o For all individuals over the age of 50, a list of the last DEXA scan dates, as well as copies of the most recent DEXA scan reports for each of the individuals in this category. DEXA reports for the following individuals: Individual #178, dated 8/4/10; Individual #250, dated 7/7/11; Individual #418, dated 5/13/09; Individual #424, dated 8/11/10; Individual #402, dated 2/10/11; Individual #362, dated 6/21/10; Individual #483, dated 4/29/09; Individual #373, dated 6/23/10; Individual #209, dated 12/23/09; Individual #289, dated 6/12/08; Individual #147, dated 11/10/08; Individual #192, dated 6/18/10; Individual #528, dated 3/24/10; Individual #351, dated 5/13/11; Individual #544, dated 11/2/09; Individual #306, dated 11/19/09; Individual #459, dated 6/30/09; Individual #92, dated 7/6/07; Individual #202, dated 12/14/10; Individual #394, dated 5/31/11; Individual #279, dated 10/21/09; Individual #254, dated 2/22/10; Individual #234, dated 2/25/10; Individual #194, dated 8/4/10; Individual #315, dated 1/28/04; Individual #472, dated 5/23/11; Individual #201, dated 8/9/10; Individual #546, dated 8/5/10; Individual #293, dated 3/13/08; Individual #398, dated 8/3/10; Individual #524, dated 5/8/08; Individual #86, dated 12/23/08; Individual #342, dated 2/13/07; Individual #350, dated 11/2/09; Individual #18, dated 6/11/08; Individual #78, dated 8/3/09; Individual #278, dated 7/14/09; Individual #529, dated 6/16/10; Individual #541, dated 12/12/08; Individual #35, dated 3/17/11; Individual #195, dated 1/14/10; Individual #34, dated 11/16/09; Individual #370, dated 10/23/09; Individual #57, dated 10/20/09; |

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| | Individual #395, dated 2/4/10; Individual #388, dated 12/29/08; Individual #235, dated 8/28/09; Individual #165, dated 8/9/10; Individual #327, dated 3/26/09; Individual #80, dated 2/26/08; Individual #376, dated 2/23/09; Individual #52, dated 6/25/09; Individual #64, dated 7/13/11; Individual #11, dated 9/4/09; Individual #512, dated 3/3/10; and Individual #519, dated 1/6/10;<br>o For individuals' with Down syndrome, date of last thyroid test;<br>o For the 10 individuals who most recently went to the ER, copies of integrated progress notes from start of signs/symptoms, to transfer to the ER, and copies of the ER report, copies of discharge orders from ER, copy of Facility record orders, IPN progress notes after return from ER, and follow-up to any recommendations: Individual #283, dated 6/13/11; Individual #105, dated 4/7/11; Individual #32, dated 3/16/11; Individual #366, dated 4/20/11; Individual #101, dated 4/27/11; Individual #520, dated 2/28/11; Individual #293, dated 3/3/11; Individual #76, dated 6/7/11; Individual #153, dated 6/11/11; and Individual #339, dated 6/21/11;<br>o For those individuals admitted to the hospital, copy of admission history and physical, discharge summary, copy of discharge orders/recommendations from the hospital, and copy of Facility record orders, integrated progress notes and follow up for any hospital discharge orders and recommendations for: Individual #271, dated 6/5/11; Individual #348, dated 5/28/11; Individual #332, dated 6/6/11; Individual #48, dated 5/24/11; Individual #337, dated 6/26/11; Individual #250, dated 6/14/11; Individual #503, dated 4/22/11; Individual #6, dated 5/19/11; Individual #395, dated 5/6/11; and Individual #96, dated 5/21/11;<br>o For 10 most recent hospitalizations that have been completed, copy of hospital liaison nurse documentation of hospitalization: Individual #250, dated 6/14/11, 6/16/11, 6/17/11; Individual #199, dated 7/1/11, 7/5/11; Individual #6, dated 5/19/11, 5/20/11, 5/23/11; Individual #48, dated 5/24/11, 5/25/11, 5/26/11, 5/27/11; Individual #337, dated 6/27/11, 6/28/11, 6/29/11; Individual #337, dated 7/5/11, 7/6/11, 7/7/11, 7/8/11; Individual #96, dated 5/23/11, 5/24/11; Individual #346, dated 5/25/11, 5/26/11; Individual #348, dated 6/1/11, 6/2/11, 6/3/11; and Individual #395, dated 5/9/11, 5/10/11;<br>o Summary report/trend analysis of infectious disease/communicable disease for last two quarters: 1/1/11 to 3/31/11, 4/1/11 to 6/30/11;<br>o Infectious disease data per quarter by category of infection for last two quarters: Communicable disease reports for 1/1/11 to 3/31/11, 4/1/11 to 6/30/11;<br>o Avatar pneumonia tracking forms for past six months;<br>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;<br>o Drug utilization report – antibiotics from 1/13/11 through 7/13/11;<br>o Incidence rates of prior year by month for the following: pneumonia, and decubitus ulcers;<br>o Communicable Disease Report: aspiration pneumonia, pneumonia (7/1/10 to 7/1/11), dated 7/15/11; |

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| | o For the past six months, for five individuals, documentation of seizure management: Individual #119, Individual #311, Individual #21, Individual #370, and Individual #106;<br>o List of individuals seen by neurologist with dates seen and reason, since Monitoring Team's last visit;<br>o Individuals with status epilepticus since 2/15/11;<br>o Anticonvulsant Medications by patient, dated 7/13/11;<br>o Individuals transferred to community ER for uncontrolled/prolonged/new onset seizures since Monitoring Team's last visit, dated 7/18/11;<br>o Intractable (Refractory) seizure list, dated 7/11;<br>o Individuals with refractory seizure disorder who are being evaluated for VNS/stage of evaluation, dated 7/18/11;<br>o Percentage of individuals on two, three, four, and five antiepileptic drugs;<br>o Percentage of persons on older anti-epileptic drugs (Phenobarbital, Dilantin, Mysoline);<br>o Medical Provider Quality Assurance Audit – Internal Audit, dated June 2011;<br>o Medical Provider QA Audit – Results and Action Plans form, dated 5/5/11;<br>o Information from the active record: preventive care flow sheet, physician orders from July 2010 to present, integrated progress notes from July 2010 to present, the most recent BSP, the most recent annual PSP and addendums since that time, labs/x-rays/consult reports from July 2010 to present, the most recent health management care plan, the most recent annual medical assessment and physical exam, DG-1 form, the most recent nursing assessment, hospital discharge summaries for the past one year, ER visits for the past one year, and procedure reports for the past one year for the following: Individual #267, Individual #60, Individual #151, Individual #174, Individual #218, Individual #279, Individual #212, Individual #97, Individual #523, Individual #405, Individual #40, Individual #348, Individual #54, Individual #468, and Individual #284;<br>o List of individuals seen in Neurology Clinic on 8/22/11;<br>o QA medical reports, internal and external, through July 2011; Medical Provider quality assurance audit process; Internal Medical Audit QA Tracking System; Questions with Multiple "no" answers May 2011, June 2011, July 2011; Essential and non-essential compliance by provider May 2011, June 2011, July 2011; Compliance by Question - May 2011, June 2011, July 2011; Cumulative Data April 29 to July 3; External Audit 7/25/11 to 7/29/11: Questions with multiple "no" answers, essential and non-essential compliance by provider, compliance by question, compliance by provider;<br>o Medical peer review QA list of records reviewed to 8/12/11;<br>o Medical Provider Quality Assurance Audit form;<br>o Correspondence to ABSSLC administration certifying PCP as internal medical auditor, dated 2/21/11;<br>o Exit interview discussion with external medical QA audit, from 7/25/11 to 7/27/11;<br>o State Office document: SSLC Risk Guidelines, dated 6/11;<br>o Do not resuscitate information ABSSLC, updated 7/13/11;<br>o Ethics Committee and PCP notes, dated 11/24/10 for Individual #316;<br>o Status of mortality reviews as of May 2011, August 2011; |

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| | ○ W104 PoC Monitoring Tool 3/25/11, WW159 Monitoring Tool - 4/11 for Individual #96, Individual #271, Individual #316, and Individual #294;<br>○ Date unusual incident review was performed;<br>○ Date quality improvement death review of nursing services completed;<br>○ Complete death discharge summary/investigation;<br>○ Complete clinical death reviews;<br>○ Complete administrative death reviews; and<br>○ Presentation Book for Section L.<br>▪ **Interviews with**:<br>○ Richard Chengson, MD, Medical Director;<br>○ Attendees of morning medical meeting;<br>○ Pat Smith, QA Director; and<br>○ Mary White, QA nurse.<br>▪ **Observations of**:<br>○ Individual #6, Individual #228, Individual #411, Individual #287, Individual #439, Individual #498, Individual #59, Individual #88, Individual #26, Individual #523, and Individual #348;<br>○ Neurology clinic, on 8/22/11; and<br>○ Morning medical meetings on 8/23/11, 8/24/11, and 8/25/11. |
| | **Facility Self-Assessment:** The Facility determined it was not in compliance with any of the subsections of Section L. This was consistent with the Monitoring Team's findings.<br><br>The Medical Department relied upon the State Office Medical Quality Assurance checklist to assess and determine compliance with most of the subsections of this Section L. Each month approximately eight records were reviewed using the State Office Medical Quality Assurance checklist, and the results were entered into a database for future analysis. As previously mentioned, inter-rater reliability needed to be established to validate any findings. Additionally, the checklist did not provide a review of all areas of this section. There was no data included in the POI to substantiate the Facility's findings. At the time of the Monitoring Team's visit, data was available. Some of the areas noted in the analysis of the data addressed compliance with documentation requirements, but did not address quality of the medical care provided. The Medical Department was anticipating using the clinical guidelines to develop clinical indicators as objective measures of quality care. In addition, one external medical provider audits was completed on 7/27/11.<br><br>The Facility had implemented four action plans related to Section L. One addressed completion of clinical death reviews, and another addressed the review of DNRs for individuals who had them. Although the Facility indicated that it had completed the action plan related to DNRs and was in the process of completing a number of the steps in the action plan related to clinical death reviews, the quality of these efforts were of concern. The Monitoring Team's concerns are discussed in further detail below. The remaining two action plans involved the implementation of the external and internal monitoring processes. |

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| | **Summary of Monitor's Assessment:** The morning medical meeting was held each business day of the week. Minutes were recorded. The minutes focused on rounds in the Infirmary, with some additional information involving acute care for individuals not in the Infirmary. The minutes identified the staff that attended the meeting. Occasionally, the minutes included descriptions of medical staff meetings focusing on an area of concern. Generally, there was no critical thinking documented concerning clinical steps (e.g., testing, treatment, review of diagnosis, additional consultations, level of supervision, etc.) to prevent a repeat hospitalization or ER visit. There appeared to be no documentation of closure to ongoing concerns.<br><br>The Facility had begun data collection on the medical quality assurance tool used by the external reviewers. The Facility completed its first external peer review in July 2011. There has been no comparison between the audit results of the PCPs at ABSSLC and the audit results of the external reviewers. A more ambitious review was being undertaken internally.<br><br>According to a list that had been updated as of 7/13/11, 42 individuals had DNRs at ABSSLC. The Facility had reviewed all DNR orders, and five were rescinded. However, the large number of individuals with DNRs for which adequate and current justification had not been established remained a concern at ABSSLC. The most common reason for DNRs was osteoporosis, presumably due to the increased trauma during cardiac compressions. This was not consistent with the most recent draft policy that State Office had provided the Monitoring Teams for comment, which required a terminal diagnosis for a DNR to be implemented at a SSLC. Further guidance from the State Office is needed to resolve these difficult decisions to ensure state regulations are being followed for each individual.<br><br>Clinical death reviews were up-to-date. The Monitoring Team recognizes and appreciates the enormous work that went into this endeavor. However, the reviews should focus on identifying recommendations for systems improvements in some aspect(s) of medical care. Of the many clinical death reviews, only one had a recommendation involving the Medical Department directly.<br><br>There was little progress in creating a usable system to track medical issues, such as osteoporosis and pica.<br><br>The Medical Department remained noncompliant in each of the subsections of Section L. |

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| L1 | Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall ensure that the individuals it serves receive routine, preventive, and emergency medical care consistent with current, generally accepted | Given that this paragraph of the Settlement Agreement includes a number of requirements, this section of the report includes a number of different subsections 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, preventative care, consultation network, acute and emergency care, and Do Not Resuscitate (DNR) Orders. | Noncompliance |

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| | 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. | Staffing<br>A Medical Director, three staff physicians, one locum tenens physician, and a nurse practitioner staffed the Medical Department. There was a medical secretary to provide administrative assistance to the department. Since the Monitoring Team's last visit, no PCPs had been added to the Medical Department staff.<br><br>The Medical Director had a direct caseload of 21 individuals. Each of the other PCPs had a caseload, which varied from 67 to 105 individuals.<br><br>A list was submitted indicating those members of the Medical Department that remained current in CPR certification. The list was dated July 2011. Of the primary care providers in the department five out of six (83%) were current in CPR. The locum tenens physician was not listed. At the time of the Monitoring Team's visit, one additional physician would have needed recertification (expiration date 8/5/11). The two dentists on staff were listed as being current. Pharmacy staff were not listed, and it was not clear if they were located on a separate list.<br><br>Of the six PCPs in the Medical Department, a list of CME credits was submitted for five of these PCPs. This varied from four to more than 34 hours. A separate folder included the various topics that were covered. These included a wide variety of topics of internal medicine interest, many of which were applicable to the IDD population residing at ABSSLC.<br><br>Physician Participation In Team Process<br>The morning medical meeting was held each business day of the week. Minutes were recorded. The minutes focused on rounds in the Infirmary, with some additional information involving acute care for individuals not in the Infirmary. The minutes identified the staff that attended the meeting. Occasionally, the minutes included descriptions of medical staff meetings focusing on an area of concern. Generally, there was no critical thinking documented concerning clinical steps (e.g., testing, treatment, review of diagnosis, additional consultations, level of supervision, etc.) to prevent a repeat hospitalization or ER visit. There appeared to be no documentation of closure to ongoing concerns. A few examples follow:<br>▪ Individual #59 had a history of refusing medications and food. She missed seven days of antiepileptic medication, followed by a prolonged seizure with hypoxia, requiring hospitalization. On 7/9/11, she returned to the Infirmary and remained in the Infirmary at the time of the Monitoring Team's visit. In the 7/11/11 Infirmary rounds minutes, no documentation was included of closure to the issue of serial missed medication that precipitated the seizure, specifically, the system change needed to ensure missed doses of medications were communicated to the PCP. Further discussion indicated the Nursing Department | |

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| | | did not inform the PCP of the missed doses. On inquiry, neither the Medical Director, nor any in attendance at the morning meeting, had any follow-up information regarding systems changes to ensure this did not recur. On the fourth day of the Monitoring Team's visit, the CNE attended the morning meeting, and indicated that the lack of communication was due to nursing staff not following a policy in place. Reportedly, this was due in part to a new nurse being assigned to the residence, as well as a lack of emphasis on this policy during orientation. Based on this discussion, it was not clear what steps would to be taken to ensure the policy would be followed. In addition, no documentation was found reflecting potential plans to further incorporate psychology staff into the development of corrective action, including reviewing the adequacy of the current BSP, or identifying other steps to attempt to improve the individual's compliance with medication administration. The only comments were that the "cost of one ER visit will probably cover several months of Keppra suppositories" (responding to the understanding that the pharmacy requested discontinuation of Keppra suppositories and Cerebyx IM, which could not be confirmed during an interview with the clinical pharmacist), and that the psychiatrist discussed depression. "Discussing depression" was a helpful initial comment, but there was no documentation of whether medication had been started or dosage increased, etc.<br>▪ On 7/11/11, Individual #103 was admitted to the Infirmary for hypoxia. It was noted that he had had three to four pneumonias in the past, but no documentation was found of discussion about how to prevent the next pneumonia. There was no information concerning whether there was a component of GERD, dysphagia, or environmentally induced asthma. The plan listed basic lab and x-ray testing, but did not pursue critical preventive issues.<br>▪ Additionally, the documentation for morning medical meetings should provide a brief comment on the individual's history of the illness, and/or admission to the Infirmary or hospitalization beyond the current date of admission. For instance, Individual #467 had an upper arm fracture. She was admitted on 6/12/11, and the morning minutes for 6/13/11 did not indicate the reason for her fracture, whether due to osteoporosis, or peer aggression, frequent falling, etc. The shift report of 6/12/11 documented that her wheelchair had flipped over while she was strapped in it. However, this information was not reflected in the minutes. Without the shift report attached, the minutes included little information about the circumstances of the fracture. The shift report suggested the need to review supervision level as well as the safety of her wheelchair, but there was no information whether supervision level, or PNMT consultation was considered to reduce a recurrence.<br><br>The format and content of the minutes has changed over time. The Medical Director had | |

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| | | edited the content and reduced the length by removing unnecessary information. However, the minutes continued to lack brief background information, as well as descriptions of follow-up plans agreed upon, and closure to these plans.<br><br>The addition of clinical pharmacy and the PNMT nurse were valuable additions to the morning meetings. However, given that the morning meeting had the potential example to assist in the integration of clinical care across disciplines, it is recommended that the meeting include other clinical representatives when possible, including infection control staff, administrative nursing staff, and dentistry.<br><br>It also is recommended that the meeting start as a routine conference meeting, including discussion of clinical issues, plans for follow-up, and closure to previously identified items. As necessary, these meetings could include a brief discussion of medical staff business. Infirmary rounds could then be completed, so that all PCPs are knowledgeable about the individuals in the Infirmary. The current practice of providing most of the information informally in the hallways of the Infirmary was less efficient, and might be distracting in attempting to complete quality daily clinical meetings. For those items remaining unresolved during morning rounds, the Medical Director should assign the task to an attendee, including a date to return to the morning meeting with a formal response to update all members. This should be incorporated into the minutes.<br><br><u>Routine Care</u><br>For 21 individuals, a copy of the most recent annual medical summary and physical examination evaluation, as well as the prior annual medical summary and physical examination evaluation were submitted for review. Compliance was determined based on two different parameters. Timeliness was determined if the most recent annual medical summary and physical examination evaluation was completed within 365 days of the prior annual evaluation. For the 21 individuals, compliance was nine out of 21 (43%).<br><br>As part of the monitoring review process, the Monitoring Team selected the medical records of 15 individuals to determine compliance with several requirements of Section L.1. Every 30th name listed on a census was selected, after the first name was chosen by random selection. Documents reviewed included preventive care flow sheet, physician orders from July 2010 to the present, integrated progress notes from July 2010 to the present, most recent BSP, last annual PSP and subsequent addendums, labs, x-rays, consult forms from July 2010 to the present, the most recent health management plan, the most recent annual medical assessment and physical exam, the DG-1, the most recent nursing assessment, any hospital discharge summary for the past year, ER visits for the past year, and any consult reports and procedure reports from the past year. Each aspect is discussed as the relevant preventive or routine care topic is discussed. | |

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| | | From 15 medical records reviewed, 13 (87%) annual medical assessments had been completed in a timely manner. Active problem lists appeared to be thorough in 15 (100%). A subset of six annual medical assessments was reviewed for a smoking history. All six (100%) had information about smoking history. None (0%) had information discussing requirements for transition. The DG-1 forms were reviewed. One was not submitted of the 15 records reviewed. Of the 14 DG-1s reviewed, 11 (79%) had updated diagnoses.<br><br>The 15 medical records also were reviewed to determine whether the physician IPN note used the SOAP format. In all 15 (100%), the SOAP format was used, and included date and time on the IPN.<br><br>No medical record (0%) had a PCP quarterly review of medical progress during any quarter in the prior year.<br><br><u>Preventive Care</u><br>Based on the sample of 15 individuals using the sampling methodology described above, the following summarizes the Monitoring Team's findings with regard to preventative care.<br><br>Current vision screening was documented in 12 out of 15 of the records reviewed (80%). Audiological screening was current in 14 out of 15 records reviewed (93%).<br><br>The influenza vaccination had been given to all 15 of the individuals (100%) in a timely manner during 2010. However, finding documentation of influenza vaccination was difficult, because it was not consistently documented in the IPN, or in other preventive/vaccination log sections of the record. It was only consistently documented in the nursing assessments.<br><br>Whether the individual needed to receive varicella vaccine (depending on birth date and immunity status), and whether it was given if indicated, was recorded in 13 of the 15 active records reviewed (87%).<br><br>A list was submitted indicating women residing at ABSSLC who were over the age of 40, along with the date of last mammogram, and the reason, if it was not done or outdated. A total of 152 women were identified as being over the age of 40. The American Cancer Society recommendations were to be followed, according to a DADS SSLC policy #009.1, dated 2/16/11. Of these 152 women, seven had reasons not to have a mammogram (guardian refusal, inability to physically provide proper positioning for the test, etc.). Of the remaining 145 women, 69 had mammograms within the prior year. This was a | |

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| | | compliance rate of 69 out of 145 (48%). Information was submitted on templates created by the residences. There was no uniform reporting system, indicating a Facility-wide system was not in use to track mammograms at ABSSLC. The Medical Director should meet with the information technology department to develop a simple system for tracking the completion of mammograms, and the next due date (e.g., an Excel spreadsheet), which will assist with compliance in this area. The current "Preventive Care Flow Sheet" used at ABSSLC was submitted. In the mammogram section was an entry stating "every 1 -2 years for women aged 40 or older." This was not consistent with the American Cancer Society. Rather than having to change the form over time, it is recommended that the entry be replaced with "follow the guidelines of the American Cancer Society."<br><br>From the sample of 15 medical records reviews, three females over the age of 40. Of these, all three (100%) were up-to-date on mammogram testing.<br><br>From the sample of 15 medical records reviewed, there were three males age 50 or greater. Of these all three (100%) had a PSA test in a timely manner.<br><br>The Medical Department submitted a list of those individuals over the age of 50 with the date of the last colonoscopy, with the reason for the colonoscopy. A total of 198 names were submitted. Of these, 14 of these had reasons not to order a colonoscopy. Therefore, the eligible population was 184 individuals. Of these, 132 completed a colonoscopy, and three had alternate testing considered acceptable as clinical equivalents. There were five individuals for whom the entries were incomplete or needed further explanation and could not be interpreted. However, proof of a procedure could not be verified based on the submitted documentation. Of the 184 individuals for whom a colonoscopy or clinical alternative was indicated after the age of 50, 135 had completed an appropriate procedure, for a compliance rate of 135 out of 184 (73%).<br><br>From the sample of 15 medical records reviewed, five individuals were over the age 50. Of these, for one individual, the guardian refused to provide consent. For one individual, a recent attempt had been made (in 5/11), but was not successful (the consultant determined general anesthesia would be required). Of the remaining three individuals, all three (100%) had colonoscopies completed within the past 10 years.<br><br>A list of individuals with a diagnosis of osteopenia or osteoporosis was submitted. Identification of the medications and dosages of the medications treating these diagnoses also was requested. Additionally, for all those over 50, a list of the last DEXA scan date and copies of the most recent DEXA scan report were requested. This information was requested, because for those with a diagnosis of osteopenia or osteoporosis, a T score usually would be an important aspect of the work-up provided through a DEXA scan. | |

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| | | Additionally, based on the T score, treatment would be ordered to optimally treat the individual.<br><br>The data submitted indicated that no Facility-wide method existed for tracking this important area of health care. Each residence used its own template to provide this information, which made it difficult to standardize the information. T scores were not linked to individuals, and only one residence linked the date of the most recent DEXA to the individual's information.<br><br>Based on this somewhat limited information, as well as the other documents requested, a total of 84 individuals with a diagnosis of osteopenia or osteoporosis were reviewed. Of these, 47 had a DEXA scan submitted. At least some individuals that had not had a DEXA scan report submitted were under the age of 50. Of the 84 individuals reviewed, 19% had treatment, which was not optimal for the diagnosis. For instance, 10 individuals were diagnosed with osteopenia and were at risk for progression to osteoporosis, but were not prescribed a bisphosphonate or other medication for this diagnosis. Five individuals had a diagnosis of osteopenia, but the dosage of bisphosphonate was at a higher dosage level used for osteoporosis. One individual with osteoporosis was undertreated medically. However, the data submitted was also problematic and incomplete, in that 48 of the 84 had no information as to whether they were taking calcium and vitamin D supplements. Whether the information submitted to the Monitoring Team listed these supplements was dependent on the residence.<br><br>In addition, the radiology report recommended repeat DEXA scans in two years. The ABSSLC "Preventive Care Flow Sheet" indicated a DEXA scan every two years for those with a diagnosis of osteopenia or osteoporosis. However, 16 individuals with T scores indicating osteopenia or osteoporosis had their last DEXA scan more than two years prior to the date of submission of the data (i.e., 7/11). This aspect of care requires State Office guidance to ensure standardization across all campuses.<br><br>The Medical Director should meet with the information technology department to develop a simple, comprehensive and complete system for tracking diagnoses and treatment of osteoporosis/osteopenia to guide the Medical Department in assuring quality in this aspect of preventive care. Additionally, the data submitted was categorized by residence of the individual, which became problematic for those individuals who had recently changed residences.<br><br>From the sample of 15 medical records reviewed, seven had a diagnosis of osteoporosis or osteopenia. Of these, all (100%) had supplemental calcium and vitamin D prescribed. Five had a bisphosphonate ordered. There was one record indicating a diagnosis of both osteopenia and osteoporosis (Individual #97). This individual and another with | |

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| | | osteopenia were only prescribed calcium and vitamin D. Given the high-risk population, additional treatment for osteopenia and osteoporosis prevention should be considered. A clinical guideline concerning osteopenia/osteoporosis would be helpful in determining the diagnostic tests and treatments indicated for those with these diagnoses.<br><br>A list of those with Down syndrome was submitted, along with the date of the last thyroid test. A total of 18 individuals were identified with a diagnosis of Down syndrome. Although not identified, it was assumed the list was created in July 2011 in preparation for the Monitoring Team's visit. All (100%) had a current thyroid test.<br><br><u>Consultation Network</u><br>The Facility provided access to a number of medical specialties in the area. A list was submitted indicating the number of consultations per specialty that were completed over the time period of January 1, 2011 through June 30, 2011. The list included the following: Aesthetics - one consultation, allergist - one consultation, cardiology - 61 consultations, dermatology - one consultation, endocrinology - 49 consultations, gastroenterology - 48 consultations, hematology/oncology - 32 consultations, infectious disease - one consultation, internal medicine - three consultations, pedorthics - two consultations, nephrology - three consultations, neurology - eight consultations, neurosurgery - three consultations, ophthalmology - 87 consultations, optometry - 33 consultations, orthopedics - 24 consultations, otolaryngology - eight consultations, pediatrics - three consultations, podiatry - five consultations, pulmonary medicine - two consultations, radiology - one consultation, rheumatology - 10 consultations, sleep study - five consultations, surgery - two consultations, urology - three consultations, and wound care - 29 consultations.<br><br>Additionally, several specialty clinics were held on campus each month. For the time period from February 1, 2011 through July 31, 2011, this included the following specialty clinics: pelvic and pap clinic on 3/23/11, 3/31/11, 4/6/11, and 6/20/11; gynecology clinic on 3/17/11, 4/27/11, and 6/29/11; urology clinic on 2/4/11, 3/4/11, 4/1/11, 5/6/11, 6/3/11, and 7/1/11; neurology clinic on 2/14/11, 2/28/11, 3/14/11, 3/28/11, 4/11/11, 4/25/11, 5/9/11, 5/23/11, 6/13/11, 6/27/11, 7/11/11, and 7/25/11; ENT clinic on 3/8/11, 4/12/11, and 7/12/11; Dermatology clinic on 2/16/11, 3/30/11, 4/20/11, 5/25/11, 6/22/11, and 7/20/11; Surgery clinic on 2/10/11, 3/10/11, 3/24/11, 4/7/11, 5/5/11, 6/2/11, 6/30/11, 7/14/11, and 7/28/11; podiatry on 2/15/11, 3/15/11, 4/19/11, 5/17/11, 6/21/11, and 7/19/11; dental surgery on 2/8/11, 2/11/11, 3/25/11, 4/22/11, 5/20/11, 6/14/11, and 7/15/11; visual acuity clinic on 2/17/11, 3/29/11, 4/14/11, 4/28/11, 5/12/11, and 7/7/11; and endocrinology clinic on 7/6/11, and 7/28/11.<br><br>Overall, the kinds and frequency of appointments with specialists indicated that there | |

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| | | were no gaps in access to any specialty. The participating consultants provided quality and thorough care. There did not appear to be a delay in accessing care when consultation was needed.<br><br><u>Acute and Emergency Care</u><br>The active record was reviewed for 10 individuals who had most recently gone to the Emergency Room (ER) and returned. Eight of the 10 had gone to the ER from their residence. Two had gone from the Infirmary to the ER. The following summarizes the results of this review:<br>▪ Information was submitted indicating that the ER was notified of the arrival of the individual with appropriate medical background information provided for five of the 10 (50%).<br>▪ Prior to the transfer to the ER, a PCP was on site for eight of these transfers. In six records (75%), the PCP had written an IPN that included the date, time, vital signs, and reason for the transfer. In five of the six (83%), the SOAP format was utilized.<br>▪ When the individual returned to the Facility after evaluation at the ER, eight of the 10 active records (80%) had an IPN. Of these eight, seven (88%) utilized a SOAP format.<br>▪ These notes included the date, time, and summary of ER information and findings in eight IPN notes (100%).<br>▪ When returning to the Facility, four returned to the individual's residence, and five returned to the Infirmary. For one individual, this information could not be determined.<br>▪ Five of the 10 records (50%) had additional PCP notes as follow up to the original concern. The reasons for transfer were as follows: Two had gastrointestinal problems, three had seizures, two had trauma, one had hypertension with perceived neurological changes, and one had altered mental status due to adverse reaction to medications.<br>▪ All treatment was considered timely. There were no perceived delays in care in transferring the individuals to the ER.<br><br>Several additional observations were noted from review of these ten records and the individuals' transfer information. These include the following:<br>▪ It was difficult to determine when an individual was admitted to the Infirmary. There was no clear notation of admission or discharge, or ongoing information indicating the location of the individual. It is recommended that there be some method of identification of Infirmary stays in the active record.<br>▪ The individual who had an adverse reaction to medications was given another individual's regimen of medications. Once identified, close observation and appropriate treatment was prompt. A contributing cause of the error was that | |

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| | | the nurse administering the medication became distracted by another occurrence at the time the medications were being prepared. Nursing Administration should ensure that nurses have dedicated time to pass medications, and other staff should be called to assist and intervene as needed to allow the medication pass to be completed without interruption.<br>▪ One of the injuries occurred when an individual fell out of a sling/Hoyer lift. This is generally considered a preventable event, and the habilitation team/PNMT should review and assist with ensuring appropriate equipment is available and adapted to the individual's needs, as well as ensuring competency-based training of the direct support professionals in utilizing the equipment safely.<br>▪ An individual was taken to the ER who had not had a seizure since 2004, but had seizures after being taken off Ativan. This case would benefit from a retrospective review among the Medical Department staff.<br>▪ Pica was identified in more than one individual who was not included in the pica database.<br>▪ An esophagogastroduodenoscopy (EGD) had to be cancelled due to aspirin not being held for five days. The Medical and Nursing Departments should review such cancellations, and develop a tracking system in which recommendations and consultation orders are included, and monitoring occurs to ensure these occurrences are minimized.<br>▪ At times it was difficult to determine if the hospital was notified of an individual being transferred to the hospital. It is recommended that a document or form be placed in the record that the person contacting the ER personnel completes.<br>▪ One individual was sent to the ER with concerns for changes in the neurological presentation, including a foot drop. However, the ER was able to determine the dropped foot was a chronic problem. Attention to detail in the annual physical examination would have prevented confusion about this issue. Thorough documentation of the physical exam either might have prevented the need for the transfer, because the on-call PCP would have had that valuable information, and/or the ER would not have had to sort through physical findings to determine which was chronic and which was an acute finding.<br>▪ Most if not all of these issues also should have been discussed in the morning medical meeting, including action steps to prevent a recurrence, with a closure note once additional information was obtained and/or planned steps were completed, and brought back to the meeting for discussion. However, they had not been.<br><br>Additionally, ten active records were reviewed for those individuals admitted to the hospital. The following provide the results of this review:<br>▪ Eight individuals returned to ABSSLC. Two died while in the hospital. Of the | |

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| | | eight individuals that returned to ABSSLC, five (63%) had IPNs post hospitalization. In one, a notation indicated that it had been dictated, but it had not been submitted for review.<br>▪ Of the five post-hospital IPNs submitted, four (80%) included vital signs.<br>▪ All five (100%) included date, time, and summary of hospital events and findings.<br>▪ All five (100%) were in SOAP format.<br>▪ All 10 records of the hospitalized individuals (100%) included a copy of the hospital admission history and physical.<br>▪ Nine of the 10 (90%) included a copy of the hospital discharge summary.<br>▪ Although seven of the 10 (70%) included hospital liaison nurse notes for the individuals, for two of these, the notes were not included in the submitted documents from the active records, indicating they were not filed with the active record. The Monitoring Team obtained them through a second request for the hospital liaison's notes. Additionally, for one individual, although the hospital liaison nurse wrote a lengthy note on two separate hospital days, only one of those notes was submitted as part of the active record, indicating a problem with filing these documents.<br>▪ For seven of the eight individuals that returned to the Facility (88%), several PCP notes were included as part of the follow-up.<br>▪ Of the 10 hospitalizations, five were for pneumonia or aspiration pneumonia, two were for cardiac illness, one was for altered mental status, one was for an ileus and possible urinary tract infection (UTI), and one for physiologic and metabolic changes coincident with detergent ingestion.<br><br>A few observations of these 10 hospital admissions were noted, including the following:<br>▪ The individual admitted with the detergent ingestion was not tracked in the pica database.<br>▪ Five out of the 10 admissions (50%) were for pneumonias and aspiration pneumonias, indicating the ongoing challenge of this diagnosis. Two of these individuals died of aspiration pneumonia.<br>▪ The hospital liaison nurse's notes were thorough, and tracked the necessary clinical information. This was helpful to the PCP and nursing staff in preparing for the return of the individual.<br>▪ There appeared to be need for improvement in filing of the hospital liaison nurse's notes, as well as the dictated physician IPNs. Additionally, requests for the hospital discharge summaries should be followed up to ensure they are received and filed in the record.<br>▪ The dictated PCP notes generally were thorough and clinically focused on the most important aspects of care that day. These notes also resolved the problem of legibility, an important area of concern when reviewing any record. | |

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| | | Chronic Conditions and Specific Diagnostic Categories<br>A submitted list of fractures showed that six fractures had occurred from January 1, 2011 through June 30, 2011. Of these, three were humeral fractures. Since other sites are usually more commonly fractured (e.g., nose, finger, ankle, vertebrae, hip, wrist), it is recommended that fractures by site be closely monitored. For the size of the campus, one might expect some other fracture sites to have been listed, and the Medical Department should review the list to determine if the database was complete and updated regularly. For humeral fractures, steps to reduce the frequency (e.g., environmental changes, behavior management, diagnostic evaluations) would be an important step to reduce the frequency of this type of fracture.<br><br>Additionally, a list of individuals that visited the ER for injuries was submitted. Over the prior six months, the number totaled 52 ER visits for injuries. The type of injury (e.g., burn, laceration, abrasion, bruise, etc.) was not submitted. The Medical Department should request and review information related to injuries by type, and cause (e.g., SIB, peer to peer aggression, ataxia due to toxicity, etc.) as a first step to begin decreasing the number of injuries per month, especially serious injuries.<br><br>The Facility submitted a list of 16 individuals with who had engaged in pica actions or activity. One individual had 168 episodes of pica recorded over the prior six months, which should lead to close communication and frequent meetings between the Medical Department, psychology, and other members of the PST to resolve this behavior. Other individuals had pica behavior numbering one to nine events over the prior six months. However, concerns were raised about the completeness of the database. During the review of the 15 medical records/active records, a number of incidences of pica had been recorded in the progress notes, but were not entered into the "List of Individuals engaging in pica in the last 180 days." These included Individual #105 (4/14/11 ingested aloe vera, 4/09/11 ingested bowel movement), Individual #348 (6/6/11 ingested laundry detergent and was hospitalized at that time, 5/27/11 ingested laundry detergent), and Individual #218 (3/22/11 ingested McDonald's wrapper). It is recommended that there be a system created to ensure data is identified correctly as pica, and entered into the database.<br><br>Several documents were submitted reviewing infections at ABSSLC over the prior six months. Quarterly data was submitted for the first two quarters of the calendar year 2011. The two quarters were similar with the following exceptions and observations:<br>▪ Fewer outbreaks (defined as three or more individuals with the same symptoms) were noted in the second quarter.<br>▪ Slightly fewer cases of pneumonia (eight in the first quarter and six in the second quarter) were noted with the same number of aspiration pneumonias identified | |

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| | | each quarter (four per quarter).<br>▪ The category "other" was used less in the second quarter, indicating more accurate and complete information and determination of the source of the infection, if possible (21 in the first quarter and six in the second quarter).<br><br>Incidence rates and absolute numbers of specific diagnoses were submitted. Pneumonias were listed per month from July 2010 through June 2011. For the time period July 2010 through December 2010, 40 pneumonias were reported. In the time period of January 2011 through June 2011, 22 pneumonias were reported. This was a reduction approaching 50%. The reason for this drop in pneumonias was not clear. The recent pilot program with emphasis on aspiration pneumonia, the development of a PNMT, the rigorous review and criteria needed for a diagnosis of aspiration pneumonia or pneumonia by the medical staff, a change in completeness of reporting, etc. were all possibilities.<br><br>Further information was submitted concerning aspiration pneumonia. A total of 23 individuals were diagnosed with aspiration in the prior 12 months. Of these, 15 occurred in the last six months of 2010, and only eight occurred in 2011. Of the individuals listed in 2010, six were taking meals orally, eight had a gastrostomy tube (G-tube) and one had a jejunostomy tube (J-tube). In 2011, three were taking meals orally, four had a G-tube and one had a J-tube.<br><br>A separate document was submitted listing pneumonias in the past year. There was one pneumonia (Individual #503) listed on both the aspiration pneumonia and the pneumonia lists. For the pneumonia list, a total of 39 cases of pneumonia were identified during the prior 12 months. There were 25 that occurred prior to 12/31/10, and 14 that occurred in 2011. For those occurring prior to 12/31/10, 12 were taking food orally, 10 were fed by G-tube, one was fed by J-tube, and two were not recorded. For pneumonias occurring in 2011, eight were taking meals orally, and six were fed by G-tube. Separately, the Avatar system tracked pneumonias, and had an additional pneumonia listed for Individual #503 on 5/2/11.<br><br>The data indicated four deaths were related to pneumonia in the prior one-year period. There were two deaths from aspiration pneumonia listed in the prior one-year period.<br><br>Overall, the tracking of pneumonias appeared reasonably complete. Of interest, there appeared to be a dramatic reduction in pneumonias and aspiration pneumonias between the last two quarters in 2010 and the first two quarters in 2011. Continuing data collection will determine if this improvement is sustained.<br><br>The Facility submitted information concerning decubitus ulcers. Over the prior 12 | |

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| | | months, 151 decubitus ulcers were reported. Although certain diagnoses are associated with decubitus ulcers, most decubitus ulcers are preventable. The documentation did not indicate if these ulcers were new ulcers per month, or were carried over month to month, and inadvertently counted in the total number of ulcers. Ulcers can take weeks to months to heal, and could have a long time span before healing. Due to the number or decubiti at the Facility, it is recommended that an interdisciplinary skin integrity committee be formed or reconvened, with the goal of both monitoring progress and healing, and providing expertise as needed in this area of health. Since the Monitoring Team's last visit, no skin integrity committee meetings had occurred.<br><br>The Facility submitted a list of those individuals who had been transferred to the community ER for uncontrolled/prolonged/new onset seizures since the Monitoring Team's last visit. Two individuals were identified. However, based upon the Monitoring Team's review of the 10 ER visits discussed earlier in this section, three individuals had been sent to the ER for seizures. This indicated need for an improved tracking of information.<br><br>A list of those with status epilepticus since 2/15/11 was submitted. Two individuals were named on the list. A separate document listed those individuals considered to have intractable or refractory seizures, defined as 36 or more seizures in the last three months. A total of 15 individuals were named. A separate list indicated that one individual with refractory seizure disorder was currently being evaluated for a vagal nerve stimulator. However, his name was not on the list of those considered to have intractable/refractory seizures, suggesting some lack of completeness of the database.<br><br>The Facility submitted information indicating the number of antiepileptic medications that were prescribed per individual with seizure disorders. For 91 individuals (32% of those on seizure medications), two antiepileptic medications were prescribed. For 41 individuals (14% of those on antiepileptic medications), three antiepileptic medications were prescribed. For six individuals (2% of those on antiepileptic medications), four antiepileptic medications were prescribed. From the information given, it was calculated that 147 individuals (52% of those taking antiepileptic medications) were prescribed one antiepileptic medication. Of the 285 individuals prescribed antiepileptic medications, 111 individuals (39%) were prescribed Phenobarbital, Dilantin, or Mysoline. Currently, 26 individuals at ABSSLC had vagal nerve stimulators as part of their seizure management.<br><br>The Facility submitted neurology consultation notes documenting seizure management for five individuals. The following provides a summary of the review of these records:<br>▪ Each of the five individuals (100%) had been seen twice since 1/1/11.<br>▪ The notes indicated a description of the seizures, the medications and dosage, | |

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| | | recent history of level of control, and plan.<br>▪ For two individuals (40%), reference was made to the presence or not of side effects. However, for the remaining three documentation of presence or not of side effects (e.g., ataxia, excessive somnolence, etc.) would be helpful in tracking the effect of any side effects on quality of life, and in ongoing monitoring by nursing, pharmacy, PCP, etc. The neurology notes had a set format to the information, and adding a brief entry addressing the presence or not of side effects is recommended.<br><br>The neurology clinic was observed and it was an efficient system, which appeared to meet the needs of the individual as well as the consultant. An interdisciplinary team including the PCP, psychiatrist, and clinical pharmacist attended and shared information as the neurologist examined the individuals.<br><br>From the 15 medical records reviewed, 11 had a diagnosis of GERD. Of these, there were many different treatments, and a standardized approach would ensure basic areas of treatment were considered and documented. One individual with GERD was only treated with H2 antagonists, others with proton pump inhibitors, one with Carafate, and two with no medications. One had been treated with a fundoplication only, and another treated only with positioning.<br><br>For treatment and prevention of constipation, 14 out of 15 medical records reviewed indicated one or more routine laxatives were prescribed.<br><br>A few other observations were noted from review of the 15 medical records:<br>▪ Individual #468 had a history of GERD and had a fundoplication, but was on no medication for GERD. However, the record indicated she was noted to have brown emesis on 3/24/11, had asthma (bronchospasm can be induced by reflux and aspiration of gastric acid and gastric contents), and had taken steroids. Further work-up for GERD was recommended.<br>▪ It was noted during the annual medical evaluation that Individual #405 had not had any annual lab tests completed. This suggested the need for a system to ensure physician orders for tests and treatments are followed through to completion.<br>▪ It could not be determined if the individual who was unable to cooperate for a colonoscopy was rescheduled for the procedure under general anesthesia. General anesthesia has its own risk/benefit ratio, and any preventive test requiring general anesthesia should have documentation of the risk/benefit information, and decision based on this information.<br>▪ The PCP IPN notes on Individual #212 were of excellent quality. | |

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| | | Do Not Resuscitate Orders<br>According to a list that had been updated as of 7/13/11, 42 individuals had DNRs at ABSSLC. The justification for the DNRs included osteoporosis (19 individuals), and scoliosis (nine individuals). There were six individuals for whom it was documented that no medical justification for the DNR existed, but the DNR was based on parent/family/LAR request. Additionally, five individuals had their DNR order rescinded in the prior six months. Orders for rescinding the DNRs were routinely documented in the record of each of the five individuals. However, examples forwarded were from 2010 (e.g., Individual #213, Individual #232).<br><br>The large number of individuals with DNRs for which adequate and current justification had not been established remained a concern at ABSSLC. Six individuals had no diagnosis justifying the order. The most common reason for DNRs was osteoporosis, presumably due to the increased trauma during cardiac compressions. This was not consistent with the most recent draft policy that State Office had provided the Monitoring Teams for comment, which required a terminal diagnosis for a DNR to be implemented at a SSLC. Further guidance from the State Office is needed to resolve these difficult decisions to ensure state regulations are being followed for each individual.<br><br>Mock Code Drills and Emergency Response Systems<br>Findings and recommendations related to mock code drills and emergency response systems are discussed with regard to Section M.1 of the Settlement Agreement. | |
| L2 | Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall establish and maintain a medical review system that consists of non-Facility physician case review and assistance to facilitate the quality of medical care and performance improvement. | Two types of non-Facility physician case review are discussed with regard to this section. One was the Clinical Death Review Committee, in which a conference call was held. The other involved non-facility physicians conducting audits of individuals' records.<br><br>Since the Monitoring Team's last visit, the Medical Department and Facility Administration had completed 21 clinical death reviews and administrative death reviews. These related to deaths from 4/8/10 to 6/8/11. Clinical death reviews had not been completed for only two deaths from July 2011. Within the 21 clinical death reviews, four recommendations were included concerning hospital communication and interaction, six recommendations with focus on nursing care and administration, and one recommendation requiring action from the Medical Department. In conducting clinical death reviews, it is important for the Medical Department to review and learn from the life of the individual, and potentially identifying systemic areas needing improvement or change. That out of 21 clinical death reviews, only one recommendation was for medical staff suggested the need for more in-depth clinical review to identify areas that would benefit from system improvement. These recommendations should have a clearly defined tracking system with documentation of closure. | Noncompliance |

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| | | To ensure that the clinical death reviews did not get backlogged in the future, a system was created to track to completion the clinical and administrative death reviews. Each death was tracked through the Quality Assurance Department, using a monitoring tool in which each step of the process was defined and dated at completion. In the first 24 hours, an unusual incident review was completed, and a quality improvement death review of nursing services was started, with confirmation that it was in process at 72 hours. Once notified of the death, the PCP had five days to complete a death summary. A clinical death review was to be completed within 14 days unless an autopsy was performed, which then was tracked at 45 days. At 21 days the administrative death review was completed, with some exceptions noted. This new process appeared to be working.<br><br>Since the Monitoring Team's last visit, six deaths had occurred. The following summarizes the findings from the Monitoring Team's review of related documentation:<br>▪ These individuals ranged from age 21 to age 54.<br>▪ One died within approximately nine weeks of admission to ABSSLC.<br>▪ Cause of death was pneumonia in three cases (50%), and cancer in two cases (33%). There was one case of failure to thrive in which case the family/guardian would not allow a feeding tube. Hospice provided terminal care. There was an ethics committee meeting on 11/24/10 discussing the case, and there was a handwritten note from a member of the committee. It was not clear from the note if the full membership of the committee was present. However, the interpretation was that a discussion of members of the committee occurred with the family to informally provide a consensus. The PCP then placed a DNR order. Separately, the PCP wrote a summary of the meeting. The members of the family at that time were undecided about a feeding tube. Presumably they decided against a feeding tube. It is recommended that the documentation from the ethics committee be formalized, to include a typed note identifying those members present, those members calling in by conference call, names of family/guardian present or calling in, a brief summary of the ethical question to be resolved, review of state laws and agency regulations pertaining to the case, and conclusion, with a vote of membership.<br><br>An external peer review medical audit was completed July 25 to 27, 2011. This was the first external audit for ABSSLC. The external audit scheduled for April 25 through 27, 2011 was cancelled due to an ICF inspection that week. No formal report was available from the audit. It is recommended that a lead medical peer reviewer be assigned the task of summarizing the results of the audits. Individual PCP results indicated that the PCPs compliance rates ranged from 81% to 92% in the essential areas, and 69% to 82% compliant in the non-essential areas. | |

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| | | The goal was for completion of five percent of the records per quarter. During the July 2011 audit, 25 records were reviewed for six PCPs. Over four quarters, that would be approximately 100 records reviewed. The current census was 443. This would be a review rate of 22.5%. During future visits, the auditing team should ensure that the 20% goal is achieved by the end of the fourth visit. | |
| 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. | Internal audits had occurred. The audit results from "Round 2" were submitted. The questions were from the same State Office Medical Quality Assurance review developed for non-Facility physician reviewers to complete. "Round 2" referred to the addition of items identified in prior surveys, such as counseling against smoking.<br><br>PCP peers completed the internal audits. One of the PCPs was appointed as the lead in internal peer review and medical auditing. The QA Department randomly selected the records reviewed. A 5% sample size per PCP was assessed per quarter. The sample was to be divided into three months, and distributed to the PCP auditor/Medical Director. When the information was collected, the forms were returned to the QA nurse, who entered the data into the internal medical database audit system. From 3/7/11 through 8/11/11, this lead PCP completed 20 record audits. The other PCPs also were involved in internal peer review record audits, and the other PCPs audited an additional 10 records. Inter-rater reliability remained to be resolved. Each of the PCPs has been both a reviewer and a subject/examinee for the tool used. However, some of the questions remained with wide interpretation of results. There was no data to demonstrate inter-rater reliability had occurred, but there was ongoing discussion between the State Office and ABSSLC concerning this matter.<br><br>A number of concerns related to inter-rater reliability arose in reviewing the tools and their completion. The following is one example of many. One of the questions was sufficiently vague as to create concerns for inter-rater reliability: "are the diagnostic tests and/or therapeutic procedures medically appropriate?" Although instructions and guidance are needed for any questionnaire in order to ensure inter-rater reliability, the physician reviewing the record would rely on personal experience and training, resulting in excessive subjectivity in the results. The question appeared to focus on the tests that were run and procedures done, and an approach providing more clarity might be to review whether the tests and procedures confirmed a diagnosis or guided treatment. If a test or procedure did not change treatment or confirm current treatment, then the burden of unnecessary testing could be an important consideration. The "Action Needed" step appeared to address a separate issue, specifically that the reviewer determined there should have been additional tests or procedures ordered. These were two different issues. In addition to reviewing the questions included on the tool to ensure clarity, instructions should be developed for the tool, and a process for testing inter-rater reliability between the various reviewers should be established and | Noncompliance |

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| | | implemented. Such efforts should be aimed at improving both the reliability as well as the validity of the data.<br><br>The reviews provided practical information useful to the PCPs in improving documentation and other aspects of care. Areas that appeared to need the most improvement included updating the Active Problem List with each new problem, or as the problem was resolved; the need for medication orders for acute problems to include indications and duration for all medications prescribed; documentation of responses to significant lab values in the integrated progress note; initialing and dating of all diagnostic test results and consults; providing a signature with time and date for each progress note; providing pertinent current and past medical history in information communicated with a referral to a consultant; and ensuring medical and surgical consultant recommendations were addressed in the integrated progress notes within five working days after receiving the consultant report. These findings highlighted the value of an ongoing monitoring process of ensuring quality care. Each aspect identified focused on documentation, which is a component of demonstrating quality care. It is recommended that the monitoring process be expanded to include clinical reviews using clinical indicators.<br><br>As part of the QA process, the database analysis was distributed along with corrective action plans. These corrective action plans highlighted the areas of concern for each PCP, and the goal for improvement with future documentation. The QA Department tracked these until closure. Monthly and quarterly compliance reports were generated. Formal training was provided to the PCPs on 6/2/11. The monthly and quarterly data summarized the deficiencies, and the more problematic areas were an opportunity for the Medical Director to meet with the PCPs for further discussion and plans for improvement.<br><br>While the Monitoring Team was onsite, the physician member of the Monitoring Team, the ABSSLC Medical Director and the DADS Medical Coordinator spent time discussing each of the questions on the tool, as well as the results of the reviews conducted at ABSSLC. The discussion focused on improving inter-rater reliability, as well as on those results that indicated poor compliance. For these areas, the group discussed how to resolve the problem/improve compliance. For instance, the active problem list was not in the same volume as the integrated progress notes, and the DADS Medical Coordinator had begun to address this administratively. If the active problem list was located near the integrated progress notes, the expectation was that compliance with updating the active problem list would improve. This is one of many examples that the group discussed. In order for this review tool to continue to provide valuable assistance to the Facility, the Facility should work with State Office to identify questions that require clarification and/or specific instructions, improve inter-rater reliability, and add or | |

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| | | delete questions as systemic issues are addressed and resolved and compliance increases in specific areas.<br><br>In addition to the important monitoring/auditing of records, it also will be important for the Facility to develop a set of clinical indicators and outcomes through which to identify areas of strength, as well as areas of concern. | |
| L4 | Commencing within six months of the Effective Date hereof and with full implementation within 18 months, each Facility shall establish those policies and procedures that ensure provision of medical care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan. | The Medical Department listed one Facility-wide policy as a clinical guideline to the Medical Department. Specifically, the Facility listed the DADS SSLC policy: At Risk Individuals as the guideline the PCPs should use to review the active record to determine current and ongoing clinical needs. The implementation of this policy is discussed in Section I.<br><br>The Facility also submitted the Medical Department policy for "Medical Services 03-01.01," revised 2/15/10. This policy required further updating. For instance, a brief entry should be added concerning requirements for transition to the community (e.g., shadowing, multiple overnight stays, creating list of gestures and sounds and the interpretation of those gestures and sounds to the new team receiving the individual, whether the individual is unusually sensitive to dosages of certain classes of medication, etc.). The updated version noted in the Presentation Book had not been utilized at the time of the Monitoring Team's visit, and should be expanded to determine steps needed for a successful transition process, as well as the requirements for successful community living. Additionally, the standard across the SSLC system was for quarterly medical reviews to be completed by the PCPs. This should be added to the policy, along with a standard form for completion, if appropriate.<br><br>As the State Office develops and issues clinical guidelines, ABSSLC will need to be prepared to implement them, and modify its policies and procedures to be consistent with the guidelines. | Noncompliance |

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

1. The Medical Department should ensure locum tenens physicians are current with CPR certification. (Section L.1)
2. With regard to the morning medical meetings:
    a. The morning medical meeting discussions would benefit from being held in a conference room separate from the Infirmary rounds.
    b. 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 individuals and individuals who required on-call intervention since the last meeting, and discussion about how to prevent reoccurrence of an illness, etc.
    c. Documentation in the minutes should include a brief history of the individual leading to the Infirmary or hospital admission.
    d. The minutes should include documentation of task assignments to gather information and/or implement action steps based on the critical concerns discussed, with a deadline date by which the information is shared at the morning meeting, with a concise closure

note.

e. Consideration should be given to expanding the morning meeting membership to include nursing administration, infection control, dentistry, habilitation services, and psychology. (Section L.1)

3. The Medical Department should request assistance and guidance from the State Office concerning the large number of DNR orders at the Facility for which adequate clinical justification was not present. (Section L.1)
4. The Medical Department should track timely completion of annual medical assessments, and require/ensure that PCPs complete quarterly notes. (Section L.1)
5. For each individual, the "preventive care flow sheet" should be updated regularly to include date of vision screening, flu vaccine administration, etc. (Section L.1)
6. The Medical Director should meet with the information technology department to develop a simple, accurate, complete, and useful system for tracking (e.g., an Excel spreadsheet) the completion of, and the next due date for many aspects of routine and preventive care, including mammograms, colonoscopies, and osteoporosis. (Section L.1)
7. A method should be developed and implemented to identify in the active record when an individual is in the Infirmary. (Section L.1)
8. Nursing Administration should ensure that nurses have dedicated time to pass medications, and other staff should be called to assist and intervene as needed to allow the medication pass to be completed without interruption. (Section L.1)
9. Because the database for individuals with pica was incomplete, it should be reviewed, and improvements made. (Section L.1)
10. A form or other procedure should be created and implemented to document notification of the ER of an individual being transported to that facility. (Section L.1)
11. The Medical and Nursing Departments should review cancellations of tests due to failures to follow related orders, and develop a tracking system in which recommendations and consultation orders are included, and monitoring occurs to ensure these occurrences are minimized. (Section L.1)
12. Hospital liaison nurse notes should be filed in the record in a timely manner. (Section L.1)
13. For humeral fractures, the Facility should review important factors related to this type of fracture (e.g., environmental changes, behavior management, diagnostic evaluations). (Section L.1)
14. Medical monitoring of fractures, injuries, and seizures requiring ER care would benefit from an accurate and complete tracking and review system. The Medical Director should meet with IT and incident management staff to determine the type of information that already exists, as well as any additional information that should be included. (Section L.1)
15. An interdisciplinary skin integrity committee should meet to monitor and provide technical assistance related to those individuals with decubiti. (Section L.1)
16. As recommended previously, a system 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 system also should allow tracking of the stage of ulcer and length of time until healing. (Section L.1)
17. Neurology clinic notes should include a brief entry about the absence or presence and type of side effects from AEDs prescribed. (Section L.1)
18. A system should be created and implemented to track all consultant recommendations and physician orders to completion. (Section L.1)
19. The Medical Department should develop a process for improving recommendations included in clinical death reviews. This should include identification of systems needing improvement or change (e.g., improved communication pathway, equipment), changes related to efficiency (identifying duplication of paperwork), clinical interventions that require improvement or change, etc., with a focus on impacting the care of the individual as well as the effectiveness/efficiency of the PCP. Recommendations should be tracked to closure. (Section L.2)
20. Documentation from the ethics committee should be formalized, to include a typed note identifying those members present, those members calling in by conference call, names of family/guardian present or calling in, a brief summary of the ethical question to be resolved, review of state laws and agency regulations pertaining to the case, and conclusion, with a vote of membership. (Section L.2)
21. External peer review audits should be finalized with a written report that summarizes the results of all of the records reviewed, and provides

any systemic recommendations. (Section L.2)

22. The external peer review process should ensure that 20% of the records are reviewed over each 12-month time period. (Section L.2)
23. In addition to reviewing the questions included on the tool to ensure clarity, instructions should be developed for the tool, and a process for testing inter-rater reliability between the various reviewers should be established and implemented. Such efforts should be aimed at improving both the reliability as well as the validity of the data. In addition, the Facility should work with State Office to add or delete questions as systemic issues are addressed and resolved and compliance increases in specific areas. (Section L.3)
24. In addition to audits that address largely documentation compliance, the monitoring process should be expanded to include clinical reviews using clinical indicators. (Section L.3)
25. In addition to the important monitoring/auditing of records, it also will be important for the Facility to develop a set of clinical indicators and outcomes through which to identify areas of strength, as well as areas of concern. (Section L.3)
26. The medical services policy should be expanded to include further information in the annual medical assessment, including special needs during the transition process. (Section L.4)
27. Facility policy also should be revised to include the expectations for quarterly medical assessments. (Section L.4)

| SECTION M: Nursing Care | |
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| 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:<br>▪ **Review of Following Documents**:<br>o ABSSLC's POI;<br>o ABSSLC's Nursing Supplemental POI;<br>o ABSSLC's Nursing Department Presentation Book;<br>o Nursing Services: Management of Transabdominal Feedings, revised 4/19/11;<br>o Nursing Services: [No specific heading, but focused on Restraint], revised 4/15/11;<br>o Nursing Services: Bowel Management Procedures, revised 4/18/11;<br>o DDS: Nursing Peer Review, revised 5/9/11;<br>o Nursing Services: Medication Administration Via Nasogastric Tube, Jejunostomy Tube Or Gastrostomy Tube, reviewed 4/20/11;<br>o Guidelines for Homes: Hypothermia/Fever Management, reviewed 7/22/11;<br>o Nursing Services: Respiratory Assessment, revised 3/11;<br>o Nursing Services: Management of Acute Illness/Serious Injury, revised 6/10/11;<br>o Nursing Services: Statement of Policies In Relation to Medication Procedures, revised 4/11;<br>o Nursing Services: Development of Care Plans, revised 5/27/11;<br>o State Office's Documentation Guidelines;<br>o ABSSLC's nursing staffing information for turnover and overtime;<br>o Resume for Program Compliance Nurse;<br>o Nursing Monitoring tools with instructions;<br>o Registered Nurse QA job description;<br>o Nursing QA data, from February through July 2011;<br>o Training curriculum and presentation regarding Acute Illness;<br>o QA and Nursing summary data for Nursing Department's monitoring data, from February through July 2011;<br>o ABSSLC's procedure for Inter-rater Reliability;<br>o Revised Nursing monitoring tools with instructions;<br>o Nursing Monitoring data, from February through July 2011;<br>o ABSSLC's lists of individuals who were seen in the emergency room, hospital, and Infirmary;<br>o Revised Preventative Care Flow Sheet;<br>o Monthly Infection Control Report for the Infirmary;<br>o Monthly Infection Control Reports, from February through July 2011;<br>o Drug Utilization Discrepancy Report data for Infection Control, and Action Plan;<br>o Outbreak Investigations for Residence 6400 for February 2011; Residence 6450 for March 2011; and Residences 6730, and 6740 for February 2011;<br>o Draft curriculum for Infection Control Training;<br>o The Nurses' Meeting minutes, dated 4/19/11 to 4/20/11;<br>o Infection Control Committee meeting minutes, dated 1/13/11, and 5/6/11; |

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| | o Infection Control Monitoring data, from February through July 2011;<br>o ABSSLC's monthly Mock Drill Reports, from February through July 2011;<br>o Nursing and QA raw data for Mock Drills;<br>o Medical Emergency Response Drill Workgroup meeting minutes, dated 8/2/11, 8/9/11, and 8/17/11;<br>o List of 4444 (medical emergencies), since February 2011;<br>o Symptoms/Signs training curriculum from State Office;<br>o The medical records for the following individuals: Individual #418, Individual #87, Individual #387, Individual #23, Individual #267, Individual #20, Individual #119, Individual #25, Individual #138, Individual #199, Individual #126, Individual #429, Individual #311, Individual #19, Individual #393, Individual #123, Individual #362, Individual #162, Individual #328, Individual #7, Individual #319, Individual #184, Individual #216, Individual #26, Individual #417, Individual #437, Individual #158, Individual #545, Individual #185, Individual #201, Individual #502, Individual #382, Individual #385, Individual #365, Individual #11, Individual #73, Individual #500, Individual #451, Individual #206, Individual #182, Individual #30, Individual #77, Individual #213, Individual #450, Individual #33, Individual #10, Individual #111, Individual #96, and Individual #94;<br>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);<br>o ABSSLC's Risk lists for health indicators;<br>o ABSSLC's Pharmacy Medication Room Inspections from February through July 2011;<br>o Nursing Service Medication Station Surveys, from February through July 2011;<br>o Medication Administration Observation tracking data;<br>o Nursing Monitoring data for Infirmary Positioning;<br>o Minutes of the Medication Error Committee, dated 2/16/11, 3/23/11, 4/27/11, 5/25/11, and 6/29/11;<br>o Medication Administration Observation tools from February through July 2011;<br>o ABSSLC's medication variance data, from February through July 2011; and<br>o Medication Observation Reports.<br>▪ **Interviews with**:<br>o Frank J. Kluza, RN, BA, Chief Nurse Executive (CNE);<br>o Mary White, RN, MSN, Quality Enhancement Nurse;<br>o Krista Hamilton, RN, BSN, Infection Control Nurse;<br>o Marilyn Branson, RN, Infection Control Manager;<br>o Elizabeth Greer, RN, Nursing Educator;<br>o Teresa Lowry, RN, Nurse Manager;<br>o Mary Willingham, RN, Program Compliance Nurse;<br>o Crystal Garcia, RN Case Manager;<br>o Carol Johnson, RN; |

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| | ○ Nicole Spalding, RD, LD;<br>○ Tricia Reyes, MS, RD, LD;<br>○ Linda Hinshaw, Facility Director;<br>○ Connie Horton, FNP, State Consultant;<br>○ Debra Schroeder, RN, Nurse Manager;<br>○ Valerie Kipfer, MSN, RN, State Office Nursing Services Coordinator;<br>○ Karen Mayfield, PT, DPT;<br>○ Lindsey Tierce, PT, DPT;<br>○ Debbie Sessions, MS, CCC/SLP;<br>○ Tammy Siegfried, RN, PNMT Nurse; and<br>○ Marjorie Hutchinson, RN, Nurse Manager.<br>▪ **Observations of**:<br>○ Medication Administration in Residence 6521;<br>○ PSP for Individual #403, on 8/22/11; and<br>○ Use of emergency equipment at the Infirmary and Residence 6521. |
| | **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 all of the sub-provisions. This was consistent with the Monitoring Team's findings.<br><br>Although the Facility self-assessment of noncompliance was in alignment with the findings of the Monitoring Team, no indication was provided in the POI of which information, observations, or data the Facility used to base its findings. No relevant data was identified to substantiate its findings of noncompliance, or to assist it in identifying areas requiring attention. In addition, no mention was made of actions implemented to demonstrate forward movement and progress for areas where actual progress had been made, such as in infection control and medical emergency response systems.<br><br>In its POI, the Facility included two Action Plans addressing training for the direct support professionals regarding signs and symptoms of illness and injury, and for Infirmary nurses addressing positioning programs and behaviors. However, no other Action Plans were included addressing deficient clinical issues found from the past reviews that the Facility should have viewed as priorities. In addition, the actions and interventions the Facility planned to implement and accomplish by the next review were not identified. |
| | **Summary of Monitor's Assessment:** Although ABSSLC had an increase in nursing turnover since the last review, they were able to fill most of the vacant nursing positions and maintain adequate staffing. Thus, the Facility had not needed to use any agency nurses, but did use overtime for situations when the Facility needed to augment nursing coverage. Positive staffing changes included the reallocation of a full-time Campus Nurse (RN) position to a Program Compliance Nurse position, which had been filled at the time of the review. Also, an RN position was reassigned and filled as a dedicated member of the Physical Nutritional Management Team. In addition, the Nurse Recruiter RN position that was assigned in February 2010 to work part time with QA, had been assigned to work full time with QA. Also, since the last review, an additional RN position was added to the Infirmary, and the two weekend RN III positions were returned |

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| | to regular eight-hour shifts. The end result was a total of nine RNs in the Infirmary with three RNs on each shift.<br><br>Since the last review, ABSSLC's QA Nurse, Program Compliance Nurse Monitors, and Nursing Department made progress in the following areas: instructions were developed for the monitoring tools for nursing; the auditing of specific areas within nursing was divided among the QA Nurse, Program Compliance Nurse, Hospital Liaison, Nursing Education, and Campus Nurses with some purposeful overlap; in August 2011, the QA Nurse began presenting an overview of nursing auditing data to the Nurse Managers; the Facility continued to generate monitoring data from the Nursing Monitoring tools, and it was entered into the Facility's QA database that generated a data summary report for each of the Nursing Health Monitoring tools; and the QA Program Compliance Monitors continued to provide oversight monitoring of the medical emergency response drills. However, many aspects of an adequate QA process were not yet in place, including a lack of adequate instructions for audit tools, and a lack of nursing care protocols to define the standards against which nursing practice at the Facility would be judged. In addition, neither clinical competence of the reviewers or inter-rater reliability had been established.<br><br>In the area of Infection Control, the Facility had made significant positive gains in building necessary elements of the infrastructure. Some of the progress noted specifically included: the IC staff continued to work with the unit staff regarding accurately reporting individuals with infections for data reliability; the Facility was in the process of implementing root cause analyses for infectious outbreaks; a structured format was implemented to organize and document actions taken in response to outbreaks that should lend to the Facility's ability to analyze the event more clearly; and the Facility recently had developed a very promising monitoring tool addressing clinical practice items that was to be implemented by the next review. Also, some progress was made regarding the Medical Emergency Response system, such as the recent implementation of a Medical Emergency Response Committee to discuss issues related to the Facility's emergency drills and systems.<br><br>However, consistent with the findings from the past reviews, no progress was made in the critical clinical areas addressing nursing Health Management Plans, nursing assessment and documentation in response to changes in status, quarterly and annual nursing assessments, and/or the development and implementation of nursing protocols. |

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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, | Given that this paragraph of the Settlement Agreement includes a number of requirements, this section of the report includes a number of different sub-sections that address various areas of compliance, as well as factors that have the ability to affect the Facility's compliance with the Settlement Agreement. These sections include staffing, quality enhancement efforts, assessment, availability of pertinent medical records, infection control, and medical emergency systems. Additional information regarding the nursing assessment process, and the development and implementation of interventions | Noncompliance |

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| | monitor, intervene, and keep appropriate records of the individuals' health care status sufficient to readily identify changes in status. | is found below in the sections addressing Sections M.2 and M.3 of the Settlement Agreement. Information and recommendations addressing nursing documentation regarding restraints is included in Section C.<br><br>In assessing its progress, ABSSLC indicated its POI that since the last review, the following steps were initiated regarding this requirement of the Settlement Agreement:<br>▪ *"04/07/2011-- Completed retraining with the infirmary RNs on communication with direct care professionals, knowledge of PNMP and behavior program.*<br>▪ *04/20/2011-- started an action plan to address the recognition of signs and symptoms of acute illness or injury by DSP. This action plan was completed on 05/30/2011."*<br><br><u>Staffing</u><br>At the time of the review, ABSSLC had a census of 443 individuals. Since the last review, ABSSLC's allotted positions for Registered Nurses (RNs) decreased from 82 to 78 due to two positions being reallocated to QA, one position frozen due to the closure of home 5961, and one moved to the Physical Nutritional Management Team. In addition, allotted positions for Licensed Vocational Nurses (LVNs) decreased from 104.5 to 101.5 due to frozen positions from building closures. Nursing vacancies included two RN positions and four LVN positions. This represented an increase in LVN vacancies from the last review. However, the Chief Nurse Executive reported that although considerable turnover had occurred in the Nursing Department since the last review, the Facility had not needed to use any agency nurses. Overtime was used for situations when the Facility needed to augment nursing coverage. The structure of the Facility's nursing services remained the same since the previous review.<br><br>In addition, the CNE had reallocated a full-time Campus Nurse (RN) position to a Program Compliance Nurse position. At the time of the review, this position had been filled. Also, as noted above, an RN position was reassigned and filled as a dedicated member of the Physical Nutritional Management Team. In addition, the Nurse Recruiter RN position (part time) that was assigned in February 2010 as a part-time position with QA had been assigned to work full time with QA. Also, since the last review, an additional RN position was added to the Infirmary, and the two weekend RN III positions were returned to regular eight-hour shifts. The end result was a total of nine RNs in the Infirmary with three RNs on each shift. These positive staffing reallocations should assist the Facility in its efforts in moving toward achieving compliance with the requirements of the Settlement Agreement.<br><br>Overall, ABSSLC continued to maintain an adequate number of nursing staff. From discussions with the CNE, in spite of the difficulty in the retention of nurses during the past six months, there was no indication that the Facility had fallen below minimum | |

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| | | staffing levels. As recommended previously, the Facility should continue its efforts in recruiting, maintaining, and evaluating reallocations of nursing positions to meet the requirements of the Settlement Agreement. Also, as ABSSLC policies are reviewed and/or revised, the Facility should ensure that policies, procedures, or protocols address the integration of these new positions.<br><br><u>Quality Enhancement Efforts</u><br>From discussions with the QA Nurse, the CNE, the Program Compliance Nurse, as well as review of the raw data from QA and Nursing generated from the Nursing Health Monitoring tools, ABSSLC was committed to moving forward in meeting the requirements of the Settlement Agreement. From interviews with the QA Nurse, Program Compliance Nurse and CNE, progress made since the last review included:<br>▪ Instructions were developed for the monitoring tools for nursing;<br>▪ On 7/18/11, the Facility revised ABSSLC - Review Process: Quality Assurance Process/Plan (QAP). This document specifically described the quality assurance system in terms of the organizational structure, functional responsibilities of management and staff, lines of authority, and required interfaces for those planning, implementing, assessing, monitoring, and improving the system. The QAP documented the elements of the State Center's QA process by identifying how and when quality system audits would occur;<br>▪ Nursing had reallocated and filled a full-time RN position for a Program Compliance Nurse;<br>▪ The auditing of specific areas within nursing was divided among the QA Nurse, Program Compliance Nurse, Hospital Liaison, Nursing Education, and Campus Nurses, with some purposeful overlap;<br>▪ In August 2011, the QA Nurse began presenting an overview of nursing auditing data to the Nurse Managers;<br>▪ The Facility continued to generate monitoring data from the Nursing Monitoring tools which was entered into the Facility's QA data base;<br>▪ The Facility's QA database, which generated a data summary report of the audit data for each of the Nursing Health Monitoring tools, was very impressive. Specifically, the data was presented by item for the specific monitoring tool. This method of presentation gave the data meaning, in that trends could easily be identified and outcomes of corrective actions easily evaluated; and<br>▪ The QA Program Compliance Monitors continued to provide oversight monitoring of the medical emergency response drills.<br><br>With that being said, in order for the Facility to move into a position of sustainable substantial compliance, foundational systems have to be built solidly first. The integrity of this foundational framework will affect the determination of substantial compliance in most, if not all of the clinical and nonclinical areas. To adequately and consistently | |

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| | | monitor all of the areas required by the Settlement Agreement, the Facility should first ensure the following systems are adequate:<br>▪ Although the Facility had initiated the process of developing instructions for the Nursing Health Monitoring tools, overall, the instructions were not clear or specific enough. They did not outline where the required documentation should be found and what specifically should be included in the documentation to meet compliance. In addition, in determining compliance, items addressing the quality of nursing documentation should be compared to quality standards, such as nursing protocols. Consequently, without clear and specific instructions, each auditor will use his/her judgment to assess compliance, which should not be the case. The Facility and the State should collaborate on developing specific instructions for the Health Monitoring tools.<br>▪ The auditors scoring the Health Monitoring tools must be clinically competent in the areas they are reviewing in order for the data generated to be an accurate reflection of the current practices.<br>▪ Inter-rater reliability needs to be established for each of the Health Monitoring tools to ensure that all auditors are consistently determining compliance using the same process and criteria. The lack of clear and specific instructions for the monitoring tools will negatively affect inter-rater reliability. Although the Facility reported that a procedure had been developed for inter-rater reliability, the QAP provided by the Facility addressing this issue did not describe how this process was to be conducted. Consequently, from discussions with the QA Nurse, the Program Compliance Nurse and the CNE, no consistent and adequate method had been used to establish inter-rater reliability. The Facility and the State should collaborate on developing a specific procedure regarding the establishment of inter-rater reliability to ensure consistency of the process throughout the SSLCs.<br>▪ Regarding the presentation of data, as noted in previous reports, it should include the total population being reviewed (N), and the sample of that population that was audited (n) to yield a percent sample, indicating the relevance of the compliance scores.<br><br>Although a review of the QA Nurses and Nursing Department's audits for the Nursing Health Monitoring tools appeared to have generated some relevant data, because of the problematic issues listed above, the data generated were unreliable. Initiating the structures listed above should facilitate the accuracy of the data, and bring the Facility's self-assessment more into alignment with the findings of the Monitoring Team. At this point in time, the Facility should consider decreasing the number of Health Monitoring audits conducted, and implement the remaining critical pieces of the monitoring system to generate credible data going forward. In addition, the Facility should give thoughtful consideration to prioritizing the reimplementation of the Health Monitoring based on the | |

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| | | significant problematic areas that affect the health and safely of the individuals at ABSSLC.<br><br><u>Assessment and Documentation of Individuals with Acute Changes in Status</u><br>Although, since the last review, the Facility had provided training regarding signs and symptoms of acute illness or injury, and sepsis, from discussions with the CNE, the Facility had not implemented any overall system modifications that would have resulted in any measurable changes regarding the documentation of nursing assessments, identification of health care problems, the timely notification of physicians/practitioners of health care problems, and/or the on-going monitoring of nursing reassessments and interventions to readily identify changes in status. Consequently, no progress had been made in addressing this requirement of the Settlement Agreement.<br><br>A review of 17 individuals' medical records (Individual #524, Individual #96, Individual #407, Individual #498, Individual #101, Individual #503, Individual #452, Individual #417, Individual #546, Individual #541, Individual #100, Individual #147, Individual #395, Individual #48, Individual #332, Individual #439, and Individual #10), who had been transferred to a community hospital, emergency room, or the Infirmary found:<br>▪ Nurses promptly and consistently performed a physical assessment on any individual displaying signs/symptoms of potential or actual acute illness in 0% of the records.<br>▪ Licensed nursing staff timely informed the PCP of symptoms that required medical evaluation or intervention in 0% of the cases.<br>▪ Appropriate information was communicated to the PCP in 0% of the cases.<br>▪ The nurse performed appropriate and complete assessments as dictated by the symptoms in 0% of the cases.<br>▪ The nurse conducted frequent assessments of the individual's clinical condition in 0% of the cases.<br>▪ A plan of care was developed including instructions for implementation and follow-up assessments in 0% of the cases.<br>▪ The documentation indicated that acute illness/injuries were followed through to resolution in 0% of the cases.<br><br>A review of these 17 individuals found that the same significant problematic clinical issues regarding nursing assessments and documentation that were identified during the past three reviews. The overall problematic issues that were found in all 17 records included specifically:<br>▪ The chronic lack of nursing documentation rendered it impossible to accurately determine when changes in status were initially occurring. Gaps in nursing documentation were found up to 13 days for individuals with significant health issues; | |

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| | | ▪ There was a consistent 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;<br>▪ There was a consistent lack of complete and appropriate nursing assessments noted in response to status changes in vital signs, and oxygen saturations;<br>▪ There was a chronic lack of follow-up from health issues noted in previous nurses' progress notes;<br>▪ The nursing notes consistently lacked specific description, size, and location of skin issues, such as reddened area, injuries, or bruises;<br>▪ There was consistent inadequate documentation and nursing assessments addressing the administration and follow-up effectiveness for PRN medications (as needed medications);<br>▪ There was consistent inadequate assessments and follow-up addressing indications and/or complaints of pain;<br>▪ There was a chronic lack of documentation of individuals' activities and tolerance for activities during the day, evening, and night to indicate any changes in mental status;<br>▪ There were basically no mental status assessments documented during status changes;<br>▪ There were significant gaps in nursing documentation when nurses' notes indicated that they were monitoring the individual's status;<br>▪ There was a consistent lack of documentation indicating that lung sounds were assessed and documented for significant respiratory issues;<br>▪ There was a consistent lack of assessment of bowel sounds, and abdomen exams documented for individuals with constipation or receiving PRN laxatives;<br>▪ Physicians/Practitioners were consistently not timely notified of changes in status, due to nurses' inadequate follow-up;<br>▪ The type of temperatures taken were not consistently documented;<br>▪ There was consistently no documentation that nursing communicated with the PNMT regarding changes in status for individuals at risk of aspiration/choking;<br>▪ There was consistent lack of communication between shifts regarding status changes and the need for regular assessments, and follow up;<br>▪ There was a consistent lack of specific descriptions of the individuals' behaviors, assuming that all staff reading the progress notes were familiar with the individuals;<br>▪ There was a consistent lack of analysis of contributing problematic issues affecting changes in status documented in the nursing notes;<br>▪ There were a number of chronic inappropriate abbreviations that could not be interpreted;<br>▪ There was a consistent lack of documentation regarding the individual's status and assessment at the time of transfer to hospital or emergency room; | |

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| | | ▪ There was inconsistent documentation indicating that an information packet was sent to the receiving hospital at the time the individual was transferred;<br>▪ There was inconsistent documentation that the nurse or physician notified the receiving facility of the individual's transfer;<br>▪ There was inconsistent documentation of the time, date, and/or method of transfer to the receiving facility in the progress notes;<br>▪ There was a consistent lack of a complete nursing assessment upon return to the Facility, especially addressing the same symptoms that precipitated the transfer to a community hospital;<br>▪ There was a consistent lack of regular follow-up days after the transfer occurred for symptoms related to the reason for the hospitalization;<br>▪ Heath Management Plans addressing health issues were consistently inadequate with regard to the goals and nursing interventions, and were not effectively modified after Infirmary stays and/or hospitalizations;<br>▪ Dates and times were not consistently documented for progress notes;<br>▪ A significant number of nursing progress notes and signatures were illegible; and<br>▪ There was a consistent lack of systematic documentation addressing the care of healthcare equipment individuals required, such as catheters, tracheotomies, and G-tubes.<br><br>These findings were consistent with the findings from each of the previous reviews. Although the Facility had received the nursing competency-based training provided by the State Nurse Practitioner group, and were in the process of completing the nurses' demonstration of skill competencies at the time of the review, this intervention alone had not resulted in any improvements regarding assessment and documentation. Without the implementation of nursing protocols to guide nursing practices in conjunction with the competency-based nursing skills training, forward movement in addressing this requirement will be significantly deterred. The Facility's POI indicated that it was not in compliance with the elements of this requirement, which was consistent with the findings of the Monitoring Team. Based on the number of medically compromised individuals at ABSSLC, this area should be considered a priority for implementation of plans of actions addressing the significant deficits in nursing care.<br><br><u>Availability of Pertinent Medical Records</u><br>From a limited review of records while on site, it was noted that very few documents were not found in the medical records during the review. This was a considerable improvement from the last review. The Facility should 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. | |

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| | | Infection Control<br>Since the last review, ABSSLC continued to have two registered nurses who were responsible for the Infection Control duties for the Facility. However, one of the RNs indicated that she would be retiring shortly after the review week, leaving only one RN to manage the IC responsibilities. At the time of the review, no indication was given as to whether or not the second IC position would be filled.<br><br>Although the Facility's POI did not include any information regarding progress addressing Infection Control, the following information gathered during the review, and from the exceptional content and organization of the IC Presentation Book indicated that IC had made significant forward movement in the process of building necessary elements of the infrastructure to progress in meeting the requirements of the Settlement Agreement. Some of the progress noted specifically included:<br>▪ The IC staff continued to work with the unit staff regarding accurately reporting individuals with infections for data reliability;<br>▪ Completion dates for interventions were added to the standard format of the IC meeting minutes;<br>▪ The Facility was in the process of implementing root cause analyses for reviewing infectious outbreaks;<br>▪ A structured format was implemented to organize and document actions taken in response to outbreaks that should improve the Facility's ability to analyze the event more clearly;<br>▪ The IC staff recently had developed a very promising monitoring tool addressing clinical practice items that was to be implemented by the next review;<br>▪ A formalized immunization schedule was constructed and implemented to ensure all individuals were receiving their immunizations timely, and was added to the ABSSLC's policies;<br>▪ The Preventative Care Flow Sheet was revised to reflect current guidelines for immunizations;<br>▪ Training was in process to address nursing documentation related to antibiotic use, and immunizations;<br>▪ The Facility developed and implemented a protocol addressing emergency management of vaccine reactions;<br>▪ The Facility was in the process of developing a new draft curriculum for Infection Control Training;<br>▪ The minutes of the Infection Control Committee contained significantly more information and analyses of the Facility's infection control data and actions initiated for issues such as Peripherally Inserted Central Catheter (PICC) line infections, conjunctivitis, and immunization documentation; and<br>▪ The Pharmacy and Therapeutics Committee presented information from a Drug | |

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| | | Utilization Evaluation regarding the vaccine Zostavax, for individuals age 60 and above. This resulted in interventions to alert physicians/practitioners when individuals were eligible for the vaccine.<br><br>Clearly, since the last review, the Facility and IC staff critically reviewed many of its systems regarding infection control, and began developing and implementing formal systems. However, at the time of the review, these systems were largely informal and thus, unreliable. The positive steps outlined above demonstrated sophistication in the understanding of the structure that needed to be built in order to attain and maintain compliance with the requirements of the Settlement Agreement.<br><br>Areas in need of further attention regarding infection control included systems that address clinical issues and outcomes, including;<br>▪ Although the Facility's Action Plan indicated that a system to ensure the adequacy and implementation of Nursing Care Plans addressing infectious and communicable diseases had been implemented as of 7/25/2011, the same problematic issues were found during this review as were found during the previous three reviews. Specifically, of 22 individuals reviewed that were identified as having an infectious communicable disease, only 16 (73%) had HMPs addressing the infectious issue. Of the 16 Nursing Care Plan reviewed addressing infectious diseases, none (0%) were found to be adequate (details about this review are discussed with regard to Section M.3). The Facility should develop and implement a system to ensure the HMPs for individuals with infectious/communicable disease are clinically appropriate.<br>▪ Since these issues affect clinical outcomes, the Facility should continue its efforts in the implementation of the clinical tools designed to assess the clinical practices and treatments of infectious and communicable diseases;<br>▪ IC should initiate the auditing of all individuals who are suspected and/or diagnosed with an acute infectious/communicable disease. These should be real time audits that do not fall under the randomized sampling procedures of the Facility. Due to the acute nature of infectious diseases and the potential for spread, auditing for this area should be conducted while the acute infection is active. Conducting retroactive auditing (i.e., conducting an audit after the event) would not be clinically appropriate, nor would be choosing only a percentage of individuals to audit;<br>▪ The Facility had not, but should develop a list of individuals who have had and those who still need immunizations to render them current;<br>▪ The Facility should expand its environmental monitoring auditing to include different staff members to avoid auditors from becoming used to the environment, and not accurately and adequately assessing the environment;<br>▪ The Facility should continue to conduct analyses on the IC data, implement plans | |

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| | | of action addressing problematic issues, and document the interventions implemented, and the resulting outcomes.<br><br>Since the last review, the IC staff had implemented a number of positive interventions to move forward in meeting the requirements of the Settlement Agreement. Although positive movement had been made regarding infection control issues, consideration should be given to having additional expertise in Infection Control provided to the Facility to assist the Infection Control Nurses in implementing systems to effectively operationalize the Infection Control Systems in alignment with IC standards of practice, as defined in the Health Care Guidelines and the Settlement Agreement.<br><br><u>Mock Code Drills and Emergency Response Systems</u><br>Since the last review, the Facility had made more positive steps forward in its efforts toward addressing issues regarding emergency response, including the following:<br>▪ The QA PCMs continued to audit the Medical Emergency Drills in conjunction with the Nurses producing more accurate auditing data regarding the quality of the staffs' performance during the Mock Drills;<br>▪ More participation was noted in the Mock Drills from the medical staff than previously;<br>▪ Emergency Equipment training was provided to all ABSSLC staff since the last review;<br>▪ Nurses were being asked to demonstrate the emergency equipment in conjunction with their medication observations;<br>▪ At the time of the review, the Facility had obtained a total of 28 Automated External Defibrillators (AEDs) and planned to ultimately obtain nine more;<br>▪ The Facility was beginning to implement additional emergency scenarios other than those requiring CPR;<br>▪ The Facility was conducting Medical Emergency Drills as required by policy;<br>▪ The Facility recently had implemented a Medical Emergency Response Committee, based on recommendations from a previous work-group that was formed to discuss issues related to the Facility's emergency drills and systems;<br>▪ Observations of staff's use of emergency equipment at the Infirmary and Residence 6521 found that the nurses observed were able to appropriately demonstrate the use of the oxygen, suction machines, and AEDs. Clearly, the training the Facility had implemented for this area had made a positive change since the Monitoring Team's initial reviews. However, consistent with the last review, problems were found with regard to the Emergency Cart Checklists from each unit, including blanks indicating that the emergency equipment was not being checked daily, as required, and that Nursing Managers were not checking these forms daily for completion. Also on both units, no indication was provided that any of the backup equipment, such as suction machines, was being checked. | |

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| | | The Facility should develop and implement a system to ensure that all emergency equipment is routinely checked and documented daily, and that the Nurse Managers are providing the appropriate oversight of this process.<br><br>Although there was limited information regarding any type of an analysis of the Mock Code Drills, some information addressed the performance issues related to the Mock Drills. However, the monthly Drill Reports need to analyze the drill data not just from the drills conducted during the particular month, but also across several months to identify problematic trends and strengths related to the emergency system. The data from the drills conducted since the last review was as follows:<br>▪ 78 drills conducted in February 2011 – unable to determine number passed (%);<br>▪ 14 drills conducted in March 2011 – unable to determine number passed (%);<br>▪ 99 drills conducted in April 2011 – 85 passed (86%);<br>▪ 102 drills conducted in May 2011 – 86 passed (84%);<br>▪ 116 drills conducted in June 2011 – 86 passed (74%); and<br>▪ 112 drills conducted in July 2011- 86 passed (77%)<br><br>The pass rate of the Mock Code Drills demonstrated some variability with a significant decrease in the pass rates during June and July 2011. This indicated that there were new significant issues that were not clearly reflected in the Mock Code Drills Monthly Reports. Over time, trends from the Mock Code Drills should be identified so that appropriate corrective actions can be implemented timely. In addition, this same type of analysis should be conducted for the 4444 calls (actual emergencies), and included in the minutes of the Medical Emergency Response Committee. In addition, the Facility should implement an Emergency Response Code form to track the sequence of events during actual medical emergencies, and use completed forms to review emergency responses.<br><br>Since the last review, the Facility had implemented a number of positive interventions to address the emergency response systems, especially the addition of a formal Medical Emergency Response Committee. Although many of these systems were still in the newly developed stage at the time of the review, the Facility's commitment to implementing the necessary improvements to the emergency response systems were clearly evident. | |
| 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 | In assessing its progress, ABSSLC indicated in the Facility's POI that since the last review, the following steps were initiated regarding this requirement of the Settlement Agreement:<br>▪ *"05/15/2011-- We are developing some training modules designed to hone the critical thinking skills of the nurses. We have currently developed a module on recognizing sepsis, a module on recognizing and treating stroke and are working on a module for Syndrome of Anti-diuretic Hormone (SIADH).* | Noncompliance |

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| | indicated by the individual's health status. | ▪ *07/21/2011-- We have completed the initial module (sepsis) with the nursing staff. Feedback from the staff has been very positive. 80% have completed this training the remaining will be completed by the end of the month.*<br>▪ *07/26/2011--The next module (stroke) was distributed to the nursing staff for review. Training will be completed during our scheduled nursing meeting 08/16/2011 and 08/17/2011."*<br><br>From discussions with CNE, there had been no interventions directly addressing the Nursing Comprehensive Assessments since the last review. Based on the following findings of the Monitoring Team, there had been no progress made in this area.<br><br>The Quarterly/Annual Nursing Assessments for 27 individuals who were identified by the Facility as being at risk for specific health indicators were reviewed, including those for: Individual #418 for circulation; Individual #87, Individual #25, Individual #328, and Individual #319 for weight issues; Individual #362, Individual #162, and Individual #216 for aspiration; Individual #387 for behavior; Individual #23 for constipation; Individual #267 for dental issues; Individual #20, and Individual #119 for osteoporosis; Individual #138 for urinary tract infections; Individual #199, and Individual #123 for choking; Individual #126, Individual #393, and Individual #437 for falls; Individual #429 for seizures; Individual #311 for skin issues; Individual #184 for fractures; Individual #19, Individual #26, and Individual #417 for infections; Individual #7 for respiratory; and Individual #158 for gastro-esophageal reflux.<br>▪ Of the 27 individuals' nursing quarterly assessments reviewed, 19 (70%) were timely completed. Assessments that were not timely completed, or were not included in the documentation provided were for Individual #387, Individual #417, Individual #216, Individual #7, Individual #19, Individual #119, Individual #199, and Individual #126.<br>▪ There was an adequate analysis of the health/mental health data between the previous and current quarters in none (0%) of the Nursing Summaries contained in the Comprehensive Nursing Assessments to indicate if the individual was making progress related to their health/behavior issues.<br>▪ There was an adequate assessment of the high-risk health indicators included in none (0%) of the Comprehensive Nursing Assessments.<br>▪ Nursing assessments were updated as indicated by the individual's health status in none (0%) of the Comprehensive Nursing Assessments reviewed.<br><br>Despite a number of the Comprehensive Nursing Assessments including more raw data addressing medication regimens and other additional information, no observable difference was noted in the quality of the documentation in the Comprehensive Nursing Assessment summaries since the last review. Although there were several different formats that were found among the nursing summaries, such as pasting the Health | |

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| | | Management Plan objectives in the Summary Section, there was no associated analysis of the health issues included in the summaries. In many assessments, the summaries were mainly a log of sequential dates of events, such as hospital or Infirmary admissions, or the dates an individual received a PRN ("as needed") medication for constipation, with no associated analysis of the data indicating if the health issue was getting better or worse.<br><br>Based on the consistent problematic findings found over the past reviews regarding Nursing Assessments, it was evident that nurses lacked the understanding regarding how to analyze, summarize, and document health/mental health issues in order to produce an appropriate summary of the individuals' progress regarding their health and behavioral status. The Facility should provide competency-based training to ensure nursing assessments include adequate clinical analysis, resulting in an appropriate summary of the individuals' progress regarding their health/mental health issues. Without the appropriate competency-based training regarding the documentation of a clinical analysis as should be included in the Summary Section of the Comprehensive Nursing Assessments, the quality of the assessments will not improve.<br><br>In addition, from discussions with the CNE, since the last review, no changes had been made regarding the process and content of Nursing Discharge Summaries. At the time of the review, the Facility continued to use the Comprehensive Nursing Assessment form for discharges that was noted in the last report as being inadequate. These assessments were actually the most recent quarterly Comprehensive Nursing Assessment, and not an assessment for someone who was being discharged from the Facility where they had resided for a number of years. It is imperative that the Facility review and revise its current nursing discharge procedures and documentation requirements to ensure that documentation addressing transition planning and implementation is specific enough to maintain continuity of care in the community.<br><br>A significant lack of clinical assessments for critical clinical health indicators, a lack of timely and appropriate follow-up on unresolved issues, a lack of an analysis of health/mental health issues, and a lack of critical thinking were found in all the Comprehensive Nursing Assessments reviewed. The Facility's POI indicated that it was not in compliance with the elements of this requirement, which was consistent with the findings of the Monitoring Team. | |
| 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 | In assessing its progress, ABSSLC indicated that since the last review, the following steps were initiated regarding this requirement of the Settlement Agreement:<br>▪ *"04/16/2011 - Risk training has been completed.*<br>▪ *06/01/2011 - All of the individuals living at Abilene State Supported living Center had their initial At Risk assessment completed. PST members will be completing* | Noncompliance |

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| | 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. | *additional At Risk assessments annually with the individuals schedule (sic) PSP meeting and whenever there is a significant change in their condition."*<br><br>From discussions with the CNE, since the last review, no interventions directly addressing Health Management Plans (HMPs) had been implemented. Consequently, no progress made had been made in this area as illustrated by the following findings of the Monitoring Team.<br><br>The records of 27 individuals who the Facility identified as being at high risk for specific health indicators were reviewed, including: Individual #418 for circulation; Individual #87, Individual #25, Individual #328, and Individual #319 for weight issues; Individual #362, Individual #162, and Individual #216 for aspiration; Individual #387 for behavior; Individual #23 for constipation; Individual #267 for dental issues; Individual #20, and Individual #119 for osteoporosis; Individual #138 for urinary tract infections; Individual #199, and Individual #123 for choking; Individual #126, Individual #393, and Individual #437 for falls; Individual #429 for seizures; Individual #311 for skin issues; Individual #184 for fractures; Individual #19, Individual #26, and Individual #417 for infections; Individual #7 for respiratory; and Individual #158 for gastro-esophageal reflux.<br><br>Of the 27 individuals' Health Management Plans (HMPs) reviewed:<br>▪ Thirteen (48%) were found to have a HMP addressing their high-risk health/mental health indicator. Those that did not have a related HMP included: Individual #418, Individual #387, Individual #23, Individual #19, Individual #123, Individual #362, Individual #162, Individual #7, Individual #184, Individual #216, Individual #26, Individual #417, Individual #437, and Individual #158.<br>▪ None (0%) of the goals listed in the 13 HMPs were clinically appropriate.<br>▪ None (0%) of the nursing interventions contained in the 13 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.<br>▪ None (0%) of the 13 HMPs were found to be clinically adequate.<br>▪ None (0%) of the 13 HMPs included proactive interventions addressing the health indicator.<br>▪ None (0%) of the 13 HMPs were adequately individualized. There were some HMPs in which it appeared that attempts had been made to individualize them, particularly the HMP for Individual #20 regarding osteoporosis. The date of the DEXA Scan, the resulting score, and some information addressing the individual's specific mobility issues were included in the HMP. However, this information did not translate into individual-specific nursing interventions based on the individual's needs and functioning. | |

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| | | As noted during the previous reviews, ABSSLC's Nursing HMPs continued to lack:<br>▪ Clinically appropriate goals/objectives related to the etiology of the identified health/mental health problems;<br>▪ Individual-specific interventions based on the individuals' needs;<br>▪ Adequate specific directions for caring for individuals who were identified as being at high risk related to their health/mental health issues; and<br>▪ Proactive interventions directed at preventing or minimizing the specific health risks.<br><br>Overall, the Health Management Plans reviewed were essentially the basic protocol templates for individuals who had specific health issues, such as constipation, seizures, falls, and pneumonia, with only a few incorporating minimal modifications.<br><br>While on site, a live review of Individual #498's medical record was conducted with some members of the nursing staff, the Facility Director, the CNE, the State Office Nurse Practitioner Consultant, the State Office Nursing Services Coordinator, the QA Nurse, as well as members of the Facility's Physical and Nutritional Management Team. The documentation indicated that the individual was at risk for aspiration, was enterally nourished by a gastrostomy feeding tube (G-tube), and had several past Infirmary and recent hospital admissions related to aspiration pneumonias and respiratory issues. In addition, the PNMT was following this individual. The Integrated Progress Notes (IPNs) reviewed indicated that a number of changes in the individual's status, such as decreased oxygen saturations, and variability in vital signs were occurring. In reviewing the documentation, specifically the interdisciplinary progress notes, a number of significant problematic issues were found regarding the recent care of this individual. Some of these problems included:<br>▪ Lack of recognition by nursing of changes in status;<br>▪ No nursing assessments conducted in response to changes in status;<br>▪ No consistent and regular nursing documentation to establish baselines and promptly identify changes in baselines regarding physical assessments, mental status, daily activities, positioning, treatments provided, pain assessments, vital signs, oxygen saturations, functioning of G-Tube, site inspections for G-Tube, and bowel and urinary output;<br>▪ Significant gaps in the nursing documentation (i.e., up to thirteen days without an IPN) for an individual with several health risks and changes in status;<br>▪ No indication that the physician was notified of changes in status;<br>▪ No indication that the PNMT was notified of changes in status;<br>▪ No IPNs indicating that Individual #498 was being followed, assessed, or monitored by the PMNT, even after a recent hospitalization; and<br>▪ No Nursing HMPs adequately addressing the individual's current health risks | |

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| | | that provided specific nursing interventions to guide nursing care.<br><br>These critical deficits that were found regarding the care of this individual related to the fact the ABSSLC did not have nursing protocols in place, and no clinically adequate HMPs were guiding care for this individual. Prompt discussions should occur between the Facility's Nursing Department and the State Office to evaluate whether or not what the Facility believed to be adopted templates for HMPs are a barrier, rather than a functional and usable outline for the development of clinically appropriate and adequate HMPs. This discussion likely should include other SSLCs' Nursing Departments, and immediate actions should be taken based on this evaluation.<br><br>An additional sample of individuals' records was requested for review to determine if individuals with infectious diseases had appropriate care plans to address their needs. The HMPs for 22 individuals (Individual #545, Individual #185, Individual #201, Individual #502, Individual #382, Individual #385, Individual #365, Individual #11, Individual #73, Individual #500, Individual #451, Individual #206, Individual #182, Individual #30, Individual #77, Individual #213, Individual #450, Individual #33, Individual #10, Individual #111, Individual #96, and Individual #94) that had a variety of infections since the last review period.<br>▪ Of the 22 individuals reviewed, 16 (73%) had HMPs addressing the infectious issue. Those that did not have a related HMP included: Individual #382, Individual #365, Individual #11, Individual #182, Individual #30, and Individual #96.<br>▪ Of the 16 Nursing Care Plans reviewed addressing infectious diseases, none (0%) were found to be adequate. Some of the deficiencies noted included:<br>o The significant lack of individualization of the HMP template;<br>o The lack of criteria for documentation, including who was to document, how often, where the documentation was to be done, who was to review the documentation, and how often it would be reviewed;<br>o Inappropriate goals that did not address the prevention of the spread of the infectious illness, but rather indicated that the individual would remain free from the infection, when the individual already had the infection;<br>o The lack of specific interventions addressing teaching and education for staff, as well as the individual regarding prevention of the spread of the infection;<br>o The lack of proactive interventions; and<br>o The lack of documentation demonstrating that interventions were actually being implemented.<br><br>Consistent with the findings of the previous reviews, no system was in place that ensured | |

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| | | that individuals with infectious diseases were being provided the appropriate infection control measures, or clinically appropriate interventions to prevent the spread of infections. As noted in past reports, due to the clinical ramifications of not having HMPs adequately addressing infectious and communicable diseases, it is imperative that this requirement of the Settlement Agreement be addressed. Nursing Administration, in conjunction with the Infection Control Nurses should develop and implement a system to ensure that the HMPs addressing infectious and communicable diseases are clinically adequate, individualized, and are being implemented consistently.<br><br>In order for progress to be made regarding this requirement, the Health Care Protocols the Facility was using as the template for HMPs should be individualized to meet the individuals' needs, with appropriate goals, specific nursing interventions that include proactive interventions, and identification of who will be implementing the action, how often it will be implemented, where it will be documented, and when the effects of the intervention will be reviewed and by whom. Regardless of the HMP format or template, as required by Sections G and F of the Settlement Agreement, collaboration with other disciplines regarding care plans should occur so that an interdisciplinary team approach is used consistently, and interventions from other disciplines are integrated in all Health Management Plans. Thoughtful and serious consideration should be given to the use of an integrated Health Management Plan that would incorporate all clinical disciplines' goals and interventions regarding an individual's health risk into one plan. The Facility indicated that it was not in compliance with this requirement of the Settlement Agreement, which was in alignment with the findings of the Monitoring Team. | |
| 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. | In response to this requirement, ABSSLC's POI indicated that in July 2011, the Facility hired a Registered Nurse for the position of a Program Compliance Nurse. The Facility reported that she had been working with the QA Nurses regarding inter-rater reliability, and improving communication between the compliance monitors and case managers regarding the auditing process and findings.<br><br>In addition, the Presentation Book for Section M indicated the following policies and procedures had been revised or reviewed:<br>▪ Nursing Services: Management of Transabdominal Feedings, revised 4/19/11);<br>▪ Nursing Services: [No specific heading, but focused on Restraint], revised 4/15/11;<br>▪ Nursing Services: Bowel Management Procedures, revised 4/18/11;<br>▪ DDS: Nursing Peer Review, revised 5/9/11;<br>▪ Nursing Services: Medication Administration Via Nasogastric Tube, Jejunostomy Tube Or Gastrostomy Tube, reviewed 4/20/11;<br>▪ Guidelines for Homes: Hypothermia/Fever Management, reviewed 7/22/11;<br>▪ Nursing Services: Respiratory Assessment, revised 3/11; | Noncompliance |

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| | | ▪ Nursing Services: Management of Acute Illness/Serious Injury, revised 6/10/11;<br>▪ Nursing Services: Statement of Policies In Relation to Medication Procedures, revised 4/11; and<br>▪ Nursing Services: Development of Care Plans, revised 5/27/11.<br><br>From review of these policies/procedures, no indication was provided of what, if any revisions/changes were made to these documents. As requested in the Monitoring Team's document request, policy changes should be highlighted. In addition, a number of problematic issues were found, including:<br>▪ Specific criteria for documentation was missing from most of the policies/procedures;<br>▪ Specific timeframes were not included or clearly indicated, such as how frequently nursing assessments and reassessments should be conducted and documented, as well as when critical indicators should be reported to the physician/practitioner or PNMT.<br><br>Overall, since the previous review, adequate modifications had not been made to the procedures and protocols contained in the resource books that the Facility obtained after the initial review. Such modifications were necessary in order to bring them into alignment with the Facility's structure and systems. These modifications should include identification of the specific responsibilities of disciplines, clear and appropriate timeframes for initiating nursing assessments, the type of assessments that should be conducted, the frequency of these assessments, and the parameters and time frames for the reporting of symptoms to the practitioner/physician and PNMT, if indicated. Based on the Monitoring Team's findings with regard to Sections M.1, M.2, M.3, and M.5, the Facility's interventions thus far had had no positive impact on the nursing practices, or reporting protocols that the Settlement Agreement required.<br><br>In addition, the State Office's Documentation Guidelines did not include essential and specific nursing protocols that defined the criteria for nursing care and the associated documentation requirements. The significant and consistent problematic findings regarding nursing assessments, Health Management Plans, and the nursing care and documentation for individuals, especially individuals with high-risk health indicators and/or changes in status warranting Infirmary and hospital admissions, indicated a continued lack of comprehension regarding the importance of nursing protocols and how they structure nursing practice and documentation to ensure they are in alignment with quality standards of practice. In addition, at the time of the review, the Facility did not have a plan for when these procedures and protocols would be developed/modified, and implemented.<br><br>Due to the lack of appropriate nursing protocols, no structured system was in place | |

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| | | guiding nursing practice and documentation at ABSSLC to ensure that:<br>▪ Clinically appropriate nursing assessments were conducted and documented at the appropriate clinical frequency;<br>▪ Timely communication occurred with practitioners/physicians or other disciplines regarding changes in status;<br>▪ Appropriate and clinically adequate HMPs were developed that outlined specific nursing interventions; and<br>▪ Audits addressing nursing practice included quality standards by which to accurately measure the nursing care and documentation.<br><br>In spite of several previous joint discussions between members of the Monitoring Team, the State Office Nursing Discipline Coordinator, the State Office Consultant, and other State Office staff regarding nursing practice and documentation, no progress had been made addressing this requirement. Due to the ongoing negative findings discussed in detail with regard to Sections M.1, M.2, M.3, and M.5 of the Settlement Agreement, it is urgent that the Facility develops and implement nursing protocols.<br><br>The findings from this review and the previous three reviews indicated that ABSSLC was continuing to fail to adequately and timely address the health care needs of the individuals residing at the Facility. Consequently, the Facility had not met the Settlement Agreement requirement that: "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." It was now more than 24 months from the effective date of the Settlement Agreement, and no progress had been made toward compliance. The Facility indicated that it was not in compliance with this requirement, which was consistent with the findings of the Monitoring Team. | |
| M5 | Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall develop 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. | Since the last review, in order to comply with this provision of the Settlement Agreement, ABSSLC had begun to implement the revised State policy addressing At-Risk Individuals. The Facility's POI for Section M.5 indicated that all the individuals residing at the ABSSLC had received an initial risk assessment, and that the PSTs were now reviewing these risk indicators at the annual PSPs and in response to any significant changes in status. However, according to the Facility's POI for Section I, the process for identifying and notifying the appropriate disciplines of a significant change of status was still in the development stage and had not been yet implemented. From a review of 13 individuals who had hospitalized due to significant changes in status (details are provided with regard to Section M.1), the Monitoring Team found that this system had not, in fact, been implemented.<br><br>Also, information contained in the Presentation Book for Section M indicated that during Nursing Meetings held on April 19 and 20, 2011, nurses were given information | Noncompliance |

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| | | regarding the use of the aspiration trigger sheets. Although these activities, as well as the progress made in the PSP process as noted below and with regard to Section I.1, were positive steps in addressing individuals who were at risk, no progress was noted with regard to nursing staffs' role in assessing and documenting clinical indicators of risk for each individual.<br><br>To assess the Facility's overall risk screening process, including nursing's role in the process, members of the Monitoring Team observed four individuals' PSP meetings (Individual #403, Individual #146, Individual #484, and Individual #30) while on site. Overall, the Monitoring Team noted considerable improvements, although not consistent across all teams, in the PSTs' clinical discussions, the use of supporting clinical data when determining risk levels, use of the new Risk Guidelines when the PSTs were discussing the individuals' risk levels, and in the facilitation of the PSPs. Some of the problematic areas the Monitoring Team identified included (more specific findings are provided with regard to Section I.1 of the Settlement Agreement):<br>▪ The PSTs needed to consistently use the Risk Level Guidelines and specific clinical data when determining risk levels;<br>▪ PSTs were uncertain whether or not to rate risk levels based on if supports were in place, or to rate the risk as if the supports were not already implemented;<br>▪ The PSPs were extremely lengthy resulting in some team members and individuals leaving the PSPs;<br>▪ The PSTs discussions regarding Action Plans for high and medium risks did not include measurable, functional, outcomes and interventions;<br>▪ Most of the interventions mentioned during the PSP meetings addressing high/medium risks did not reflect a clinical intensity in alignment with the level of risk designated by the teams; and<br>▪ When discussing interventions for high-risk indicators, the PSTs did not focus on proactive measures to include in the action plans.<br><br>Regarding the nursing assessments for risk indictors, the CNE reported that for individuals who were at high or medium risk for aspiration, nursing was using the Aspiration Pneumonia Enteral Nutrition Evaluation to meet the required nursing assessment for risk. However, a review of the APEN indicated that nursing's role was to complete the areas of the APEN that addressed the history of aspiration pneumonias, and other respiratory infections/conditions, and related hospitalizations, which did not constitute a nursing assessment. In addition, for those individuals who were designated as having high or medium risk indicators in areas other than aspiration, nursing was using the last quarterly or annual Comprehensive Nursing Assessment to meet the nursing assessment of risk requirement. These Comprehensive Nursing Assessments were used even if they had been completed months prior to the meeting determining risk | |

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| | | levels, and included little to no information or assessment of the specific risk indicator(s). Neither the APENs nor Comprehensive Nursing Assessments were adequate or representative of a focused assessment addressing health risk indicators. Neither of the forms lent themselves to the presentation of an adequate risk assessment.<br><br>A review of the APENs and Comprehensive Nursing Assessments for 27 individuals (Individual #418, Individual #87, Individual #387, Individual #23, Individual #267, Individual #20, Individual #119, Individual #25, Individual #138, Individual #199, Individual #126, Individual #429, Individual #311, Individual #19, Individual #393, Individual #123, Individual #362, Individual #162, Individual #328, Individual #7, Individual #319, Individual #184, Individual #216, Individual #26, Individual #417, Individual #437, and Individual #158) found that none (0%) were adequate nursing risk assessments, since none specifically addressed the high-risk health indicators, had been updated regarding health issues related to the high-risk health indicators, or included a nursing assessment. Specific findings and examples are provided with regard to Section I.2 of the Settlement Agreement.<br><br>A review of these 27 individuals' records was conducted to assess nursing staff's role in the assessment of the health categories that nursing was responsible for in the Integrated Risk Rating forms. The review found that none (0%) consistently contained specific clinical information to enable the PSTs to adequately evaluate and designate risk levels. Some of the problematic issues included:<br>▪ Lack of data regarding the number of seizures during the past year compared to previous years, needed medications changes to stabilize the seizure disorder, and the date of the last seizure activity;<br>▪ Lack of DEXA Scan scores, date(s) obtained, and treatments for osteoporosis;<br>▪ Lack of specific dates and locations of past fractures;<br>▪ Lack of results of cultures and sensitivities for urinary tract infections to evaluate hygiene practices by staff;<br>▪ Lack of specific data indicating regular bowel medication regimens, frequency of needed bowel PRN medications, and additional factors such as medications, fluid intake, and positioning affecting risk of constipation;<br>▪ Lack of specific information such as dates, locations, and organisms of infections; and<br>▪ Lack of Braden Scores, frequency of specific skin issues, responses to treatments, and additional factors, such as immobility, nutritional status, or incontinence affecting risk related to skin integrity.<br><br>A review of the same 27 individuals records was conducted to assess nursing staff's role in the development and implementation of Action Plans related to the high and medium risk indicators found that nursing: | |

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| | | ▪ Established and implemented a plan within fourteen days of the plan's finalization, for each individual, as appropriate, in none of the (0%) cases.<br>▪ Implemented a plan that met the needs identified by the PST assessment in none of these cases (0%).<br>▪ Included preventative interventions in the plan to minimize the condition of risk in none of the cases (0%).<br>▪ When the risk to the individual warranted, took immediate action in none of the cases (0%).<br>▪ Integrated the plans into the PSPs in none of the cases (0%).<br>▪ None (0%) of the plans showed adequate integration between all of the appropriate disciplines, as dictated by the individual's needs.<br>▪ For none of the plans (0%), there were appropriate, functional, and measurable objectives incorporated into the PSP to allow the team to measure the efficacy of the plan.<br>▪ Plans included the clinical indicators to be monitored and the frequency of monitoring for none of the individuals (0%).<br><br>Overall, the 27 Action Plans reviewed were found to be clinically inadequate in that they were generic in nature, not individualized, and were not reflective of the clinical intensity that should be provided for heightened health and mental health risks. The lack of clinically adequacy and individualization of the Action Plans were actually parallel to the inadequacy of the Nursing Health Management Plans, which unfortunately indicated problems regarding clinical competency rather than the inadequacy of a particular form.<br><br>In addition, the areas that the At-Risk Individuals policy designated nursing staff as responsible for assessing should be reviewed to determine which discipline is the most appropriate to conduct those assessments. For example, Speech Therapy has expertise assessing issues regarding aspiration and dysphagia, which is not within the scope of nursing practice. Additionally, it is within the scope of practice for Physical Therapy to assess balance, and gait regarding the risk for falls, which might result in a better and more comprehensive assessment than nursing staff could provide. Consequently, when these areas had been identified as being at risk and a risk assessment was warranted, nursing staff had only provided a summary of the problematic issues related to these areas, and not a clinical assessment.<br><br>While on site, the Monitoring Team discussed with the CNE, the State Office Nurse Practitioner Consultant, and Nursing Discipline Coordinator the issues related to that the current Comprehensive Nursing Assessment and APENs not appropriately meeting the requirements of an adequate assessment for addressing health risk indicators, and the need for review to occur to determine if some of the areas would be better assessed by another discipline. In order for progress to occur regarding this requirement of the | |

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| | | Settlement Agreement:<br>▪ The Facility, in conjunction with the State, should specifically define the nursing assessment process regarding at-risk individuals;<br>▪ Updated nursing assessments should be conducted when addressing high/medium risks indicators; and<br>▪ A review should be conducted of the areas that nursing assesses for risk to determine if other disciplines should be performing those risk assessments in alignment with various disciplines' scopes of practice.<br><br>The findings with regard to Sections M.1, M.2, and M.3 address the on-going significant deficits regarding aggressive and timely recognition and lack of implementation of clinical interventions for individuals who were at risk due to their health/mental health issues further demonstrating the significant lack of progress that has been made regarding this requirement. At the time of the review, ABSSLC's POI indicated that they were not in compliance with this requirement of the Settlement Agreement, which was consistent with the findings of the Monitoring Team. | |
| M6 | Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall implement nursing procedures for the administration of medications in accordance with current, generally accepted professional standards of care and provide the necessary supervision and training to minimize medication errors. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan. | In response to this requirement, ABSSLC's POI indicated that since the last review, progress made included the following:<br>▪ *"04/16/2011-- We are incorporating variance reports from the pharmacy into our medication variance data to attempt to broaden the scope to include medical and pharmacy errors.*<br>▪ *07/21/2011-- The medication error committee continues to meet and address systemic issues. Most pressing issues continue to be staffing on the 2-10 shift and unreconciled errors. Our clinical pharmacist has assisted several homes in consolidating medications and redistributing times to reduce workloads at medication times. We have had homes with high unreconciled errors counting all drugs each shift in an effort to pinpoint when errors occur so that we can take corrective action with specific nurses rather than defuse the teaching by addressing a large group of nurses. We continue to hire nurses as we can. We are utilizing our direct care RNs to assist in medication administration when we are required to double homes. Our current error rate has continued to decrease from 134 in 02/2011 to 32 in 05/2011.*<br>▪ *06/22/2011--Clinical Pharmacist has begun reporting information regarding Prescriber variances. The Action Plan related to this has been modified to exclude Pharmacy Variances until Statewide standards of measurement are determined by the work group. Collaboration of Pharmacist with individual homes to analyze med pass times and workload and to simplify regimens has begun. This is a new effort to decrease the potential for medication errors."* | Noncompliance |

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| | | Since the previous review, the Nursing Department in conjunction with the Pharmacy had implemented a number of positive interventions addressing the overall medication administration system. Some of these interventions included the following:<br>▪ The minutes of the Medication Error Committee meetings contained more information regarding the trends of variances, including the category of errors, severity, shift, unit, and home;<br>▪ Un-reconciled errors were being reported, and broken out of the data by month;<br>▪ Although inter-rater reliability had not yet been appropriately established for the Medication Observation monitoring tool, Medication Administration Observation data was being aggregated monthly, and included in the minutes of the Medication Error Committee meetings;<br>▪ In an effort to use more of a medication variance system than a medication error system, the Medical and Pharmacy Departments were beginning to initiate the reporting of variances to broaden the evaluation and assessment of the Facility's overall medication system;<br>▪ Some interventions were included in the minutes of the Medication Error Committee meetings addressing problematic issues that included the responsible person and date implementation was due;<br>▪ The Medication Error Committee evaluated the procedure for controlled drugs taken to school;<br>▪ The results of medication room inspections that the Pharmacy Department conducted resulted in retraining for nurses;<br>▪ The Pharmacy worked with Residences 6450, 6460, and 6480 in adjusting medication times based on medication compatibilities;<br>▪ During the Medication Error Committee meeting on 2/16/11, the Nurse Manager and Primary LVN from Residence 6370, the residence that had the most medication variances, presented issues related to inconsistent staffing and work load associated with medication variances; and<br>▪ Minutes of the Medication Error Committee meetings reflected an increase in the critical review of the Facility's medication system, as well as medication variances. For example, when variance data decreased, the minutes reflected that although the data demonstrated a positive outcome, it could also be a product of under-reporting.<br><br>A review of the medication variances reported by the Facility indicated the following;<br>▪ February - 134 reported variances;<br>▪ March - 115 reported variances;<br>▪ April - 73 reported variances;<br>▪ May - 32 reported variances;<br>▪ June - 37 reported variances; and | |

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| | | ▪ July - 77 reported variances.<br><br>Building on these systems, the Facility, through its Medication Error Committee, should continue to expand its analysis of the medication variance data. Also, as additional reliable variance data is collected, it should be thoroughly analyzed to identify trends, and plans of correction should be generated.<br><br>From discussion with the CNE, due to staffing, and other various issues, the Facility had not been able to conduct the required medication observations, consisting of observing each nurse each quarter. From the available Medication Administration Observations audit data, there were few comments found on the audits addressing if the nurse checked the PNMP for the correct position, and/or the medication administration instructions prior to administering the medications. The lack of comments found on the audits regarding this practice indicated that the nurses had appropriately completed this process. However, this finding did not comport with the Monitoring Team's findings, based on observations of medication administration at Residence 6521. The following significant issues were found while observing medication administration. These issues were consistently found during the previous reviews, most of which placed already medically compromised individuals at risk. Specifically, the nurse did not:<br>▪ Ensure individuals were in the proper positioning prior to and after medication administration;<br>▪ Utilize the PNMP when administering medications;<br>▪ Check residuals before administering medications for an individual with a gastrostomy tube;<br>▪ Know an individual was at risk for aspiration;<br>▪ Recognize that formula bubbling at the mouth of an individual was a sign of possible aspiration, rather than something the individual "usually did," and that this symptom warranted an assessment; and<br>▪ Receive competency-based training on the PNMPs for individuals for whom she was responsible for administering medications.<br><br>Given the ongoing problematic issues noted above regarding medication administration, progress had not occurred in this area, and individuals continued to be placed at risk, especially those individuals at risk for aspiration.<br><br>From discussions with nursing staff, a monitoring system was put in place at the Infirmary in response to a mortality where proper positioning and appropriate adaptive equipment were found not to be consistently implemented for Individual #10. However, for individuals that had a PNMP and were transferred to the Infirmary, no competency-based training on the individual-specific PMNP interventions had been provided to the | |

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| | | Infirmary staff. Based on the consistent problematic issues observed during the review regarding medication administration, the auditing process for this area continued to inadequately capture compliance regarding positioning and interventions for medication administration in alignment with the PNMPs. From observations, and discussions with nursing staff, there continued to be a critical lack of understanding within ABSSLC's Nursing Department regarding the clinical importance of consistently implementing the PNMPs. The Facility should develop and implement a system to ensure that prior to any nurse providing care to individuals with a PNMP, as well as those individuals with a PNMP transferred to the Infirmary, nurses are provided competency-based training regarding the PNMPs. In addition, training should be provided to nurses that are designated as auditors for medication administration observations regarding how to appropriately assess compliance regarding positioning and medication administration, including following the instructions in the PNMPs.<br><br>Although the Facility's overall medication monitoring systems were still in the early developmental stages, the initiation of regular reviews, analysis of trends, moving toward a medication variance system, and the use of the Medication Observation data in evaluating corrective actions related to the medication administration system were positive steps forward. The Facility had developed some of the basic infrastructure and implemented some very promising basic systematic processes regarding the medication administration system. Increased collaboration between the Pharmacy, Nursing, and Medical Departments is essential in constructing a solid process that lends to a critical review of the overall medication system. The Facility should continue to develop and implement strategies to increase the reliability of the medication variance data, such as conducting regular reviews and spot checks of the Medication Administration Records (MARs), and documenting these as audits.<br><br>At the time of the review, significant issues regarding administration of medications practices continued to exist that were in need of prompt and aggressive corrective actions. Although the Facility had made progress since the last review regarding this requirement of the Settlement Agreement, the Facility indicated that it was not in compliance with the elements of this requirement, which comported with the Monitoring Team's findings. | |

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

1. The Facility should ensure that all newly created or reallocated positions are appropriately integrated into the Facility's policies, procedures or protocols. (Section M.1)
2. The Facility should ensure that each monitoring tool has appropriate instructions that identify the specific criteria that constitute compliance with each item being monitored. (Section M.1)

3. The Facility, in conjunction with the State, should develop and implement a procedure for establishing inter-rater reliability to ensure it is executed appropriately and consistently. (Section M.1)
4. 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. (Section M.1)
5. At this juncture, the Facility should decrease the number of Health Monitoring audits conducted, and implement the remaining critical pieces of the monitoring system. This is necessary to generate credible data going forward. Once these systems are put in place, the Facility should give thoughtful consideration to prioritizing the reimplementation of the Health Monitoring tools, based on the problematic areas that affect the health and safely of the individuals at ABSSLC. (Section M.1)
6. The QA Nurses, Program Compliance Nurse, and the Nursing Department should ensure that they are clinically competent, critically auditing clinical issues, and focusing on the quality of the nursing services provided, not the just completion of required documentation. (Section M.1)
7. The Facility should address urgently and aggressively the lack of the implementation of nursing protocols to guide nursing care, as well as the lack of development of appropriate Health Management Plans, and the associated documentation. (Section M.1)
8. The Facility should increase its efforts in the implementation of the clinical tools assessing the clinical practices and treatments of infectious and communicable diseases, since these issues affect clinical outcomes. (Section M.1)
9. The Facility should initiate the auditing of all individuals who are suspected and/or diagnosed with an acute infectious/communicable disease. These should be real time audits that do not fall under the randomized sampling procedures of the Facility. Due to the acute nature of infectious diseases and the potential for spread, auditing for this area should be conducted while the acute infection is active. Conducting retroactive auditing (i.e., conducting an audit after the event) would not be clinically appropriate, nor would be choosing only a percentage of individuals to audit. (Section M.1)
10. A schedule addressing when individuals' records will be researched to identify possible needed immunizations should be developed to ensure individuals are appropriately prioritized and that no one is overlooked. (Section M.1)
11. The Facility should expand its environmental monitoring auditing to include different staff members to avoid auditors from becoming used to the environment, and not accurately and adequately assessing the environment. (Section M.1)
12. The Facility should conduct analyses on the Infection Control data, implement plans of action addressing problematic issues, and document when the interventions were actually implemented. (Section M.1)
13. The Infection Control Committee Meeting minutes should include a comprehensive analysis that identifies trends in the IC data, describes inquires into problematic trends, corrective actions addressing any problematic trends, the process for monitoring outcomes in relation to the activities, and the interventions of the Infection Control Department in conjunction with the practices on the units. (Section M.1)
14. The Facility should expand its use of the Root Cause Analysis process, and generate interventions in alignment with the findings from the process using an interdisciplinary approach. (Section M.1)
15. 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. (Section M.1)
16. The Facility should develop and implement a system to ensure that all emergency equipment is routinely checked and documented daily, and that the Nurse Managers are providing the appropriate oversight of this process. (Section M.1)
17. The Facility should implement an Emergency Response Code form to track the sequence of events during actual medical emergencies, and use completed forms to review emergency responses. (Section M.1)
18. Trends from the Mock Code Drills and 4444 calls (actual emergencies) should be identified, so that appropriate corrective actions can be implemented timely, and included in the Mock Code Drills Committee minutes. (Section M.1)
19. The Facility should maintain the data addressing emergency competency training in the same format as the data from other nursing monitoring tools for consistency of presentation, and to facilitate the comparison of compliance by items from month to month and across other nursing areas. (Section M.1)

20. The Facility should provide competency-based training to ensure nursing assessments include adequate clinical analysis, resulting in an appropriate summary of the individual's progress regarding his/her health/mental health issues. (Section M.2)
21. The Facility should review and revise its current nursing discharge procedures and documentation requirements to ensure that documentation addressing transition planning and implementation is specific enough to maintain continuity of care in the community. (Section M.2)
22. Competency-based training should be provided to the nursing staff regarding the criteria and structure of the development of adequate Health Management Plans. (Section M.3)
23. As required by Sections G and F of the Settlement Agreement, collaboration with other disciplines regarding care plans should occur so that an interdisciplinary team approach is used consistently, and interventions from other disciplines are integrated in all Health Management Plans. Thoughtful and serious consideration should be given to the use of an integrated Health Management Plan that would incorporate all clinical disciplines' goals and interventions regarding a health risk into one plan. (Section M.3)
24. Prompt discussions should occur between the Facility's Nursing Department and the State Office to evaluate whether or not what the Facility believed to be adopted templates are a barrier, rather than a functional and usable outline for the development of clinically appropriate and adequate HMPs. This discussion likely should include other SSLC's Nursing Departments, and immediate actions should be taken based on this evaluation. (Section M.3)
25. Nursing Administration, in conjunction with the Infection Control Nurses, should develop and implement a system to ensure that the Health Management Plans addressing infectious and communicable diseases are clinically adequate, individualized, and are being implemented consistently. (Section M.3)
26. It is critical that the Facility develops and implements adequate nursing protocols. Modifications to the available resource materials should include identification of the specific responsibilities of disciplines, clear and appropriate timeframes for initiating nursing assessments, the type of assessments that should be conducted, the frequency of these assessments, and the parameters and time frames for the reporting of symptoms to the practitioner/physician and PNMT, if indicated. (Section M.4)
27. A review should be conducted of the areas that nursing assesses for risk to determine if other disciplines should be performing those risk assessments in alignment with various disciplines' scopes of practice. (Section M.5)
28. The Facility, in conjunction with the State, should specifically define the nursing assessment process regarding at-risk individuals. (Section M.5)
29. The Facility should expand its analysis of the medication variance data in conjunction with the Pharmacy and Therapeutics Committee. As additional reliable variance data is collected, it should be thoroughly analyzed to identify trends and plans of correction generated. (Section M.6)
30. The Facility should develop and implement a system to ensure that prior to any nurse providing care to individuals transferred to the Infirmary, nurses are provided competency-based training regarding the PNMPs. (Section M.6)
31. Training should be provided to nurses designated as auditors for medication administration observations regarding how to appropriately assess compliance regarding positioning and medication administration, including following the instructions in the PNMPs. (Section M.6)
32. The Facility should develop and implement strategies to increase the reliability of the medication variance data, such as conducting regular reviews and spot checks of the MARs, and documenting these as audits. (Section M.6)
33. Further collaboration between the Pharmacy, Nursing, and Medical is necessary to construct a solid process that lends itself to a critical review of the overall medication system. (Section M.6)

| SECTION N: Pharmacy Services and Safe Medication Practices | |
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| 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:<br>▪ **Review of Following Documents**:<br>o All DUE reports completed since last monitoring visit: Follow-up DUE drug audited: Valproic acid and divalproex sodium for time period January 2011; Valproic acid (VPA) DUE follow-up study analysis March 2011; DUE data collection form, drug audited: Vitamin D2 and D3 retrospective study conducted May 2011; Vitamin D supplementation and monitoring DUE analysis June 2011; DUE data collection form, drug audited levothyroxine, retrospective study conducted August 2011;<br>o Pharmacy and Therapeutics Committee (P&T) Meeting minutes, dated 4/27/11;<br>o Medication Error Committee meeting minutes, dated 1/26/11, 2/16/11, 3/23/11, 4/27/11, 5/25/11, and 6/29/11;<br>o Drug utilization evaluation Schedule 2011;<br>o Quarterly Drug Regimen Reviews (QDRRs) for the following individuals (10% of individuals living at Facility, most recent that have been completed with physician signatures and dates): Individual #387, dated 6/8/11; Individual #119, dated 6/6/11; Individual #424, dated 4/21/11; Individual #402, dated 7/5/11; Individual #30, dated 6/15/11; Individual #7, dated 6/6/11; Individual #151, dated 6/17/11; Individual #74, dated 6/15/11; Individual #95, dated 6/15/11; Individual #26, dated 6/15/11; Individual #375, dated 6/2/11; Individual #509, dated 6/17/11; Individual #29, dated 6/17/11; Individual #366, dated 7/5/11; Individual #229, dated 6/17/11; Individual #394, dated 7/5/11; Individual #455, dated 6/8/11; Individual #272, dated 6/2/11; Individual #91, dated 6/6/11; Individual #526, dated 6/15/11; Individual #286, dated 6/2/11; Individual #53, dated 6/6/11; Individual #374, dated 6/7/11; Individual #107, dated 6/2/11; Individual #153, dated 6/15/11; Individual #137, dated 6/8/11; Individual #274, dated 6/8/11; Individual #253, dated 6/6/11; Individual #56, dated 6/15/11; Individual #270, dated 6/6/11; Individual #486, dated 6/15/11; Individual #191, dated 6/17/11; Individual #430, dated 6/15/11; Individual #287, dated 6/17/11; Individual #94, dated 6/15/11; Individual #35, dated 7/5/11; Individual #195, dated 7/5/11; Individual #539, dated 6/7/11; Individual #397, dated 6/7/11; Individual #124, dated 6/17/11; Individual #353, dated 6/6/11; Individual #54, dated 6/6/11; Individual #324, dated 6/15/11; Individual #391, dated 6/17/11; and Individual #206, dated 7/5/11;<br>o Patient interventions, from 3/1/11 through 7/8/11;<br>o For the past six months, any adverse drug reaction reports (ADR) completed;<br>o For the past six months, any data summaries used by the Facility regarding medication variances, and/or quality assurance/enhancement reports, including subsequent corrective action plans: total errors fiscal year 2010/2011 through 5/11, unreconciled errors fiscal year 2010/2011 through 5/11, total/unreconciled errors fiscal year 2010/2011 through 5/11, monthly errors by category for 8/10 to 5/11, sorted by node for 6/10 to 5/11, sorted by severity for 7/10 to 5/11, monthly totals by type for 7/10 to |

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| | 5/11, data sorted by shift for 6/10 to 5/11, errors by unit for 7/10 to 5/11, data sorted by residence for 8/10 to 5/11, data sorted by selected residence for 8/10 to 5/11, medication errors sorted by error node for 1/11 to 5/11 (error node: administering, dispensing, documenting), medication errors sorted by severity for 1/11 to 5/11 (Severity A, B, C, and D), medication errors sorted by error type for 1/11 to 5/11 (extra dose, omission error, other, wrong administration technique, wrong dose, wrong patient, wrong time), medication errors sorted by shift for 1/11 to 5/11 (Shift 1, 2, and 3), medication errors sorted by Unit for 1/11 to 5/11 (Units 1 through 6), medication errors sorted by residence for 1/11 to 5/11, medication errors sorted by nurse for 1/11 to 5/11, medication errors sorted by individual for 1/11 to 5/11, Analysis of Medication Error data from May 2011, email from PharmD to CNE, dated 6/28/11, and memos from nurse educator to CNE, dated 2/10/11, 3/23/11, and 4/27/11;<br>o Copies of the last 10 medication error forms completed and any plans of correction arising from review of the medication errors;<br>o Copy of any communication between Pharmacy and Nursing Departments concerning medication errors/variance (emails, memos, etc.) since the last compliance visit: report from PharmD to Med Error Committee, dated 12/22/10, and emails from PharmD to CNE, dated 6/1/11, 6/28/11, and 7/5/11;<br>o Medication Administration Observation tool, dated 5/11, and 6/11;<br>o Drug Regimen Review Profile for individuals with J-tubes: Individual #75, Individual #53, Individual #359, and Individual #83;<br>o Drug Regimen Review Schedule per residence;<br>o Restraint checklist, face-to-face assessment, debriefing, and reviews for crisis intervention restraint for the following: Individual #87 on 6/18/11 at 19:35 hour, Individual #87 on 6/30/11 at 18:30 hour, Individual #87 on 7/8/11 at 14:20 hour, Individual #424 on 4/2/11 at 14:00 hour, Individual #95 on 5/21/11 at 04:12 hour, Individual #95 on 5/26/11 at 20:00 hour, Individual #95 on 5/26/11 at 17:35 hour, Individual #95 on 5/26/11 at 16:30 hour, Individual #95 on 5/27/11 at 04:50 hour, Individual #48 on 6/16/11 at 19:40 hour, Individual #48 on 6/16/11 at 21:15 hour, Individual #546 on 5/3/11 at 10:02 hour, Individual #465 on 5/6/11 at 15:30 hour, Individual #332 on 7/7/11 at 11:45 hour, Individual #332 on 7/7/11 at 15:10 hour, Individual #323 on 6/20/11 at 13:30 hour, Individual #287 on 5/31/11 at 17:00 hour, Individual #59 on 5/10/11 at 12:15 hour, Individual #59 on 6/15/11 at 09:00 hour, Individual #324 on 3/21/11 at 15:38 hour, Individual #150 on 6/16/11 at 15:00 hour;<br>o Trend analysis of chemical restraint use July 2010 – April 2011 (graph);<br>o Summary list of all chemical restraints administered over the last six months;<br>o Antiepileptic and Psychotropic Medications: surveillance studies and drug levels updated May 28, 2009, Section 3 – Medical 03-06.04; and<br>o Presentation Book for Section N.<br>▪ **Interviews with**:<br>o Marla Knight, R. Ph., Pharm D, Clinical Pharmacist. |

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| | **Facility Self-Assessment:** Overall, the Facility determined it was in substantial compliance with Sections N.1, N.2, N.3, N.4, N.6, and N.7. It determined it remained out of compliance with Sections N.5 and N.8. The Facility's findings were partially consistent with the Monitoring Team, which found the Facility in compliance with Sections N.4, and N.7. The difference in findings for Section N.1 appeared to be due to the Facility's lack of review of each of the requirements of the section, which should have identified that lab information or the need for lab values to be obtained was not being included in the review the new medication orders. Further, data for the internal monitoring (10% review of drug-drug interactions) of the new order processing was not provided. For Section N.2, there was no information provided to determine timeliness of the QDRR reports. For Section N.3, there was need for review of clinical justification of use of anticholinergics.<br><br>For some of the sections in which the Facility found itself to be in compliance with the Settlement Agreement, no objective data was offered to confirm the finding. For example, for Section N.1, the Facility merely stated that the process was being completed as required, and documentation would show this. As noted above, this was not sufficient to identify an area of noncompliance. For only a few subsections, the Facility's POI indicated that reviews had been conducted. It was unclear of what the reviews consisted (i.e., methodology), who conducted the reviews, or what monitoring tools were used. Based on the information provided, it did not appear that the Facility had an adequate self-assessment process in place for Section N.<br><br>One action plan was included for Section N.8, related to the development and implementation of a medication variance system. Although this action plan provided some reasonable steps, these represented only the some of the initial steps that would need to be taken to develop and implement a comprehensive medication variance system. |
| | **Summary of Monitor's Assessment:** The Pharmacy Department had made substantial progress in many areas. The Monitoring Team found the Facility to be in compliance with Section N.4, and N.7. Sections N.2, N.3, and N.4 relate to quarterly drug regimen reviews, and the Pharmacy Department's review of such areas as polypharmacy, use of newer generation antipsychotic medication, and chemical restraint use. Chemical restraints were tracked separately, and a new procedure that began in March 2011 resulted in marked improvement in the pharmacy obtaining all required restraint forms, and completion of forms in a brief period of time. Section N.7 addresses drug utilization evaluations and follow-ups. The Facility had consistently completed them on a quarterly basis. Additionally, the quality of the reviews was impressive, and the pragmatic impact on clinical care demonstrated the value this information being brought to the PCPs.<br><br>For Section N.1, a remaining area of noncompliance was a review of necessary lab work and identification of prior abnormal lab values for aspects of care that would affect choice and dosage of medication. There was little communication in the "patient interventions" section about the need for lab either prior to administration of new orders, or an ongoing basis. Lab testing results were not available through WORx, but were needed as part of the review process. This would assist with compliance with the Facility policy outlining specific tests and frequencies of tests for antiepileptic drugs (AEDs) and antipsychotic medication, although testing should include a review for all classes of medication, especially with |

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| | individuals with chronic renal failure or chronic liver disease.<br><br>Section N.6 addresses adverse drug reaction reporting. Although significant progress had been made, the submitted data indicated the need for correcting some areas related to documentation. In addition, the Facility needed to put systems in place to ensure timely review of ADRs with prescribing practitioners, and remedial action on an individual and/or systemic level to potentially prevent recurrence. Section N.8 addresses the development and implementation of a medication variance system. There was need to include pharmacy dispensing variances and PCP prescription variances in the data. The pharmacy currently provided database management and analysis, and additionally had assisted the Nursing Department with action plans for reducing error rates. As this area remained incomplete, it is considered noncompliant, but much progress had been made. |

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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 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. | The Pharmacy Department was composed of a Chief Pharmacist, a Clinical Pharmacist (PharmD), two additional pharmacists, and four pharmacy technicians.<br><br>The Pharmacy Department used the WORx system to process new orders for side effects, allergies, drug interactions with current drug regimen, and dosage regimens.<br><br>As part of this initial order process, areas of concern were communicated with the PCP before the order was completed. The WORx system allowed for documentation of interventions (communication) between the pharmacy and the PCPs. In March 2011, there were 35 interventions; in April 2011, 43 interventions occurred; in May 2011, 45 interventions occurred; and in June 2011, there were 60 interventions. In all but two intervention entries, the name of the medication was listed.<br><br>Additionally, the Clinical Pharmacist reviewed 10% of the new orders with drug interactions each month. This was done through the WORx software. When the pharmacist reviewed the drug interaction section, a "viewed" box was recorded as checked. This box could be retrospectively reviewed for any new prescription by a monitor (e.g., the Clinical Pharmacist). If the interaction was considered significant, this was then recorded in the "interventions" section, which documented communication with the PCP. This information also was retrieved as part of the 10% review of new orders that the Clinical Pharmacist conducted. However, there was no data submitted to determine which/numbers of orders were chosen for review, the drug interaction of concern, and the degree of compliance, with trend analysis over time.<br><br>An area in which evidence was not provided to substantiate compliance was the systemic approach used to review "the need for laboratory results, additional laboratory testing regarding risks associated with the use of the medication." Occasional "intervention" | Noncompliance |

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| | | entries documented communication indicating the need for a drug level, but there was no systemic approach identified to ensure lower doses of medications were given if adjustments needed to be made for chronic renal insufficiency, discussing the need for initial or follow-up ammonia levels, platelet counts, etc., for specific medications which might impact these lab results. These were thoroughly discussed in the QDRRs, but appeared to be missing as part of the initial order process in the pharmacy.<br><br>As an example, the ABSSLC policy entitled: "Antiepileptic and Psychotropic Medications: Surveillance Studies and Drug Levels updated May 28, 2009" provided guidance for test ordering at the initiation of treatment and serially. This provided an example of the role the pharmacist should play in communicating with the PCP to ensure new orders had these additional laboratory orders written or completed as appropriate. Several of the AEDs have recommendations for laboratory testing to be completed and results reviewed prior to initiating treatment to ensure it is safe to commence treatment. The pharmacist should play a key role in ensuring such policies and protocols are followed.<br><br>To ensure that individuals do not receive medication incompatible with J-tube administration, the pharmacy continued to place these classes of medication in the allergy section of the individual's history. This provided a warning to the pharmacist to review the medication before dispensing certain classes of medications to those individuals with J-tubes. Examples of these were submitted on the drug regimen review profiles for Individual #75, Individual #53, Individual #359, and Individual #83. On review of these documents for these specific individuals, there were two concerns. If the individual was hospitalized and would benefit from IV quinolones, the information forwarded would limit the antibiotic options, as the individual would be labeled with an allergy to this class of medication. This was especially concerning for Individual #83, who already had an allergy listed to another class of antibiotics. Additionally, for three of the four individuals, who have J-tubes, the allergy section was confusing, because it listed "no known drug allergies," as well as the medications that should not be given through a J-tube. It is recommended that to reduce confusion, this information be placed in the section after allergies under "notes."<br><br>At the time of the review, the Facility was in compliance with the portions of this section related to reviewing new orders for significant drug interactions, side effects allergies, and dosage adjustments. The Clinical Pharmacist monitored these new orders to ensure the steps were completed. However, the remaining barrier to compliance with this section was the review of needed lab and identification of prior abnormal lab values indicating need for dosage adjustments or changes to another class of medication. | |
| N2 | Within six months of the Effective Date hereof, in Quarterly Drug | Quarterly Drug Regimen Reviews were completed according to a rotating schedule to ensure individuals in each residence were reviewed every three months. This required | Noncompliance |

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| | Regimen Reviews, a pharmacist shall consider, note and address, as appropriate, laboratory results, and identify abnormal or sub-therapeutic medication values. | that seven to eight residences be reviewed each month.<br><br>However, there was no information to indicate the dates of the previous quarterly drug regimen reviews to determine timeliness of completion. QDRRs should be completed within a 90-day time period from the prior evaluation. A listing of completion of the QDRRs over serial quarters in the past year would provide the needed information to determine this area of compliance.<br><br>A total of 45 completed QDRRs were submitted for review. They were completed from 4/21/11 through 7/5/11. In all 45 (100%), appropriate laboratory results were identified, with pertinent normal values as well as abnormal values (especially drug levels). A list was provided of current medication with the last test date recorded, with pertinent abnormal values listed. These were matched to the annual protocols and specific medication class protocols (such as atypical antipsychotics).<br><br>For consistency and clarity, it is recommended that the thyroid stimulating hormone (TSH) that was listed be identified in all cases as abnormal or normal for those on thyroid medication, and for those on lipid lowering agents that lipid panels specifically indicate either actual values or whether the values were normal or abnormal. Currently, these were recorded as normal or abnormal for some individuals, but simply listed for others. In interpreting this information, the reader would assume these values were normal, but to provide more clarity the test results should be treated similarly in each QDRR. The Clinical Pharmacist provided an extensive review of lab results, and the above recommendations would enhance clarity.<br><br>However, the Facility remained out of compliance with this provision, because as noted above, information was not provided to substantiate the timeliness of the reviews. | |
| N3 | Commencing within six months of the Effective Date hereof and with full implementation within 18 months, prescribing medical practitioners and the pharmacist shall collaborate: in monitoring the use of "Stat" (i.e., emergency) medications and chemical restraints to ensure that medications are used in a clinically justifiable manner, and not as a substitute for long-term treatment; in monitoring the use of benzodiazepines, anticholinergics, | This provision of the Settlement Agreement encompasses a number of requirements. Each of them is discussed below, including the Pharmacy and Medical Departments' roles in addressing the use of "Stat" medications and chemical restraints, as well as benzodiazepines, anticholinergics, polypharmacy, and monitoring the metabolic and endocrine risks associated with second generation antipsychotics.<br><br><u>"Stat" Emergency Medications/Chemical Restraint Use</u><br>"Stat" medication/emergency chemical restraints was monitored through the use of the "Restraint Checklist" form, which included the "Administration of Emergency Medication Protocol (chemical restraint)," "Face-to-Face-Assessment, Debriefing, and Reviews for Crisis Intervention Restraint." The last page of this lengthy document included a "chemical restraint clinical review" that the pharmacist was to complete. The Pharmacy Department was to address three areas of the chemical restraint use: whether the | Noncompliance |

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| | 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. | medication was used in a clinically justified manner, the potential medication-related risks that should be considered, and actions/recommendations, if any. Since the Monitoring Team's last visit, the Pharmacy Department had initiated a new process for chemical restraint documentation. The end result was the more timely completion of the form by the Pharmacy Department, as well as improved database management informing the Pharmacy Department when each chemical restraint occurred, to ensure none was overlooked.<br><br>The Facility submitted 21 completed "Restraint checklist" forms. Forms were submitted for chemical restraints between 3/21/11 and 7/8/11. This included all chemical restraints during this time period except for Individual #37, who was restrained twice on 3/25/11, and subsequently, was transferred to a state psychiatric facility. No further information was available for those two restraints. For one individual, Individual #323 with chemical restraint on 6/20/11, the last page of the document, which included the pharmacy response, was not submitted. For the other 20 chemical restraint forms submitted, documentation was completed.<br><br>The following information is based on the completed chemical restraint forms provided (19):<br>▪ All pharmacy reviews (100%) answered the three key areas required by pharmacy. In addition to including the medication, dosage, and route of administration, they included a review of whether it was clinically justified, a list or potential risks, and action steps to consider in monitoring the individual to ensure safety after administration of the chemical restraint. A description of effectiveness of the restraint also was given.<br>▪ The pharmacist had signed and dated each of them (100%). The time period between the event and the completion date by the pharmacist varied from one day to 11 days. More specifically, for April, the form was completed in one day, for May, the form was completed from two to 11 days, for June, the form was completed from one to five days, and in July, the form was completed from three to four days.<br>▪ In all cases (100%), the psychiatrist subsequently signed the document the same day as the pharmacist or within two days of the pharmacy review, indicating the system provided prompt communication to the psychiatrist. This indicated a rapid turn around response from the Pharmacy Department as well as sign off by the psychiatrist.<br>▪ For the last three months (May, June, July 2011), 19 chemical restraints were administered. Of these 18/19 were completed and submitted, for a more recent compliance rate of 95%.<br><br>Given that the turnaround of information from the Pharmacy Department was now rapid, | |

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| | | it is recommended that the recommendations include not only the physiological parameters that should be monitored based on the risk profile of the medication administered and the drug regimen of the individual, but also provide guidance to the PST as to the options for future chemical restraints. The Pharmacy Department also indicated the level of effectiveness, which provided valuable information to the PCPs and PST. However, the Pharmacy Department should provide guidance as to whether to maintain the same medication and dosage for future chemical restraints for that individual if effective, or suggest a lesser dosage if needed in the future. If the restraint was not effective, the Pharmacist should recommend the chemical restraint options that best meet the needs of the individual based on risk and current drug regimen (i.e., increase the dosage, change the medication, or add a second medication, with or without adjustment of the prior chemical restraint, for example). This additional recommendation is not considered a substantial issue for compliance, but provides additional information to an already valuable document.<br><br>The Pharmacy Department also tracked use of chemical restraints. According to a graph entitled "chemical restraints", which illustrated chemical restraint use from July 2010 through April 2011, usage had a downward trend over several months. Chemical restraint use appeared to have peaked in September 2010, with 18 chemical restraints, and use has been drifting downward since that time. The last major spike in chemical restraint use was in January 2011, at which time, 13 chemical restraints were recorded. However, the curve had troughs and peaks, indicating chemical restraint use was an ongoing challenge. The more recent data for April showed one restraint and May showed 10 restraints, demonstrating the ongoing variation in absolute numbers of chemical restraint use over the recent months.<br><br><u>Benzodiazepine Use</u><br>If the individual was prescribed a benzodiazepine, it was identified in the QDRR, and potential side effects and drug interactions were discussed. Of the 45 QDRRs reviewed, there were nine individuals who had been prescribed this class of medication, and all had discussion of risks, and all were reviewed for appropriate diagnosis. Compliance was 100% for this area.<br><br>In addition to the information provided in the QDRR, the Clinical Pharmacist provided information to the PCPs concerning the potential association of benzodiazepine use and dysphagia.<br><br><u>Anticholinergic Monitoring</u><br>Of the 45 QDRRs reviewed, 28/29 discussed the anticholinergic effects of the drug regimen prescribed. The exception was the QDRR for Individual #95, in which the anticholinergic effect of Chlorpromazine was not discussed. Compliance was 97%. | |

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| | | In addition to the material provided in the QDRR, the pharmacy distributed a list of those medications that have high anticholinergic activity, grouped by each PCP's caseload/residence. During the 4/27/11 P&T Committee meeting, the Clinical Pharmacist provided an in-service to the PCPs reviewing the potential serious sequelae of anticholinergic side effects (e.g., aspiration pneumonia, dry mouth, sedation, urinary retention, constipation) to heighten awareness of the need to minimize prescribing medications with these side effects.<br><br>However, the Settlement Agreement requires a pharmacy review of clinical justification of those medications prescribed with anticholinergic activity. Defining the anticholinergic drug load level on a medication or combination of medications prescribed would identify the risk involved and provide clarity to the degree of risk, rather than simply warning the PCPs that an anticholinergic side effect risk exists in prescribing a medication or combination of medications. However, the clinical justification of the medications should include a review of the current anticholinergic side effects the individual was experiencing (if any), and whether the amount of side effects justifies the continuation of the medication causing or contributing to the anticholinergic side effect. This should be completed for all individuals on Cogentin, but also any other medication or combination of medications with significant anticholinergic potential. Developing criteria to determine when the side effects reach an unacceptable level (and no longer clinically justifiable) might require collaboration with the PCP and guidance from the Psychiatrist and Medical Director.<br><br>In part due to the QDRRs and increased awareness of the side effects caused by anticholinergics, as of the 4/27/11 P&T committee meeting, anticholinergic use was reported to have decreased 48% over the prior five quarters. From the first quarter of 2010 through the first quarter of 2011, the number of prescriptions for high anticholinergic medications had dropped from 124 to 65.<br><br><u>Polypharmacy</u><br>Polypharmacy was identified in 18 of the 45 QDRRs reviewed. Many of these involved polypharmacy for medical diagnoses and not psychiatric diagnoses. Review included whether the prescription was appropriate (i.e., clinically justified), whether there were potential interactions with other drugs or food, and whether monitoring/evaluation had occurred of effectiveness and appropriateness of the drug regimen, as well as the side effects. Compliance was 100%.<br><br>In part due to the QDRRs, as well as the Polypharmacy Committee, and other educational in-service sessions provided to the Medical Department, prior to the 4/27/11 P&T Committee meeting, psychotropic drug use had decreased over the five quarters. | |

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| | | Tracking of psychotropic medication use documented that 203 prescriptions for drugs were eliminated, which was a 27% reduction in psychotropic drug use. Also, the number of psychotropic medication per person had been reduced from an average of 3.12 medications per person to 2.57 medications per person.<br><br><u>New Generation Antipsychotic Endocrine and Metabolic Side Effects</u><br>For those on new generation antipsychotics, the QDRR listed these medications, and monitored metabolic and endocrine effects in 20 out of 20 reviews (100%). Focus was on glucose levels, Hemoglobin A1C, if appropriate, lipid panels, and weight.<br><br>The Facility had effectively addressed the Pharmacy Department's role in monitoring and collaborating with practitioners on the use of chemical restraints, use of benzodiazepines, polypharmacy, and metabolic and endocrine effects of new generation antipsychotics. However, the Facility had not yet complied with the Settlement Agreement requirement that it monitor: "the use of… anticholinergics… to ensure clinical justifications and attention to associated risks." As discussed above, the Facility had not adequately addressed the risks or clinical justification of the anticholinergic medications. As a result, 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 QDRRs appeared to be of great value to the PCPs. Review of 45 QDRRs showed the following:<br>▪ Of the 45, 44 QDRRs (98%) had the PCP signature.<br>▪ Of the 45, 44 (98%) had the date the PCP reviewed the document.<br>▪ Evidence of PCP review of recommendations and agreement or disagreement with justification and plan was documented in 45 out of 45 (100%).<br>o Agreement was documented in 44 out of 45. For three out of 45, the box indicating agreement was not checked, but the recommendations were followed for all three.<br>o There was disagreement by the PCP for only one QDRR, which appeared to be a misinterpretation by the PCP, and a note of clarification and plan was recorded on the QDRR.<br>▪ Psychiatry reviewed the QDRR when there was polypharmacy due to psychotropic medication. A psychiatrist reviewed 14 QDRRs, and agreed with all recommendations. Compliance was 100%. | Substantial Compliance |
| 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 | As noted with regard to Section J.12, this provision of the Settlement Agreement stipulates a quarterly side effect monitoring for individuals receiving psychotropic medication with instruments such as the Monitoring of Side Effect Scale or Dyskinesia Identification System: Condensed User Scale. 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 was reviewed of 31 individual records who were | Noncompliance |

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| | dyskinesia. | receiving psychotropic medication at the time of the on-site review of the Facility.<br><br>The review of the records for these 31 individuals yielded documentation that a MOSES evaluation had been performed as specified over the last year, and was current for all but the following three individuals: the records of Individual #544 and Individual #274 were missing the second pages of the recent MOSES, which contained signatures and dates; and the most recent MOSES for Individual #510 was dated 1/26/11. Thus, the overall successful completion rate was 90%. This documentation, which was completed by a member of the Nursing Department, was also inspected to ascertain if it had been reviewed and signed by the prescribing physician in a timely manner (defined as within seven to 10 calendar days from completion). This analysis indicated that the individual's PCP had reviewed and signed the corresponding MOSES assessment in a timely manner for the following fifteen individuals (48%): Individual #376, Individual #50, Individual #103, Individual #133, Individual #95, Individual #135, Individual #125, Individual #455, Individual #323, Individual #303, Individual #74, Individual #235, Individual #136, Individual #218, and Individual #315. For the remaining individuals, the signature of the PCP occurred well beyond seven to 10 days after the completion of the evaluations, and for many, did not occur until almost a month later.<br><br>As noted above, the DISCUS was also to be performed on a quarterly basis for all of the individuals who received antipsychotic medication. The sample of 31 individuals who received psychotropic medication indicated that documentation of current and quarterly evaluations for the last year could be identified for 29 of the 31 individuals contained in the sample. However, Individual #235 was not receiving antipsychotic medication and, thus, monitoring with the DISCUS was not necessary. The record for Individual #74 did not contain any DISCUS forms, and the individual was receiving the antipsychotic agent Risperidone and, thus, should have been monitored with the DISCUS. Thus, overall, the documentation was complete for 29 of the 30 individuals who required periodic monitoring (97%). The parameter of the prescriber's review and signature was also assessed utilizing the same criteria described above for the MOSES. This analysis indicated that for 13 of the 30 records reviewed (43%), the documents had been reviewed and signed in a timely manner.<br><br>The specific individuals for whom this documentation was identified were as follows: Individual #50, Individual #133, Individual #95, Individual #135, Individual #125, Individual #455, Individual #505, Individual #323, Individual #103, Individual #136, Individual #228, Individual #376, and Individual #303. For the remaining individuals, the prescribing provider's review and signature occurred well beyond seven to 10 days after the completion of the evaluation, and for many, did not appear until almost a month had past. | |

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| | | 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 Gastroesophageal Reflux Disease (GERD), it contains 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%). This process generated a list of the following seven individuals: Individual #232, Individual #333, Individual #457, Individual #21, Individual #117, Individual #53, and Individual #409. The documentation that was provided in response to this request indicated that the MOSES had been performed every six months and was current for the following five individuals (71%): Individual #409, Individual #333, Individual #457, Individual #21, and Individual #117. The MOSES had been reviewed and signed by the prescriber in a timely manner for the following four individuals (57%): Individual #409, Individual #457, Individual #21, and Individual #117.<br><br>The review of the corresponding documentation for the DISCUS evaluations indicated that the DISCUS was current and had been performed quarterly for the following five individuals (71%): Individual #53, Individual #232, Individual #457, Individual #21, and Individual #117. The DISCUS forms had been reviewed and signed by the prescribing provider in a timely manner for the following four individuals (57%): Individual #53, Individual #457, Individual #21, and Individual #117.<br><br>These results suggested that the Facility's system for ensuring that the MOSES and DISCUS were performed as required for individuals who received psychotropic medication was functioning with a 90% (MOSES) to 97% (DISCUS) successful completion rate. However, the mechanisms to ensure that the prescribing providers reviewed the results of these important clinical assessments, which members of the nursing staff performed, needed improvement, as well as systemic changes. The corresponding mechanism for assessing for 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 can be improved, so that the completion rates for the MOSES and DISCUS for individuals who received Reglan are comparable to those obtained for the population of individuals who receive traditional antipsychotic agents. The issue of the prescribing provider's timely review of these documents will also require attention. | |
| N6 | Commencing within six months of the Effective Date hereof and with | The April 27, 2011 P&T Committee meeting included reports on two adverse drug reactions. For Individual #33 (date of occurrence 11/14/10 and incident data date of | Noncompliance |

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| | 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. | 1/31/11), who was prescribed Zyprexa, elevated liver function test abnormalities were noted. On further review, no titration of the dosage had occurred, and the order was out of compliance with dosing guidelines. Additionally, the Pharmacy Department's review did not catch this variance, and the pharmacy staff had been in-serviced regarding starting doses and titration schedules for Zyprexa. This information also was communicated to the psychiatrist.<br><br>The other ADR reported was on 2/12/11, for the administration of Clozapine to Individual #405, in which the individual developed orthostatic hypotension, lethargy, and subsequently fell. The recommended starting dosage was not ordered, but a higher dosage was initiated, which may have contributed to the side effects that occurred. The P&T Committee was the mechanism through which communication of important information learned from ADRs was transmitted to the prescribing PCPs and Nursing Department.<br><br>Requested separately were ADRs for the six months prior to the Monitoring Team's visit. This included eight ADRs, one of which was determined not to be an ADR, but an expected reaction (local reaction to a Zostavax vaccination). The Pharmacy Department provided information for all eight ADRs, but in the submitted copy, only three of these were dated. Based on this, it was difficult to determine the rapidity of the pharmacist's completion of information. Additionally, in reviewing minutes of the Medication Error Committee, the Monitoring Team identified three other ADRs not submitted in response to this request, for a total of 11 ADRs occurring between 1/31/11 and 6/15/11. Additionally, there were six Med Watch reports from a state psychiatric Facility, and the importance of these was not clear. If the individual was ultimately admitted or readmitted to ABSSLC, it was not clear from these documents. Additionally, there was one report of a medication packaged from the distributor with obvious contamination of a foreign substance.<br><br>The eight ADRs submitted as part of the request and the three discovered through committee minutes appeared appropriate and complete, except the date the pharmacy completed its review, and in some, a lack of signature from the pharmacy. In one, there was no information from the pharmacist (Individual #117's 5/10/11 ADR for Boniva and low phosphorus). The issues noted appeared to relate to the retrieval of documents and copying of them in response to the document request. Additionally, if ADRs are completed by other facilities, the relationship of the individual to ABSSLC should be clearly indicated. Initials were used, and could not readily be correlated with a census of names at ABSSLC.<br><br>Part of the ADR process is timeliness of completion of forms and reporting of information. This could not be determined for several of the ADRs, although the process | |

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| | | appeared to be working, and it appeared there had been training on ADRs for the reporting of the adverse reactions.<br><br>The ADRs represent an important knowledgebase that should be shared with the PCPs in a timely manner. The April 2011 P&T Committee meeting reviewed two ADRs, one from November 2010 and one from February 2011. Although some time is often needed to determine if an event is an ADR, once determined to be an ADR, the information should be shared expeditiously with the PCPs at a morning medical meeting. P&T meetings occur only quarterly and all PCPs might not attend. The morning medical meetings would also allow for more discussion among medical staff. The recent 11 ADRs reflected the need to review ordering dosages of Wellbutrin, Lithium and its potential adverse effects on kidney function, Tegretol and toxicity, Tegretol and hyponatremia, chlorpromazine and neuroleptic malignant syndrome, and bisphosphonates and hypophosphatemia.<br><br>The new system of ADRs appeared to be working well. A number of adverse drug reactions were identified. The Pharmacy Department was able to screen one of the potential ADRs out as an expected local reaction. However, at times, copies were incomplete for date and signature, and response by the Pharmacy Department in one case. Due to the fact that this is a new system and with the above gaps in completion of the forms, it would appear some minor documentation issues require further oversight. These inconsistencies need to be resolved before compliance can be assured. In addition, this provision of the Settlement Agreement requires that "follow-up remedial action" be implemented. The Facility needed to put systems in place to ensure timely review of ADRs with prescribing practitioners, and remedial action on an individual and/or systemic level to potentially prevent recurrence. | |
| 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 drug utilization evaluation schedule was submitted for the calendar year 2011, as well as January 2012. For each quarter, there was a new study initiated, as well as follow-up studies for prior DUEs until compliance was achieved. Since the Monitoring Team's last visit:<br>▪ In April 2011, the follow-up study was for monitoring of VPA. The two analyses completed were whether a seizure or behavior indication was documented in the record, and if specific laboratory parameters were followed.<br>▪ A new DUE was conducted May 2011 concerning Vitamin D, with focus on those with a diagnosis of osteopenia or osteoporosis and/or those currently prescribed anticonvulsant medication. Indicators included whether a Vitamin D level was obtained annually, whether a supplement was ordered for those with low Vitamin D levels, and if there was a follow-up Vitamin D level for those in whom a supplement was started.<br>▪ In July 2011, the Vitamin D data was analyzed, and TSH monitoring was begun in | Substantial Compliance |

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| | a separate monitoring plan. | those taking Levothyroxine.<br>▪ A second original DUE was developed for Levothyroxine. The retrospective study was conducted August 2011. The sample was 20% of those taking Levothyroxine. Clinical indicators included whether a TSH had been drawn in the prior 12 months, if the result was abnormal, whether a free T4 was obtained, whether a dosage change in Levothyroxine had occurred in the prior 12 months, and if so, whether a follow up TSH had been ordered six to 12 weeks after the dosage change.<br><br>Documentation of results, as well as follow up results of ongoing studies was reviewed at the P&T Committee meetings. In this way, the PCPs were able to learn the needed information that would potentially improve their prescribing practices. For follow-up study monitoring, monitoring continued until the compliance threshold of 90% was achieved. Minutes of the April 27, 2011 Pharmacy and Therapeutics Committee were submitted. The minutes included an update concerning the follow-up study on valproic acid monitoring. Compliance was noted to be 85%, which remained below the compliance threshold of 90%. The minutes indicated that nursing would develop an action plan.<br><br>The Vitamin D DUE was analyzed in a report dated June 2011. A total of 60 records were sampled. For 97% of these records, a Vitamin D level was ordered annually. If the level was low, a supplement was ordered 100% of the time. For those in whom a supplement was started, 98% had a follow-up level obtained. Overall, the medical staff were found to be in compliance with the threshold of 90%.<br><br>The Facility was in compliance with this provision. DUEs were completed in an appropriate and timely manner. Discussion of future choice of topics should occur at the P&T Committee meeting or the morning medical meeting, or both. | |
| 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. | To provide a forum to review and discuss information concerning medication errors, a Medication Error Committee met on 1/26/11, 2/16/11, 3/23/11, 4/27/11, 5/25/11, and 6/29/11.<br><br>In addition, the P&T Committee meeting of 4/27/11 provided an update of the medication errors. It was noted that the error rate had increased from October 2010 to March 2011, but the trend thereafter decreased. The bar graphs indicated a peak in both unreconciled errors and total errors in December 2010. Unreconciled errors dropped from 179 in December 2010 to 80 in March 2011. Total errors dropped from 202 in December 2010 to 115 in March 2011. Most errors were categorized as errors of administration or errors of documentation. From December 2010 to March 2011, | Noncompliance |

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| | | administration errors decreased from 198 to 98. Documentation errors increased from three to 15. For error type, most errors were considered either omission errors (81 in March 2011) or wrong dose (eight errors in March 2011). In both of these cases, there was improvement from the December 2010 data.<br><br>Most errors were considered Category C (an error occurred that reached the individual, but did not cause individual harm). In March 2011, there were two Category D errors (an error occurred that reached the consumer and required monitoring to confirm that it resulted in no harm and/or required intervention to preclude harm). It was also noted in the minutes that there were two serious errors (Category E) in which the wrong person received the medications. In response to this, nursing meetings provided instructions to use two forms of ID when administering medications. However, submitted information indicated that the wrong individual was administered medication between one and three times each month from October 2010 to March 2011. A Staff Advisory Committee was formed to assess nursing acuity needs of individuals, including the numbers of medications administered per individual. A number of individuals had moved between residences, and it was determined that this may have caused some of the errors in some residences.<br><br>The Pharmacy Department worked with the nurses in two residences (reported in the April 27, 2011 Medication Error Committee minutes as 6450 and 6460) to review and simplify the drug regimens, where possible. Subsequently, a reduced error rate was noted over several months in one residence (from 25 errors in December 2010 to five errors in March 2011). Examples of changes included reducing medication dosing from four times a day to two times a day, or from twice a day to once a day. The Pharmacy Department was asked to stock different strengths of medication, so that a nurse would only have to give one tablet instead of two for certain medication passes. There were six to seven residences that accounted for most of the errors, and it was one of these residences with which the Clinical Pharmacist worked. An email, dated 6/28/11, indicated the Pharmacy Department also worked with the nurses from 6480 and 6350 in reviewing each MAR line by line for each individual in order to simplify and decrease the number of medication passes.<br><br>The Nurse Educator continued to complete medication observations. In February 2011 19 observations were completed with the total of observations passed being 11, and the total observations failed being eight. In March 2011, 110 observations were completed, with the total of observations passed being 105, and the total observations failed being five. Concerns related to the quality of these reviews are discussed in detail with regard to Section M.6. | |

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| | | Separately, copies of the completed Medication Administration Observation Tool were submitted for 29 observations that occurred in the month of May 2011 and scored. This tool reviewed 38 areas for medication administration, and each of these was checked for compliance or non-applicability. Thirteen observations were scored a "pass," and sixteen were scored a "fail."<br><br>Copies of 10 medication error reports were submitted from June 2011. Of these, one was considered category B (an error occurred but the medication did not reach the individual), six were considered category C (an error occurred that reached the individual, but did not cause the individual harm), one was considered category D (an error occurred that reached the consumer and required monitoring to confirm that it resulted in no harm and/or required intervention to preclude harm), and two were not categorized but left blank. For the section, "Follow-up by Nursing Supervisor," two were completed, five were left blank, and three stated: "see employee developmental note." No further information was provided. That half were left blank indicated that no next step or action plan was identified to address the root cause of the error. As part of the larger endeavor to reduce medication errors, Nursing Administration should ensure completion of this section, which should include a critical brief analysis and action steps to prevent a recurrence.<br><br>The P&T Committee meeting minutes of 4/27/11 also documented that although the Pharmacy Department tracked errors and variances in medication administration, no similar information was available for the Medical and Pharmacy Departments. It is recommended that all errors and variances from the Pharmacy Department be tracked, including errors or variances in which the counterchecks corrected the error, as a demonstration the system is working. It also would determine the number of errors that reach the individual, which would be an error for both Pharmacy and Nursing Departments, because nursing staff should be checking the medications dispensed against the MAR, and contacting the Pharmacy Department to report discrepancies. It is also recommended that errors from the Medical Department be tracked. The "patient intervention" form already had the needed information. Although the entire intervention log was forwarded as Prescriber Med Variances for May (from an email communication of 6/1/11), this would not accurately provide the information needed. Certain of these entries would meet the definition of a PCP medication variance, and the Pharmacy Department should review these areas with the Medical Director and medical staff. Those patient interventions that meet the criteria of a medication variance need to be reviewed and agreed upon ahead of time, with an in-service to medical staff to ensure understanding and the purpose of the process. Entries mentioned in the "interventions" program that could be tracked as medication variances should reflect PCP orders of wrong dosage, wrong route, and ordering medication to which the individual has a listed | |

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| | | allergy. This would provide a valuable clinical tool for the Medical Department's review.<br><br>From the minutes of the 6/29/11 Medication Error Committee, medication errors continued to decline. In February 2011, there were 134 total errors with 104 unreconciled errors. In May 2011, there were 32 total errors with 19 unreconciled errors. However, without further analysis of this information, the pure numbers are fairly meaningless. For example, reductions in numbers could be due to a lack of reporting, or they could be directly related to interventions that have been put in place. The Facility should analyze the data, and use the information gained from the analysis to develop next steps. The same is true for the data being collected in relation to medication pass observations.<br><br>To be in substantial compliance, the Facility should track pharmacy errors/variances internal to the pharmacy to prevent final dispensing errors from the pharmacy, as well develop criteria for physician orders that could be considered a medication error/variance. This latter category of errors/variances should be developed with guidance from the Medical Director. Additionally, the Pharmacy Department should assist the Nursing Department in root cause analysis and innovative approaches to resolving the number of medication errors. Communication with nursing and the Medical Department, action steps taken by pharmacy to investigate errors, continued assistance with simplification of drug regimens and administration, as well as ensuring pharmacy dispensing errors are minimized should be priorities. | |

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

1. The Pharmacy Department should screen new orders for needed initial lab testing that is indicated, or ongoing serial lab testing needed that may affect dosage or frequency of medication (chronic renal failure, etc.). (Section N.1)
2. For those individuals with J-tubes, medications incompatible with this route should be separately identified, not as allergies, but as being incompatible with J-tube feeding. (Section N.1)
3. For the 10% of new orders placed for which an internal audit is completed, data should reflect the individual orders chosen, the drug-drug interaction of concern, the outcome of the analysis, and trend analysis for compliance over time. (Section N.1).
4. The QDRRs that discuss anticholinergic side effects should include a rating of anticholinergic drug load effect, as well as a review of clinical justification of continued use of medications based on the side effects the individual is experiencing or has the potential to experience. (Section N.3)
5. As recommended in the previous report, 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. (Section N.3)
6. As recommended in the previous report, 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. (Section N.3)

7. The Facility should develop and implement systems to ensure that the MOSES and DISCUS side effect assessments, which members of the nursing staff complete, are reviewed and signed by the prescribing provider in a timely manner. (Section J.12 and N.5)
8. The monitoring system for the MOSES and DISCUS of individuals receiving Reglan should be improved to increase completion rates. (Section J.12 and N.5)
9. The prescribing provider should review the MOSES and DISCUS evaluations for individuals who are prescribed Reglan in a timely manner. (Section J.12 and N.5)
10. The Facility should ensure ADR forms are all tracked and reviewed at P&T Committee meetings, and that they are all completed, dated, and signed by a pharmacist. (Section N.6)
11. The Facility should put systems in place to ensure timely review of ADRs with prescribing practitioners, and the implementation of remedial action on an individual and/or systemic level to potentially prevent recurrence. (Section N.6)
12. Nursing Administration should ensure completion of the follow-up section of the medication error report, which should include a critical brief analysis and action steps to prevent a recurrence. (Section N.8)
13. The Pharmacy Department should track and analyze the pharmacy's dispensing errors internally (as well as externally), as well as physician prescribing practices that would be considered errors/variances by the Medical Department. (Section N.8)
14. The Facility should further analyze the medication data, and use the information gained from the analysis to develop next steps. The same is true for the data being collected in relation to medication pass observations. (Section N.8)

| SECTION O: Minimum Common Elements of Physical and Nutritional Management | |
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| | **Steps Taken to Assess Compliance:** The following activities occurred to assess compliance:<br>▪ **Review of Following Documents**:<br>o Presentation Book for Section O;<br>o Presentation for Section O for the Settlement Agreement Monitoring Team, dated August 22, 2011;<br>o The following documents: Occupational Therapy/Physical Therapy/Speech Language Pathology and Registered Dietician Evaluations, Aspiration Pneumonia/Enteral Nutrition Evaluation, OT/PT/SLP consultations for the last year, Personal Support Plan and PSP Addendums for the last year, including PSPA for Integrated Risk Rating Form and Risk Action Plan, Physical and Nutritional Management Plan with pictures, PST Integrated Risk Rating Form, PST Action Plan for Risk Evaluation, person-specific monitoring for past two months, competency-based training for staff, supporting documentation for implementation of PST Risk Evaluation and Action Plan, Health Management Plan/Nursing Care Plan, and Daily Schedule for the following 12 individuals (Sample O.1): Individual #311, Individual #362, Individual #162, Individual #281, Individual #361, Individual #85, Individual #314, Individual #212, Individual #472, Individual #259, Individual # 414, and Individual #409;<br>o The following documents: APEN Evaluation, Head of Bed Elevation Evaluation, Physical and Nutritional Management Team Evaluation, PNMT Action Plan, PSP and PSP Addendums including integration of PNMT Evaluation and Action Plan, PNMP with pictures, Integrated Risk Rating Form, PST Risk Action Plan, competency-based staff training for staff related to PNMT Action Plan, individual-specific monitoring for PNMT Action Plan, supporting documentation for implementation of PNMT Evaluation and Action Plan, PNMT Discharge Plan/Summary, PNMT Review Log, Daily Schedule, Health Management Plans/Nursing Care Plans for the following eight individuals (Sample O.2): Individual #452, Individual #337, Individual #407, Individual #117, Individual #498, Individual #59, Individual #103, and Individual #353;<br>o The following documents: APEN Evaluation, Head of Bed Elevation Evaluation, Physical and Nutritional Management Team Evaluation, PNMT Action Plan, PSP and PSP Addendums including integration of PNMT Evaluation and Action Plan, PNMP with pictures, Integrated Risk Rating Form, PST Risk Action Plan, competency-based staff training for staff related to PNMT Action Plan, individual-specific monitoring for PNMT Action Plan, supporting documentation for implementation of PNMT Evaluation and Action Plan, PNMT Discharge Plan/Summary, PNMT Review Log, Daily Schedule, Health Management Plans/Nursing Care Plans for the following six individuals (Sample O.3): Individual #250, Individual #122, Individual #13, Individual #447, Individual #395, and Individual #527;<br>o The following documents: OT/PT/SLP/RD Evaluations, APEN Evaluation, HOBE |

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| | Evaluation, PSP and PSPAs for past year, PNMP with pictures, pleasure/therapeutic feeding program/plan, individual-specific monitoring for past two months, staff competency-based training, and OT/SLP Consultations for the past year, and daily schedule for the following seven individuals (Sample O.4): Individual #216, Individual #489, Individual #285, Individual #403, Individual #63, Individual #385, and Individual #492;<br>o PNMPs and dining plans for the following 21 individuals: Individual#138, Individual #23, Individual #254, Individual #415, Individual #201, Individual #92, Individual #459, Individual #278, Individual #525, Individual #164, Individual #349, Individual #65, Individual #512, Individual #424, Individual #234, Individual #206, Individual #195, Individual #140, Individual #366, Individual #290, and Individual #27;<br>o List of PNM team members and corresponding Curricula Vitae, undated;<br>o PNMT Review Log, from 6/11 through 7/11;<br>o PNMT Evaluation Sheet (template), undated<br>o List of individuals (by home) with PNM needs, undated;<br>o List of individuals (by home) without PNM needs, undated;<br>o Prioritization of Wheelchair/Adaptive Equipment Work Orders, dated 8/4/10;<br>o Completed PNMP's for Multiple Individuals, from 2/10 through 6/11;<br>o PNM Monitoring Tools (template), undated;<br>o Completed PNMP Monitoring Forms, from 4/11 through 7/11;<br>o PNM Analysis and PT/OT Analysis, dated 3/11;<br>o Dining Plan (template) with changes, dated 4/20/11;<br>o Dining Plans and Competency-based Training Sheets, from 5/11 through 6/11;<br>o PNMT Document Tracker, from 6/11 through 7/11;<br>o List of individuals on modified diets/thickened liquids, undated;<br>o List of individuals who received nutrition through non-oral methods, undated;<br>o List of individuals who require enteral feeding, undated;<br>o List of individuals whose diets have been downgraded, from 7/10 through 7/11;<br>o List of individuals with Body Mass Index (BMI) equal to or greater than 30, undated;<br>o List of individuals with BMI equal to or less than 20, undated;<br>o List of individuals who have had unplanned weight loss of equal to or greater than 10%, from 12/10 through 7/11;<br>o List of individuals with choking incidents, from 2/11 through 8/11;<br>o List of individuals who have had an aspiration/pneumonia incident, from 7/10 through 7/11;<br>o List of individuals who have chronic respiratory infections, undated;<br>o List of individuals who have chronic dehydration, undated;<br>o List of individuals who have had a skin breakdown/active pressure ulcer, from 7/10 through 6/11;<br>o List of individuals who have had a fall, from 7/10 through 7/11;<br>o List of individuals who have had a fracture, from 7/10 through 7/11;<br>o List of individuals who are non-ambulatory or require assisted ambulation, undated; |

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| | ○ List of individuals with poor oral hygiene, undated;<br>○ List of individuals who have been treated for acute/chronic pain, from 10/09 through 7/11;<br>○ List of individuals who have received Modified Barium Swallow Studies (MBSS), undated;<br>○ List of individuals who have had a choking incident, dated 3/11;<br>○ Schedule of Meals (by home), undated;<br>○ Schedule of PNM-related meetings during week of 8/22/11;<br>○ PNM Curricula used to train new staff, undated;<br>○ Agenda and Curricula used for PNM Training, undated;<br>○ List of Competency-based PNM Training Sessions, from 1/11 through 7/11;<br>○ Tools and Checklists used to provide Competency-based Training related to PNMPs and Dining Plans (templates), various dates;<br>○ PNMT Action Plans and Review, from 11/10 through 7/11;<br>○ Consultant OT ABSSLC Site Visit Report, dates of consultation from 7/12/11 to 7/14/11;<br>○ Consultant SLP ABSSLC Site Visit Report, dated 7/18/11;<br>○ New Employee Pre-Service Training, revised 8/8/11;<br>○ ABSSLC table for budgeted positions, number of staff, number of contractors and hours of each, number of unfilled positions and staff-to-individual ratio for OTs, PTs and SLPs, dated 6/30/11;<br>○ ABSSLC Risk Level Rating of High, dated 8/24/11;<br>○ ABBSLC Risk Level Rating of Medium, dated 8/24/11;<br>○ ABBSLC Communicable Disease Report, dated 7/15/11;<br>○ ABSSLC individuals seen in community hospital for past year;<br>○ ABSSLC admissions to Infirmary for past year;<br>○ Individuals seen in community ER for past year;<br>○ ABSSLC list of individuals as of 7/1/11 (incomplete list);<br>○ Persons Currently Followed by PNMT, dated 8/22/11; and<br>○ DADS SSLC At-Risk Individuals Policy, implemented 1/1/11.<br>▪ **Interviews with**:<br>○ Bobbie Holden, OT, Director of Rehabilitative Services, and PNMT member;<br>○ Debbie Sessions, MS, CCC/SLP, PNMT Coordinator;<br>○ Tammy Siegfried, RN, PNMT member;<br>○ Karen Mayfield, PT, and PNMT member;<br>○ Lindsey Tierce, PT, and PNMT member;<br>○ Nicole Spalding, RD, and PNMT member;<br>○ Tricia Reyes, RD, and PNMT member; and<br>○ Jolene Willis, Assistant Director of Programs (ADOP).<br>▪ **Observations of**:<br>○ In residences and dining rooms in 6521, 5972, 5971 and 5961. |
| | **Facility Self-Assessment:** Based on a review of the Facility's POI, with regard to Section O of the Settlement Agreement, the Facility found that it remained out of compliance with all of the sub-provisions. |

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| | This was consistent with the Monitoring Team's findings.<br><br>The POI did not present data to substantiate the Facility's findings related to compliance. The POI provided narrative updates of actions taken to move towards compliance, but did not document regular audits utilizing tools that the State Office had modified based on the Monitoring Teams' review tools. The Director of Rehabilitative Services, in collaboration with lead therapists and the respective PCM from the Quality Assurance Department, should analyze and include data from compliance audits to substantiate findings related to compliance. However, a focus should be placed on the development of adequate instructions for the audit tools, and procedures should be implemented to ensure inter-rater reliability. The absence of adequate instructions for the monitoring tool and distinct trials to achieve inter-rater reliability between therapists and the PCM will result in audit data that will not be considered reliable and/or valid.<br><br>The Facility had four Action Plans developed for Section O. Three of the four action steps for O.1 were documented as completed. The Monitoring Team did not agree that action step number two had been completed. It indicated that a physician would attend PNMT meetings as needed. A review of PNMT attendance sheets showed that the physician attended only two of the 18 PNMT meetings. The Facility should audit supporting documentation to ensure the assigned completion status is accurate. The action plan for O.1 should address the development and implementation of a Facility policy for the PNMT process, incorporating related State policies. The action plan for O.2 addressed PNMT responsibilities, which was appropriate. However, the timelines for completion were not adequate. For example, the action step for PSTs to notify PNMT members of any new diagnoses of aspiration within three working days of a diagnosis had a start date of 4/1/11, and projected completion date was 8/3/11. It was unclear why this directive was not implemented immediately. The Action Plan for O.4 addressed the development and implementation of the training initiative for Aspiration Pneumonia. All action steps were documented as completed. The Monitoring Team would not agree that competency-based training for staff had been completed, nor had monitoring results been analyzed to ensure individual-specific problems had been resolved. The Action Plan for O.4 should address the development and implementation of monitoring to document staff compliance with implementation of PNMPs and dining plans. Similarly, the Action Plan for O.5 should be expanded to incorporate the development and implementation of competency-based performance evaluations to document staff competency with the provision of individual-specific PNM supports. Action Plans for O.3, O.7, and O.8 should be developed. The Director of Rehabilitative Services should determine what revisions and additions should be made to support the achievement of compliance within all subsections. During this process it will be imperative to prioritize what will be accomplished during the six-month intervals prior to onsite compliance reviews. |
| | **Summary of Monitor's Assessment:** Since the last review, Facility Administration had appointed a new Director of Rehabilitative Services. This had generated excitement within the Habilitation Therapies (HT) Department.<br><br>Formerly, the Facility had two PNMTs, but the two teams had been consolidated into one PNMT. On a positive note, the Facility had recruited and hired a dedicated, full-time Nurse for the PNMT. The PNMT continued to face challenges to perform their duties as required by the Settlement Agreement. With the |

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| | exception of the Nurse, no other PNMT member was fully dedicated to the PNMT. PNMT members carried extensive caseloads and additional responsibilities beyond the PNMT caseload. Facility Administration, in collaboration with the Director of Rehabilitative Services, should review the PNMT's responsibilities to determine how ways to restructure to decrease their current caseloads and responsibilities.<br><br>The Monitoring Team was concerned that the PNMT only had evaluated eight individuals since the last review. Despite the fact that 31 individuals had been identified at high risk and an additional 170 individuals at medium risk for aspiration, only three of the eight individuals that the PNMT had evaluated had been identified at high risk for aspiration. The Facility should develop specific criteria for referral to the PNMT, including emergency referral.<br><br>Based on the Monitoring Team's most recent review, problems continued to exist with regard to the PNMT's review of individual Integrated Risk Rating Forms, the completion of evaluations and development of action plans, competency-based training and performance check-offs for staff on the implementation of plan's developed, individual-specific monitoring, documentation in Integrated Progress Notes, response to hospitalizations, and development of transition plans and discharge planning.<br><br>The Director of Rehabilitative Services was to be commended for beginning the process of reviewing the content for new employee orientation. However, the Monitoring Team observed multiple staff who did not properly implement prescribed PNMPs and dining plans. Additional time was needed to present training on competency-based foundational skills, and complete performance check-offs to ensure staff were able to demonstrate necessary skills and competencies.<br><br>The Facility presented multiple monitoring forms, but no policies and/or procedures existed for the implementation of these forms. In addition, no procedures had been identified for the integration of these monitoring forms into a unified system to enable data to be easily analyzed, concerns identified, and resolutions developed and implemented. As stated in the previous compliance reports, these forms identified repeated individual-specific and/or systemic concerns without resolution, such as staff non-compliance with the implementation of PNMPs. The absence of a cohesive monitoring review process did not support effective utilization of staff resources but, most importantly, the monitoring results were not presented in a way to effectively track and trend implementation of individual's PNMPs and dining plans.<br><br>Individuals who received enteral nutrition were to receive an APEN Evaluation, the purpose of which was to determine if receiving nutrition by tube was medically necessary, and, where appropriate, to implement a plan to return the individual to a less restrictive form of receiving enteral nutrition and/or a return to oral feeding. The Monitoring Team was concerned that for none of the individuals reviewed within the sample had the Facility completed an APEN evaluation. |

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| O1 | Commencing within six months of | Due to the multiple requirements included in this provision of the Settlement Agreement, | Noncompliance |

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| | the Effective Date hereof and with full implementation within two years, each Facility shall provide each individual who requires physical or nutritional management services with a Physical and Nutritional Management Plan ("PNMP") of care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan. The PNMP will be reviewed at the individual's annual support plan meeting, and as often as necessary, approved by the IDT, and included as part of the individual's ISP. The PNMP shall be developed based on input from the IDT, home staff, medical and nursing staff, and the physical and nutritional management team. The Facility shall maintain a physical and nutritional management team to address individuals' physical and nutritional management needs. The physical and nutritional management team shall consist of a registered nurse, Physical Therapist, occupational therapist, dietician, and a speech pathologist with demonstrated competence in swallowing disorders. As needed, the team shall consult with a medical doctor, nurse practitioner, or physician's assistant. All | as well as the requirements of this overarching provision of the Settlement Agreement being further detailed in other components of Section O of the Settlement Agreement, the following 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 evaluation and planning processes in which the PNMT is required to engage are discussed below in the sections of the report that address Sections O.2 through O.7 of the Settlement Agreement.<br><br>The Monitoring Team's record sample for Section O is as follows:<br>▪ Sample O.1 - 12 individuals who were identified at high risk of aspiration and had experienced a change in status, including Individual #311, Individual #362, Individual #162, Individual #281, Individual #361, Individual #85, Individual #314, Individual #212, Individual #472, Individual #259, Individual #414, and Individual #409;<br>▪ Sample O.2 - eight individuals who were evaluated by the PNMT, including Individual #452, Individual #337, Individual #407, Individual #117, Individual #498, Individual #59, Individual #103, and Individual #353;<br>▪ Sample O.3 - six individuals who were informally reviewed by the PNMT, including Individual #250, Individual #122, Individual #13, Individual #447, Individual #395, and Individual #527;<br>▪ Sample O.4 - seven individuals who received enteral nutrition, including Individual #216, Individual #489, Individual #285, Individual #403, Individual #63, Individual #385, and Individual #492.<br><br><u>The PNM team consists of qualified Speech Language Pathologist, Occupational Therapist, Physical Therapist, Registered Dietician, and, as needed, ancillary members [e.g., MD, Physician's Assistant (PA), Registered Nurse].</u><br>Since the Monitoring Team's last onsite review, the Facility had consolidated two PNM teams into one PNMT. However, only one member, the Nurse, was fully dedicated to the PNMT. With the exception of the Nurse, all PNMT members carried additional responsibilities, as well as large caseloads of individuals. As is illustrated in the chart below, this was in addition to the PNMT caseload of 22 individuals.<br><br>At the time of the review, the ABSSLC census was 443 individuals. Based on the documentation provided, the caseloads of the two PNMT PTs could only be estimated based on dividing the census into three. The following chart identifies the estimated current caseloads and/or responsibilities of PNMT members: | |

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| | members of the team should have specialized training or experience demonstrating competence in working with individuals with complex physical and nutritional management needs. | | |

| Core PNMT Member | Current Caseloads and Other Responsibilities |
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| Speech Language Pathologist | PNMT Coordinator, 60% of time PNMT member; PNMT caseload of 22 individuals, with additional caseload of 124 individuals |
| Registered Nurse | Dedicated PNMT Nurse with caseload of 22 individuals |
| Occupational Therapist | Habilitation Therapy Director, PNMT caseload of 22 individuals, and caseload of 421 individuals |
| Physical Therapist #1 | Lead PT, with caseload of approximately 147 individuals; PNMT member with caseload of 22 individuals |
| Physical Therapist #2 | Caseload of approximately 147 individuals, and PNMT member with caseload of 22 individuals |
| Registered Dietician #1 | RD caseload for 50% of campus (210 individuals), and PNMT caseload of 22 individuals |
| Registered Dietician #2 | RD caseload for 50% of campus (210 individuals), PNMT member with caseload of 22 individuals |

As documented above, the caseloads and additional responsibilities for therapists (PT, OT, and SLP) and registered dieticians remained significant, which impacted the PNMT members' ability to successfully implement the PNMT process for those individuals at highest risk. The Monitoring Team recommends that Facility Administration, in collaboration with the Director of Rehabilitative Services, develop strategies, including timelines, for the OT, PT, SLP and RD PNMT members to transition to a dedicated status, and/or determine how to significantly lower the caseloads of PNMT members.

The State Coordinator for Habilitation Therapy Services sent email documentation to the Directors of Habilitation Therapy, dated 7/25/11, that presented an upcoming schedule for PNMT core training to occur on August 9, 10, and 17, 2011, for two hours each day. These six hours of training would include training from the beginning of the PNM Core Team Training curriculum outline. Review of CVs and certificates of completion for clinical instruction for the Core PNMT members revealed the following:

- No Core PNMT members submitted attendance documentation for state-sponsored webinars conducted from February to August 2011;
- The SLP Core PNMT member submitted a Certificate of Attendance for Teaching Verbal Behavior to Children with Autism and other Developmental Disabilities and her CV documented attendance at a Dynavox presentation;
- Four Core PNMT members' CVs (i.e., two PTs, one RD, and SLP) showed attendance at the Vitamin D and Calcium Concepts and Controversies seminar;
- The OT Core PNMT member's CV listed continuing education at a 2011 Webinar for aspiration; and

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| | | ▪ One RD Core PNMT member submitted a log with multiple nutrition-related continuing education courses.<br><br>As stated in the Monitoring Team's previous report, attendance of PNMT members at state-sponsored webinars should be non-negotiable. A continuing education tracking system for PNMT members should be developed and implemented that would document attendance through training rosters and/or certificates of staff's completion of state-sponsored webinars, off-site clinical instruction and conferences.<br><br><u>PNMT meets regularly to address change in status, evaluations, clinical data, and monitoring results.</u><br>No Facility policies and/or procedures existed to define the Facility's PNMT process.<br><br>The PNMT had not met on a regular basis. Since the last onsite review, 18 PNMT meetings had been conducted, including one meeting in February, seven in March, two in April, one in May, three in June, and four in July. An SLP and PT were present at all 18 meetings (100%), but the following PNMT Core Members were not consistently represented:<br>▪ A Nurse was present in seven of the 18 meetings (39%), but since the appointment of a dedicated nurse in June 2011, attendance by the dedicated nurse was 100%;<br>▪ A Registered Dietitian did attended 15 of 18 meetings (83%):<br>▪ An Occupational Therapist was not present in 3/18 meetings (83%); and<br>▪ The PNMT PCP Liaison attended two of the 18 meetings (11%). The Facility had appointed a PNMT physician liaison, but the physician liaison was not present in multiple PNMT meetings. No additional documentation was submitted to support that the PNMT physician liaison had worked with the PNMT.<br><br>The Monitoring Team recommends that the Facility develop and implement a PNMT policy that supports State policy and formalizes the Facility PNMT process, including, but not limited to the following: identification of the roles and responsibilities of the PNMT; criteria for referral to the PNMT; meeting schedule; PNMT role in the PST Risk Evaluation process, including a review of the PST's Integrated Risk Rating Form and Risk Action Plan upon the individual's referral to the PNMT; definition of the comprehensive evaluation process; development and implementation of a PNMT Risk Action Plan that integrates the PST Risk Action Plan, APEN Action Plans, nursing care/health management plan, Behavior Support Plan (BSP), etc.; individual-specific staff competency-based training and performance check offs; individual-specific monitoring; transition planning from the hospital, Infirmary, and residence; and discharge planning and criteria. PST members should receive training on Facility PNMT policies. | |

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| | | Based on interview and documentation provided, the PNMT supported 22 individuals. Since the last compliance review, the PNMT had completed comprehensive evaluations for eight of these individuals, and 13 individuals received an "informal follow-up." One individual had been discharged. Despite the fact that 31 individuals had been identified at high risk and an additional 170 individuals at medium risk for aspiration, only three of the eight individuals that the PNMT had evaluated had been identified at high risk for aspiration. The Facility should develop specific criteria for referral to the PNMT, including emergency referral.<br><br>Sample O.1 consisted of 12 individuals drawn from the ABSSLC Risk Level Rating of High, dated 8/24/11, whose PSTs had identified them as being at high risk for aspiration pneumonia. None of these 12 individual records (0%) documented that the PST members had followed the at-risk process outlined in the SSLC At Risk Individuals policy. The following concerns were noted:<br>▪ Integrated Risk Rating Form(s)s did not consistently provide clinical rationales for risk ratings;<br>▪ PSTs had not developed an aggressive comprehensive Risk Action Plan to address high and medium risk indicators;<br>▪ Risk Action Plans did not consistently identify the clinical indicators to be monitored for wellness and/or a change in status indicating the onset of illness and/or illness;<br>▪ Risk Action Plans were not consistently incorporated within the PSP within 30 days of the completion of the plan;<br>▪ Professional staff had not provided competency-based training and performance check-offs for direct support professionals responsible for implementation of the plans; and<br>▪ PSTs had not met regularly to review and update the implementation of the Risk Action Plan.<br><br>ABSSLC was not yet in compliance with this provision of the Settlement Agreement. Individuals identified at high risk were not provided with adequate physical and nutritional supports by their respective PSTs and/or the PNMT. A dedicated PNMT was not yet available, team members had not attended adequate training, a policy governing the functioning of the PNMT had not been developed, and the PNMT had not yet reviewed many of the individuals at highest risk. | |
| 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 | <u>A process is in place that identifies individuals with PNM concerns.</u><br>As noted with regard to Section I, and Section P, PST and PNMT members had not consistently implemented the DADS At-Risk Individuals policy. The Monitoring Team recommends the development of a QA/QI auditing protocol to substantiate PST and PNMT compliance with the At-Risk Individuals policy. It is essential that PSTs and the | Noncompliance |

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| | himself or herself, who requires positioning assistance associated with swallowing activities, who has difficulty swallowing, or who is at risk of choking or aspiration (collectively, "individuals having physical or nutritional management problems"), and provide such individuals with physical and nutritional interventions and supports sufficient to meet the individual's needs. The physical and nutritional management team shall assess each individual having physical and nutritional management problems to identify the causes of such problems. | PNMT members comply with the At-Risk Individuals policy to identify the individuals at risk, and develop the supports needed to minimize and/or reduce the impact of high and medium risk indicators.<br><br>The PNM Team provides individuals identified as being at an increased risk level with a comprehensive evaluation and strategies that focus on nutritional health status, oral care, medication administration, mealtime strategies, proper alignment, and positioning during the course of the day, and during nutritional intake.<br>Review of records related to Sample O.1, including 12 individuals identified at high risk for aspiration pneumonia, revealed the following:<br>▪ In none of the 12 records (0%) was documentation found of PST and/or PNMT review/analysis of the findings of relevant discipline-specific evaluation(s), including but not limited to PNMP Clinic results, PNMP, and relevant consultation(s) leading to the development of a comprehensive evaluation summary. Such a summary should have addressed:<br>o Physical health status;<br>o Nutritional health status;<br>o Oral care;<br>o Medication administration;<br>o Mealtime strategies;<br>o Proper alignment; and<br>o Positioning during the course of the day and during nutritional intake.<br>▪ In none of the 12 records (0%) were measurable, functional outcomes identified.<br>▪ In none of the 12 records (0%) was a comprehensive review of an individual's PNMP completed to ensure staff strategies were adequate to address high risk indicators<br>▪ In none of the 12 records (0%) was congruency found between Strategies/Interventions/Recommendations contained in the PNMP, and the concerns identified in evaluations.<br>▪ In none of the 12 records (0%) were comprehensive summary results integrated into the design of the appropriate PNM support plans, as outlined in HCG VI and VIII and Settlement Agreement O.3 through O.8.<br><br>Since the Monitoring Team's last review, the PNMT had completed comprehensive evaluations for eight individuals. Three of these eight individuals were identified as being at high risk for aspiration (Individual #337, Individual #407, and Individual #100). The remaining five individuals were assigned the following high risk indicators:<br>▪ Individual #452 - high risk for dental, hypothermia, and respiratory compromise;<br>▪ Individual #117 - high risk for polypharmacy/side effects, respiratory | |

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| | | compromise and seizures;<br>▪ Individual #498 - high risk for osteoporosis and seizures;<br>▪ Individual #59 -no high risk indicators,<br>▪ Individual #103 -no high-risk indicators.<br><br>The ABSSLC Risk Level Rating of High identified 31 individuals at high risk for aspiration. The Monitoring Team was concerned that the PNMT had only evaluated three of these 31 individuals (10%). It is essential for the Facility to define criteria for referral to the PNMT.<br><br>For Sample O.2, consisting of eight individuals whom the PNMT had completed a comprehensive evaluation and/or had discharged, the Monitoring Team reviewed individual PNMT evaluations and action plans, PNMPs, individual-specific competency-based training and performance check offs, individual-specific monitoring, and other evidence submitted. The following concerns were noted:<br>▪ In none of the eight records reviewed (0%) was there documentation of the PNMT reviewing the individuals' risk levels during the comprehensive evaluation process, and updating them, as appropriate.<br>▪ In none of the eight records reviewed (0%) did the comprehensive evaluation reflect a comprehensive review/evaluation of identified risk levels.<br>▪ In none of the eight 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(s). This indicator was impacted by individuals not being appropriately identified as being at high risk for aspiration pneumonia. This impacted their PNMT evaluation and action plan, because they did not address their high risk for aspiration.<br>▪ In none of the eight records reviewed (0%) was there a PNMT Action Plan that consistently supported identified risk levels per the Integrated Risk Action Form;<br>▪ In three of the eight records (38%), a PSP Addendum for the PNMT meeting was present, which included the integration of the PNMT Action Plan.<br><br>The Monitoring Team's review of the eight individuals evaluated by the PNMT did not support compliance with the PNMT Evaluation and Action Plan process as follows:<br>**Referral to the PNMT**<br>▪ Individuals who received an enteral feeding tube had not been immediately referred to the PNMT (e.g., Individual #407 whose PNMT evaluation occurred over a month after the placement of her tube).<br>▪ The Facility had not defined referral criteria. The Facility should formalize PNMT referral criteria immediately. | |

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| | | **Integrated Risk Rating Form**<br>▪ The PNMT was not reviewing an individual's Integrated Risk Rating Forms to determine if risk ratings had changed due to a change in health status. As a first step in the evaluation phase, in conjunction with the individual's PST, the PNMT should review the individual's Integrated Risk Rating Form that the PST completed to determine if the individual's current risk ratings continued to reflect an accurate portrayal of an individual's risk for illness and/or injury. At the time of the review, this was not consistently occurring (e.g., Individual #452 for whom a diagnosis of aspiration pneumonia should have changed her risk for aspiration from medium to high).<br>▪ In the absence of the PNMT completing an updated Integrated Risk Rating, inaccurate PNMT Evaluation(s) and Action Plan(s) were developed that did not accurately reflect an individual's current risk factors that formed the foundation of a comprehensive evaluation and risk action plan.<br>▪ The PNMT was not consistently involved in revisions of individuals' Integrated Risk Rating Form(s) for individuals on their caseload due to a change in status (e.g., Individual #407 for whom the team met to review findings of an MBSS). PNMT members should be present at team meetings, and actively engaged in reviewing risk levels for individuals on their caseload. PNMT review of individual Integrated Risk Rating Forms should be standard practice at ABSSLC and memorialized through Facility policy and/or procedures.<br>**PNMT Comprehensive Evaluation**<br>▪ Individual PNMT evaluation(s) did not consistently document the date of the initial referral to the PNMT. In addition, the PNMT did not initiate a timely evaluation per the At-Risk Individuals policy that stated: "as soon as possible, or within five (5) working days," when individuals were diagnosed with a significant health status change (i.e., diagnosis of aspiration pneumonia). For individuals on its caseload and/or referred to the PNMT, the PNMT should ensure the evaluation process is initiated in a timely manner per established policy.<br>▪ Individual PNMT evaluation(s) did not consistently document when and why an individual was referred to the PNMT, including the concerns and risks that the PST had identified. This information should be included in every evaluation.<br>▪ Individual PNMT evaluation(s) did not consistently incorporate the results of a HOBE evaluation. The evaluation should incorporate the findings of a HOBE evaluation for those individuals at high and medium risk of choking, aspiration, and respiratory concerns, and other applicable health related concerns.<br>▪ The PNMT was not consistently addressing the results of an APEN evaluation. The PNMT should review the APEN evaluation to determine if recommended strategies support transitioning an individual to a less restrictive approach to enteral nutrition, and/or implementation of therapeutic/pleasure feedings, | |

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| | | potentially leading to return to oral eating. The APEN action plan should be integrated and/or revised, if appropriate, into the PNMT Action Plan. This process was not currently implemented at ABSSLC.<br>▪ The PNMT evaluation(s) did not consistently reflect an evaluation of the identified high-risk and medium-risk indicators.<br>▪ During the evaluation process, the PNMT was not consistently identifying individual-specific triggers related to an individual's identified high and medium risk indicators for the PNMT, nursing staff, and direct support professionals to monitor.<br>▪ The evaluation(s) did not consistently include a comprehensive review of an individual's PNMP to determine if staff strategies continued to be adequate to minimize risk factors. This should be standard operating procedure during the evaluation process.<br>▪ PNMT Evaluation results were based significantly on record review. The PNMT Evaluation did not consistently document and analyze collaborative hands-on assessment of the individual.<br>▪ PNMT Evaluation(s) did not consistently provide an analysis of evaluation data. The PNMT evaluations should encompass a detailed analysis of clinical evaluation data. Such analysis should support the development of recommendations and measurable outcomes to minimize and/or reduce identified risk indicators.<br>**PNMT Action Plan**<br>▪ Individual PNMT Action Plans were not integrated into Health Management Plans/Nursing Care Plans, PSPs, PNMPs, Trigger Data Sheets, Dining Plans and/or Behavior Support Plans. This did not support an intensive, integrated approach to assessing, tracking, and resolving or minimizing identified high and medium health risk indicators.<br>▪ Individual PNMT Action Plans did not consistently identify individual-specific objective clinical data through which an individual communicated wellness and/or the onset of illness. The Action Plan should identify appropriate staff to monitor these triggers. These clinical indicators should be integrated into the nursing/health care plan(s). In addition, the Action Plan should incorporate individual-specific triggers for direct support professionals to observe for and document. The plan should identify who, what, where, when and how these triggers are to be monitored and documented, as well as the process for alerting nursing/medical staff and PNMT members, if these triggers are observed.<br>▪ PNMT Action Plans were not specific in identifying how often the PNMT would conduct a hands-on evaluation of an individual's current status.<br>▪ PNMT Action Plans did not provide comprehensive action steps to address high-risk indicators. For example;<br>o The action plans for individuals at risk for aspiration action plans did | |

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| | | not provide recommendations and measurable outcomes that were adequate to reduce an individuals' risk of aspiration. For these individuals, the PNMT Action Plans did not address the completion of a HOBE evaluation to determine the safe range of elevation for mealtime, alternate positioning, tooth brushing, medication administration, personal care, and bathing/showering; identification of individual-specific aspiration triggers to be incorporated into individuals' PNMPs and trigger data sheets for direct support professionals to document an individual's communication of the potential onset of illness; identification of clinical indicators to be assessed and monitored by nursing, PNMT members including the physician and respiratory therapist; competency-based training and performance check-offs for staff identified in the PNMT Action Plan steps; and/or individual-specific monitoring related to elements of the action plan for aspiration.<br>▪ PNMT Action Plan recommendations were reviewed in PNMT review meetings, but as documented in subsequent PNMT reviews, multiple recommendations had not been implemented. Due to the high level of health risk identified with individuals supported by the PNMT, the PNMT Action Plan recommendations should be implemented with a sense of urgency. It was not acceptable that recommendations were reported from month to month without implementation and/or resolution.<br>▪ Multiple individuals on the PNMT caseload had numerous admissions to the Infirmary, emergency room and/or hospital. The PNMT Action Plans should support proactive interventions to eliminate and/or minimize Infirmary, emergency room, and/or hospital admissions. In records reviewed, a clear correlation between risk factors that placed individuals into the hospital or Infirmary and the PNMT Risk Action Plans had not been identified through individual-specific behavior triggers, and/or objective clinical data indicators that needed to be documented to support wellness or alert identified staff to the onset of illness.<br>▪ Multiple PNMT Action Plan interventions/recommendations and measurable outcomes did not answer the questions who, what, where, when, and how. For example, a measurable outcome such as: "revise the PNMP to address respiratory compromise by 2/17/11" did not identify who would revise the PNMP, what would be revised in the PNMP, which staff were to be competency-based trained and by when, who would perform performance check-offs to test staff competency, and who would monitor staff compliance of revised PNMP strategies, etc.<br>**PSP Addendum**<br>▪ PSPAs were not consistently held to discuss the Integrated Risk Rating Form, PNMT Evaluation, and/or Action Plan. PSPAs should been initiated at the | |

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| | | conclusion of the PNMT Evaluation and Action Plan process to collaborate with the PST and integrate the PNMT Action Plan into the PSP and related plans. Efforts should be made to ensure that this is standard practice and supported through Facility policy.<br><br>In addition, the PNMT completed an "informal follow-up" for 13 individuals.<br>The following observations were noted:<br>▪ For none of the 13 individuals (0%) had the PNMT completed a PNMT comprehensive evaluation.<br>▪ Three of these 13 individuals were at high risk for aspiration, but no documentation was provided to show that the PST had referred these individuals to the PNMT;<br>▪ Five of these 13 individuals did not have any high-risk indicators, making it unclear why they were on the PNMT caseload.<br><br>Individual Sample 0.3 included six of these 13 individuals for whom the PNMT had completed informal follow-up. The Monitoring Team noted the following concerns:<br>▪ The PNMT had not reviewed and updated the individuals' Integrated Risk Rating Forms.<br>▪ Individuals at high risk for aspiration did not consistently have a PNMP (e.g., Individual #527).<br>▪ Individuals that the PNMT informally reviewed did not have a PNMT Action Plan supported by a PNMT Evaluation.<br>▪ PNMT reasons for review were not related to an individual's high and medium risk indicators.<br>▪ The PNMT informal process was not integrated into the PSP. PSPAs did not consistently document the presence and status of the PNMT informal review process.<br>▪ PNMT informal review recommendations were not consistently integrated into PNMPs.<br>▪ PNMT informal review was based primarily on a record review and not an evaluation process.<br><br>The Monitoring Team recommends the Facility eliminate the PNMT "informal follow-up" process, because this process did not appear to provide individuals with supports they required, and it was not supported by the DADS At Risk Individuals policy. If it is going to remain, then Facility policy should define the criteria for individuals to be placed in this category, and define the expectations for the provision of this support.<br><br>ABSSLC was not yet in compliance with this provision of the Settlement Agreement. Individuals with significant physical and nutritional needs were not being provided with | |

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| | | adequate and effective interventions and supports sufficient to meet the individual's needs. The PNMT process was not being adequately performed, because individuals were not afforded a comprehensive PNMT Evaluation and Action Plan. | |
| 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><br>Presentation Book Section O.3 presented five individual PNMPs with highlighted changes (Individual #7, Individual #511, Individual #285, Individual #504, and Individual #213). One of these five individuals was identified as being at high risk for aspiration (Individual #285). The highlighted changes for these five PNMPs included the use of an identified notch level on Concerto bath trolleys (i.e., use Concerto head elevation at third notch), and identified click setting for ARJO bath tub trolleys to identify bathing elevation, use of bathing wedge, use of inclinometer to obtain prescribed bed elevation, and range of elevation for personal care and medication administration.<br><br>The Presentation Book did not discuss evaluation procedures or how the PNMPs were modified. Strategies were not identified for how individuals would be prioritized for these modifications. PNMP procedures should be formalized, and a process identified for PNMP modifications, with priority given to individuals identified at high risk.<br><br>Sample O.1 was comprised of 12 individuals, whose PSTs had identified them as being at high risk for aspiration. PNMPs were present for individuals within this record sample, but essential components were missing. More specifically:<br>▪ In five of 12 records (42%), positioning instructions for wheelchair and alternate positions instructions with range of elevation were included (Individual #212, Individual #314, Individual #85, Individual #162, and Individual #362).<br>▪ In 12 of 12 records (100%), transfer instructions were included.<br>▪ In 12 of 12 records (100%), the mealtime/dining plan included oral intake strategies for mealtime and snacks, and/or addressed receiving nutrition through a feeding tube.<br>▪ In 12 of 12 records (100%), the mealtime/dining plan included food/fluid textures, and/or addressed receiving nutrition through a feeding tube.<br>▪ In two of 12 records (17%) (Individual #414 and Individual 472), the time was identified that an individual needed to remain upright after eating, and/or receiving enteral nutrition.<br>▪ In 12 of 12 records (100%), the mealtime/dining plan included behavioral concerns related to intake, and/or addressed receiving nutrition through a feeding tube.<br>▪ In six of 12 records (50%), strategies for medication administration were included (Individual #472, Individual #212, Individual #314, Individual #85, | Noncompliance |

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| | | Individual #362, and Individual #311).<br>▪ In ten of 12 records (83%), strategies for oral hygiene were included (Individual #311, Individual #362, Individual #162, Individual #281, Individual #361, Individual #85, Individual #314, Individual #212, Individual #472, and Individual #259).<br>▪ In 12 of 12 records (100%), individual adaptive equipment was included.<br>▪ In six of 12 records (50%), bathing/showering positioning and related instructions were included (Individual #212, Individual #314, Individual #85, Individual #162, Individual #362, and Individual #311).<br>▪ In six of 12 records (50%), personal care instructions for elevation during checking and changing were included (Individual #212, Individual #314, Individual #85, Individual #162, Individual #362, and Individual #311).<br>▪ In 12 of 12 records (100%) communication strategies were included.<br><br>The following describes in greater detail the concerns noted with regard to PNMPs:<br>▪ The Facility did not have a PNMP policy and/or procedures. The Facility should develop procedures which, at a minimum, define the purpose, content and outcome(s) of the PNMP, outline the evaluation process used to provide justification for PNMP strategies (i.e., HOBE evaluation to identify safe elevation range), responsibility of disciplines for development and implementation of the PNMP sections, process to integrate PNMPs into the PSP, reason(s) for PNMP revision, competency-based training and performance check-offs, and PNMP monitoring.<br>▪ PNMPs for individuals identified at high risk for aspiration, have a diagnosis of GERD, and/or other related health risk indicators (i.e., respiratory concerns) did not present adequate staff strategies to support safety in a variety of activities. For such individuals, current strategies in PNMPs should be re-evaluated using the HOBE evaluation to identify safe elevation ranges. PNMPs should present safe elevation range strategies for wheelchair and alternate positioning, bathing/showering, mealtime, medication administration, personal care and oral hygiene. The degree of elevation should be clearly defined through written instructions and, if appropriate, with photographic instructions.<br>▪ PNMPs for individuals who received enteral nutrition did not provide adequate strategies to support safety and minimize their risk factors. The PNMPs of individuals who receive enteral nutrition should include staff instructions and safe elevation range for medication administration, oral hygiene, personal care (i.e., checking and changing), bathing/showering, and for wheelchair and alternate positioning.<br>▪ PNMPs for individuals identified at high risk for aspiration did not consistently identify a recommended time to remain upright after a meal. Recommended time for an individual to remain upright after a meal for those who eat orally | |

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| | | and/or were enterally nourished should be an essential PNMP staff instruction.<br>▪ PNMP positioning instructions did not consistently present optimal alignment and support in regular dining chairs and/or seating systems. Therapists should review photographic instructions for wheelchair and alternate positioning to validate that these photographs promote optimal alignment and support.<br>▪ PNMPs did not present adequate instructions for nursing staff for medication administration, and were not integrated into other related nursing/health care plans. Medication administration instructions should include position of nurse (i.e., eye level with individual), individual-specific positioning instructions, including degree of elevation in wheelchair and/or alternate position, use of adaptive equipment, presentation techniques, and medication presentation that is consistent with the prescribed diet texture and fluid consistency.<br><br>On a positive note, the Monitoring Team observed a segment of the annual PSP for Individual #484. During the meeting the Facility Clinical Pharmacist discussed with the team her concerns with the number of large whole pills that the individual was receiving during medication administration. Individual #484's PNMP, revised 6/28/11, identified her prescribed diet texture as pureed, thinned or thickened to applesauce consistency. Her prescribed diet texture should have contraindicated the presentation of whole pills. The Clinical Pharmacist was to be commended for bringing this issue forward for team discussion and resolution. Therapy and nursing representatives should work in collaboration with the Clinical Pharmacist to review the form of medication(s) being presented to individuals who have been prescribed a modified diet texture and fluid consistency. The Medication Administration Record should document the prescribed diet texture and fluid consistency and ensure medication presented is in alignment with the prescribed diet texture and fluid consistency. If prescribed medications cannot be modified to conform to the diet texture and fluid consistency, the Clinical Pharmacist and PCP should be consulted to recommend different medication alternatives.<br>▪ PNMPs did not consistently identify the position of staff and an individual during tooth brushing. Positioning for the individual and staff during oral care should be clearly defined.<br>▪ PNMPs did not document an individual's high risk factors. Consideration should be given to incorporating this information on a PNMP.<br>▪ The stated purpose of the Policy for Safe Positioning During Vomiting, undated, was: "to reduce the risk and/or prevent aspiration when a person is or has been vomiting." The policy defined the ideal position during vomiting when an individual was in bed, in wheelchair and/or walking. None of the individual PNMP's from Sample O.1 (0%) reflected vomiting precautions. An in-service was provided to nursing staff for proper positioning of an individual with | |

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| | | vomiting, but no documentation was provided for the in-service agenda and curriculum, or verification of nursing attendance. A copy of the written test for the in-service was provided. This in-service did not meet the standard of competency-based training and performance check-off to test staff competency.<br>▪ The PNMT evaluation process should include a comprehensive review and revision of an individual's current PNMP and dining plan to ensure staff strategies are sufficient to minimize identified high and medium risk indicators.<br><br>ABSSLC risk lists identifying individuals at high and medium risk for aspiration should be utilized to prioritize the review of individual PNMPs and dining plans to ensure necessary components are present.<br><br><u>PNM plans were incorporated into individual's Personal Support Plans.</u><br>Review of the individuals in Sample O.1 revealed none of the PNMPs (0%) were incorporated and/or integrated into individuals' Personal Support Plans. Information from the PNMP should be integrated within the PSP, not simply referenced and/or listed. PNMP strategies should be integrated into nursing care/health management plans.<br><br>The PNMT did not consistently document an individual's status via Integrated Progress Notes to communicate with PST members and provide evidence of the implementation of the PNMT Action Plan. The PNMT members should consistently document the status of the implementation of the PNMT Action Plan within Integrated Progress Notes, but should also review Integrated Progress Notes to determine an individual's current wellness status and/or identification of the onset of illness.<br><br>When the PNMT discharges an individual, a PSPA meeting should be held to present and discuss the PNMT Discharge Plan. This plan should continue to support the implementation of staff strategies (nursing, therapy and direct support professionals) to minimize identified health risk indicators.<br><br><u>PNMPs are developed with input from the PST, home staff, medical and nursing staff.</u><br>Sample O.1 revealed 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).<br><br><u>PNMPs are reviewed annually at the PSP meetings, and updated as needed.</u><br>A review of the Sample O.1 showed that none of the PNMPs were integrated annually at the PSP meeting, and updated as needed. As discussed above, no evidence was found that that the PNMPs were actually reviewed at the PSP meetings, discussed, and integrated into skill acquisition programs, BSPs, nursing/health management care plans, and/or daily schedules. | |

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| | | 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.<br>In none of the records for Sample O.1 (0%) were PNMPs reviewed and updated as indicated by the completion of a revised Integrated Risk Rating Form, a change in the individual's status, a transition (change in setting), and/or as dictated by monitoring results.<br><br>Individuals supported by the PNMT who had been hospitalized and experienced a change in status did not have contact with the PNMT members during their hospitalizations. Multiple individuals on the PNMT caseload had been admitted to the Infirmary and hospital. However, according to interview, the PNMT relied upon the hospital liaison nurse for updates, which was not sufficient. The PNMT should continue to follow an individual on their caseload during hospitalization. The PNMT Action Plan (including the PNMP) should be modified to provide strategies to infirmary staff and/or staff that accompany an individual to the hospital. In addition, the PNMT should develop a transition plan to prepare for the individual's return from the hospital to ABSSLC Infirmary, as well as from the Infirmary to their residence.<br><br>ABSSLC was not yet in compliance with this provision of the Settlement Agreement. Individuals with physical and nutritional needs were not being provided with adequate PNMPs, and the PNMPs were not integrated into PSPs, nursing/health care plans, BSPs, etc. | |
| 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. | Staff implements interventions and recommendations outlined in the PNMP and/or Dining Plan.<br>The Monitoring Team did not observe staff competently implementing PNMPs and/or dining plan strategies. Staff engaged in unsafe mealtime practices, which posed an undue risk of harm for individuals identified at risk of aspiration and/or choking. The Monitoring Team observed implementation of PNMPs during medication administration in the Infirmary, and in residences, including in bathrooms and dining rooms in 5971, 5972, 5962, and 6521. The following 28 individuals were observed: Individual #484, Individual #7, Individual #186, Individual #91, Individual#138, Individual #23, Individual #254, Individual #415, Individual #201, Individual #92, Individual #459, Individual #278, Individual #525, Individual #164, Individual #349, Individual #65, Individual #512, Individual #424, Individual #234, Individual #206, Individual #195, Individual #140, Individual #366, Individual #290, Individual #27, Individual #439, Individual #409, and Individual #498.<br><br>The following summarizes the results of these multiple individual observations:<br>▪ In one of eight observations (13%), staff were following dining plans that | Noncompliance |

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| | | referred to positioning, use of adaptive equipment, and/or presentation techniques.<br>▪ In one of ten observations (10%), staff were following wheelchair-positioning instructions.<br>▪ In none of three observations (0%) was staff following alternate positioning instructions.<br>▪ In none of the two observations (0%) were staff completing a pivot transfer correctly.<br>▪ In none of two observations for medication administration (0%) were nursing staff following the PNMP instructions for positioning for individuals who received enteral nutrition.<br><br>The Monitoring Team reviewed the Facility lists of Risk Level Rating of High and Medium. The lists identified seven individuals at medium risk of aspiration and ten individuals at medium risk of choking in Residence 5962; 11 individuals at medium risk of aspiration and 11 individuals at medium risk of choking in Residence 5971; and two individuals at high risk for aspiration, 17 individuals at medium risk of aspiration, two individuals at high risk of choking, and 11 individuals at medium risk of choking in residence 5972. Observations of staff within these dining rooms did not reflect staff compliance with dining plans, which had the potential to place these individuals at risk. Staff assisting individuals at mealtimes with identified high and/or medium risk levels for aspiration and choking should receive foundational (core) mealtime and individual-specific competency-based training, and successfully complete performance check-offs to document their proficiency with the prescribed dining plans.<br><br>In addition, the HT Department should provide Facility mealtime monitors with mealtime foundational (core) competency-based training, and require that they successfully complete performance check-offs. The HT Department's mealtime experts should complete mealtime monitoring with the Facility mealtime monitors to establish inter-rater reliability with the use of the mealtime monitoring form. These mealtime monitoring validations should occur at the same time in the same dining room with the same individual(s) to provide accurate mealtime monitoring inter-rater reliability. Until this is completed, mealtime monitoring data will not provide an accurate reflection of staff mealtime competency.<br><br>The Monitoring Team strongly recommends that the Facility implement an interdisciplinary mealtime safety initiative to enforce staff compliance with mealtime plans. The HT Department (i.e., OTs, PTs, SLPs, PNMP Coordinators, HT Techs, etc.) cannot be the sole discipline(s) responsible to enforce staff compliance with PNMPs during mealtimes. The Monitoring Team recommends the following:<br>▪ For each residence/dining room, identification of a mealtime | |

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| | | supervisor/coordinator to provide oversight before, during, and after the meal;<br>▪ Implementation of competency-based training for mealtime supervisors/coordinators and monitors. This should include a mealtime training curriculum with specific learner objectives and competencies to provide foundational knowledge and skills related to ensuring safety at mealtimes in the following areas:<br>o Mealtime position and alignment;<br>o Diet texture and fluid consistency;<br>o Presentation techniques to enhance nutritional intake and hydration;<br>o Care and use of adaptive equipment;<br>o Aspiration and choking precautions and rationale;<br>o Understanding a swallow study;<br>o Risk indicators and problem solving; and<br>o Techniques to promote optimal levels of independence and skill acquisition during mealtimes.<br>▪ Development and implementation of competency-based performance check-offs for mealtime supervisors and monitors to ensure competency with mealtime learner objectives.<br>▪ Establishment of a validation and re-revalidation process for mealtime supervisors and monitors, including auditing mealtime to ensure competency with mealtime indicators.<br>▪ Establishment of protocols for implementation of a mealtime monitoring schedule, and auditing of completed mealtime monitoring forms to formulate corrective strategies to address individual-specific and/or systemic areas of deficiencies for specific indicators. This process should be integrated into the Facility's QA/QI and Risk Management systems.<br>▪ Establishment of compliance benchmarks for mealtime monitoring results to celebrate success. If monitoring results fall below established benchmarks, the Facility should determine what action will be necessary, such as staff re-training and/or an administrative directive to correct deficiencies that appear to be systemic.<br>▪ Implementation of a heightened mealtime monitoring schedule for individuals identified at high risk, such as individuals at risk for aspiration pneumonia, respiratory concerns, choking, weight, fluid imbalance, etc.<br><br>In summary, ABSSLC was not yet in compliance with this provision of the Settlement Agreement. Staff were not consistently competent and/or compliant with implementing PNMPs and dining plan strategies that were prescribed to support safe mealtime practices for individuals who eat orally and/or were enterally nourished. | |
| O5 | Commencing within six months of | <u>Staff are provided with general competency-based foundational training related to all</u> | Noncompliance |

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| | 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. | aspects of PNM by the relevant clinical staff.<br>No Facility policies and/or procedures were submitted related to the provision of competency-based training for physical and nutritional supports and the implementation performance check-offs.<br><br>The Monitoring Team reviewed the New Employee Pre-Service Training schedule, dated 8/8/11. Although it provided a training curriculum for physical and nutritional supports, it was not sufficient to ensure staff competency. The curriculum included:<br>▪ Body Mechanics/Lifting (duration of four hours);<br>▪ Dieticians (duration of 45 minutes);<br>▪ Textures/Food Service (duration of 15 minutes);<br>▪ Physical Management (duration of three hours);<br><br>This resulted in new employees receiving eight hours of foundational training in physical and nutritional supports. This was not sufficient time for foundational competency-based training in physical and nutritional supports. The major issue was the absence of the provision of competency-based training with performance check-offs for physical and nutritional supports. This was a contributing factor for staff's continued incompetency in implementing prescribed PNMPs and dining plan strategies. Based on interview, the Director of Rehabilitative Services was beginning the process of reviewing the appropriateness of the training curriculum for new employees. The Director should review the Monitoring Team's previous reports related to Section O.5, in which suggestions were presented to remediate deficiencies in the Facility curriculum.<br><br>The Presentation Book for Section O included a copy of a PowerPoint presentation for Aspiration Pneumonia. The Facility was to be commended for developing and initiating this training. It was a positive initiative to increase staff's understanding related to aspiration, as well as their knowledge about strategies to minimize the risk of aspiration. The stated objective was: "The Abilene State Supported Living Center will conduct staff development and training, for all staff, on the importance of preventing Aspiration." The identified training audience included direct support professionals, investigators, registered nurses, licensed vocational nurses, and staff within the areas of food service, psychology, activity centers, vocational services, recreation, and transportation. The training schedule indicated that the duration of the course was one hour. Upon finishing the course, staff completed a written test with 12 questions. No learner objectives were presented for this course, nor was the criteria for a passing score identified. This training did not require a competency-based performance check-off. The Monitoring Team's review of the Aspiration Pneumonia PowerPoint slide show revealed the following concerns:<br>▪ The slide entitled "Risky Eating Behaviors Can Cause Aspiration" did not address the effects of poor positioning for individuals who eat orally and/or receive | |

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| | | enteral nutrition. Positioning during medication pass was discussed later in the presentation, but the importance of positioning should have been discussed at the very beginning of the course, because proper positioning minimizes the risk of aspiration.<br>▪ "Meds and Aspiration Risk" did not address the integration of PNMP strategies, such as individual-specific positioning, use of adaptive equipment, and/or presentation techniques to be followed by nursing during a medication pass.<br>▪ The "Meds and Aspiration Risk" slide stated: "Remember [nurse] to be at eye level with the person you are working with!" However, these instructions were not consistently present in individual PNMPs reviewed.<br>▪ A slide stated: "Triggers can happen during or immediately after: eating/drinking and med pass (by tube or mouth), tooth brushing, and lying down." Staff should be taught that triggers could occur anytime during the day or night.<br>▪ "Aspiration Warning Triggers" did not identify where individual-triggers would be located. Discussion of individuals at high and medium risk of aspiration should occur.<br>▪ The slide "Positioning for Tooth brushing" acknowledged that a "staff member must be at eye level during tooth brushing." This staff instruction was not consistently present in individual PNMPs reviewed.<br><br>In addition, the Monitoring Team has concerns about the ability of direct support professionals to understand and retain this level of information prior to receiving adequate competency-based foundational training in physical and nutritional supports.<br><br>Based on interview, Daily Incident Monitoring meetings documented individuals who resided at ABSSLC with shoulder injuries. A document entitled Core Competency Training: Safe Handling Techniques During Transfers, Repositioning and Escorting for staff re-training was presented for review. In addition, a staff performance check-off sheet was developed requiring demonstration for pass/fail with the following core competencies: repositioning in wheelchair, sling placement in wheelchair, stand-pivot transfer, escort with gait belt, two-person assist from floor, bed rolling, bed repositioning with draw sheet using two persons, and bed repositioning side by side with two persons. The Monitoring Team discussed with the Lead PT the need for a detailed task analysis of each of these specific foundational/core competencies. Such task analyses would provide a teaching curriculum for instructors, as well as a core competency performance check-off to test staff competency. For example, the core competency of "repositioning in wheelchair" should require multiple steps to ensure an individual was positioned correctly in a wheelchair. The specification of required steps provides a concrete record of staff pass/fail demonstration of proficiency. If a staff member fails a core competency performance check-off, the staff as well as the instructor is able to quickly identify | |

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| | | specific tasks requiring remediation. The Monitoring Team commended the Lead PT for this initiative, but additional components will need to be added to meet the standard of competency-based training and performance check-offs.<br><br><u>All foundational trainings are updated annually</u>.<br>The document entitled: "Six Months Schedule Competency Training And Development March 1, 2011 through August 31, 2011" stated that the Body Mechanics/Lifting annual refresher course "will no longer be in effect after 04-19-2011." This schedule did not identify any additional annual refresher courses related to physical and nutritional supports.<br><br><u>Staff are provided individual-specific training on the PNMP by the appropriately trained personnel.</u><br>None of the staff supporting the 12 individuals from Sample O.1 (0%) had documentation of individual-specific PNMP competency-based training and performance check-offs being provided by staff who had demonstrated competency.<br><br>Reviews of PNMT Action Plans and supporting documentation did not provide evidence of the completion of individual-specific competency-based training and performance check-offs to support staff's compliance with the PNMT Action Plan. The PNMT should provide individual-specific competency-based training and performance check-offs to ensure that staff implement prescribed and updated PNMPs, including nursing staff, supervisors, and direct support professionals.<br><br><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><br>In none of the 12 individual staff training records reviewed (0%), for staff providing assistance to individuals determined to be at high risk for aspiration, had staff successfully completed competency-based training and performance check-offs.<br><br>A review of Sample O.2 (eight individuals with a PNMT Evaluation) did not document the provision of competency-based training and performance check-offs to ensure staff was competent to implement the PNMT Action Plan, including the PNMP. The PNMT Action Plan should describe the purpose and content of the training related to identified risk indicators, identify the staff responsible for conducting the training and performance check offs, state the timeline for completion of training and performance check-offs, and identify which specific staff across shifts are to complete the training and performance check-offs (i.e., nursing, direct support professionals, supervisory staff, etc.).<br><br><u>Staff are trained prior to working with individuals and retrained as changes occur with</u> | |

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| | | the PNMP.<br>Based on a review of staff training for 12 individuals in Sample O.1, identified at high risk of aspiration pneumonia, none of the of 12 individual records (0%) revealed that staff had completed competency performance check-offs for all PNMP strategies, and/or when changes occurred to the PNMP. Staff verbalization describing a PNMP revision did not meet the standard of competency-based training and performance check-off.<br><br>In summary, ABSSLC was not yet in compliance with this provision of the Settlement Agreement. Staff responsible for individuals with physical and nutritional management problems had not successfully completed competency-based training and performance check-offs to successfully implement PNMPs and dining plans. | |
| O6 | Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall monitor the implementation of mealtime and positioning plans to ensure that the staff demonstrates competence in safely and appropriately implementing such plans. | A policy/protocol addresses the monitoring process and provides clear direction regarding its implementation and action steps to take should issues be noted.<br>Monitoring covers staff providing care in all aspects in which the person is determined to be at an increased risk (all PNM activities).<br>The Facility did not have policies and/or protocols for implementation of the following monitoring forms, nor were there procedures identified for the integration of the following forms into an overall monitoring or QA system:<br>▪ Aspiration Prevention Competency Observation Checklist for Med [Medication] Pass, Mealtime, and Oral Care;<br>▪ ABSSLC Mealtime/Oral Activities Safety Monitoring Tool;<br>▪ Positioning Tracking Sheet (to ensure proper positioning to prevent skin breakdown and/or aspiration for individuals in the Infirmary);<br>▪ PNMP Training Form;<br>▪ Positioning Tracking Form;<br>▪ PNMP Monitoring Form-Routine; and<br>▪ Abilene State Living Center Mealtime Observation.<br><br>The Facility needed to complete a comprehensive analysis of the multiple monitoring forms to determine if these forms were duplicative and, most importantly, were effective in monitoring foundational competencies for physical and nutritional supports. Monitoring forms should be based on the foundational/core competencies that the Facility identifies as being necessary for the provision of adequate physical and nutritional supports. In addition, guidelines or instructions are necessary to ensure consistent scoring. The Facility's policy should answer the questions of who, what, when, where, and why for Facility monitoring. Monitors should successfully complete competency-based training and performance check-offs, as well as scheduled validation reviews to provide confidence in monitoring data.<br><br>As stated in the Monitoring Team's previous reports, the completed forms documented | Noncompliance |

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| | | repeated individual-specific and/or systemic concerns, as well as staff non-compliance. However, no resolution was noted.<br><br>No procedures had been identified for the integration of these monitoring forms into a unified system to enable data to be easily analyzed, concerns identified, and resolutions developed and implemented. The absence of a cohesive monitoring review process did not support effective utilization of staff resources but, most importantly, the monitoring results were not presented in a way to effectively track and trend the implementation of individual's PNMPs and dining plans.<br><br><u>All members of the PNM team conduct monitoring.</u><br>Based on a review of PNMT Action Plans and supporting documentation for individuals in Sample O.2, none of these records (0%) showed that the PNMT consistently conducted individual-specific monitoring to document staff compliance with the PNMT Action Plans.<br><br><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><br>A review of Facility reports, including those from the Quality Enhancement Department, did not illustrate that a mechanism was in place to ensure timely data was provided to the PNMT 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. Facility PNMT procedures should define thresholds to trigger further evaluation based on degree of and/or frequency of certain types of incidents, and/or key health care indicators. This information should be integrated into the Facility's QA/QI, Incident Management and Risk Management systems.<br><br><u>Immediate intervention is provided if the person is determined to be at risk of harm.</u><br>Examples are provided above with regard to Section I.2 and I.3, as well as throughout Section O of individuals who were at high risk for aspiration, but the PST had not followed the State At Risk policy, or referred them to the PNMT.<br><br>In summary, ABSSLC was not yet in compliance with this provision of the Settlement Agreement. Policies and procedures were not in place for monitoring, consistent monitoring was not being completed on an individual or systemic level, and even when monitoring occurred, adequate corrective action was not developed or implemented. | |
| 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 | <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><br>For none of the 12 individuals in Sample O.1 (0%), who were at high risk for aspiration, had their PSTs completed a comprehensive Risk Action Plan, including adequate supports to minimize identified high-risk indicators. However, the PSTs had not | Noncompliance |

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| | the progress of individuals with physical or nutritional management difficulties, and revise interventions as appropriate. | provided timely follow-up to the Risk Action Plans that had been developed. The plans generally did not include measurable objectives designed to determine the efficacy of plans. As a result, the PSTs did not document progress related to individual strategies on a monthly basis, or determine the efficacy of those strategies in minimizing and/or reducing PNM risk indicators. In none of the 12 records reviewed was documentation found describing whether or not strategies were effective. As a result, changes could not be made to potentially ineffective plans. Additional information is provided with regard to Sections I.2, I.3, O.1, O.2, O.3, O.4, O.5 and O.6.<br><br><u>Person-specific monitoring is conducted that focuses on plan effectiveness and how the plan addresses and minimizes PNM risk indicators.</u><br>The PNMT did not consistently provide specific recommendations for PNMT individual-specific monitoring, nor was there consistent evidence provided to support implementation of PNMT monitoring of staff's compliance with the PNMT Action Plan recommendations and measurable outcomes.<br><br>ABSSLC was not yet in compliance with this provision of the Settlement Agreement, and no progress had been made with regard to Section O.7. | |
| 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 evaluations that address the medical necessity of the tube and potential pathways to PO status.</u><br>According to State policy, all individuals who received enteral nutrition would receive an annual Aspiration Pneumonia/Enteral Nutrition Evaluation. Evaluation 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 Monitoring Team's previous report identified the major elements of the APEN Evaluation.<br><br>Based on a review of individuals in Sample O.4 who were identified at high and/or medium risk for aspiration and were enterally nourished, none (0%) of these seven individuals had received an APEN evaluation.<br><br><u>People who receive enteral nutrition and/or therapeutic/pleasure feedings are provided with PNMPs that include the components listed above.</u><br>Based on a review of the seven individuals in Sample O.4, individuals were provided with a PNMP, but components were missing as documented below:<br>▪ In one of seven records (14%), positioning instructions with identified safe elevation range for wheelchair and alternate positions instructions were included (Individual #285).<br>▪ In seven of seven records (100%), transfer instructions were included.<br>▪ In three of seven records (43%), staff instructions were provided to identify the | Noncompliance |

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| | | prescribed time an individual was to remain upright after receiving enteral nutrition (Individual #285, Individual #385, and Individual # 403),<br>▪ In six of seven records (86%), strategies for medication administration were included (Individual #216, Individual #489, Individual #285, Individual #403, Individual #63, and Individual #492).<br>▪ In seven of seven records (100%), strategies for oral hygiene were included.<br>▪ In seven of seven records (100%), individual adaptive equipment was included.<br>▪ In six of seven records reviewed (86%), bathing/showering positioning instructions were included (Individual #216, Individual #489, Individual #285, Individual #403, Individual #63, and Individual #492).<br>▪ In six of seven records (86%), personal care instructions for elevation during checking and changing were included (Individual #216, Individual #489, Individual #285, Individual #403, Individual #63, and Individual #492).<br>▪ In seven of seven records reviewed (100%), communication strategies were included.<br><br>As stated above with regard to Section O. 3, the HT Department should develop PNMP procedures that incorporate an audit system to review PNMPs to ensure they contain required components.<br><br><u>The need for continued enteral nutrition is integrated into the PSP.</u><br>Based on a review of individuals in Sample O.4, none (0%) of the individuals' PSPs documented the rationale for the continued need for enteral nutrition, attempts to return the individual to oral intake, or the least restrictive method of receiving nutrition.<br><br><u>A policy exists that clearly defines the frequency and depth of evaluations (Nursing, MD, SLP or OT).</u><br>The component of the DADS At-Risk Individuals policy (Policy Number 006, dated 11/02/10) required "a comprehensive integrated evaluation 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 but the Facility had not followed this policy.<br><br>ABSSLC was not in compliance with this provision of the Settlement Agreement, and no progress had been made. | |

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

1. The physician liaison should be more actively engaged with the PNMT to provide support and consultation prior to, during, and after PNMT meetings. (Section O.1)

2. The Facility Administration, in collaboration with the Habilitation Therapy Director, should complete an analysis of caseloads and responsibilities of PNMT members (OT, PT, SLP, and RD), and make necessary changes to enable members to fulfill their PNMT responsibilities. (Section O.1)
3. A continuing education tracking system for PNMT members and other therapists should be implemented to consistently document attendance through training rosters and/or certificate of completion for state-sponsored webinars, off-site clinical instruction, and conferences. (Section O.1)
4. The Facility should develop and implement a PNMT policy that formalizes the PNMT process, including, but not limited to the following: identification of the roles and responsibilities of the PNMT; criteria for referral to the PNMT; meeting schedule; PNMT role in the PST Risk Evaluation process, including a review of the PST's Integrated Risk Rating Form and Risk Action Plan upon the individual's referral to the PNMT; definition of the comprehensive evaluation process; development and implementation of a PNMT Risk Action Plan that integrates the PST Risk Action Plan, APEN Action Plans, nursing care/health management plan, Behavior Support Plan (BSP), etc.; individual-specific staff competency-based training and performance check offs; individual-specific monitoring; transition planning from the hospital, Infirmary, and residence; and discharge planning and criteria. (Section O.1)
5. PST members should receive training to understand and implement the Facility's PNMT policies and/or procedures. (Section O.1)
6. To support successful implementation of the PNM process leading to an adequate and effective comprehensive PNMT Evaluation and Action Plan the following is recommended:
    a. The Facility should formalize PNMT referral criteria immediately, including emergency referrals. For example, some criteria might be individuals at high risk of aspiration for whom the PST has determined they need guidance with the action plan, or individuals diagnosed with aspiration pneumonia.
    b. PNMT review and updating of individual Integrated Risk Rating Forms during the evaluation should be standard practice at ABSSLC.
    c. For individuals on their caseload, when there is a change in status, the PNMT, in conjunction with the PST, should revise an individual's Integrated Risk Rating Form(s). This should be documented through a PSPA.
    d. When teams meet to review risk ratings, PNMT members should be present and actively engaged in reviewing risk levels for individuals on their caseload.
    e. Individual PNMT evaluation(s) should document the date of the initial referral to the PNMT.
    f. Once an individual is referred, the PNMT should initiate a timely evaluation per the At Risk Individuals policy that stated "as soon as possible, or within five (5) working days."
    g. Individual PNMT Evaluation(s) should document when and why an individual was referred to the PNMT, including the concerns and risks that the PST has identified.
    h. Individual PNMT evaluation(s) should incorporate the results of a HOBE evaluation.
    i. For individuals with tubes, the PNMT evaluation should review the results of an APEN evaluation to determine if recommended strategies support transitioning an individual to a less restrictive approach to enteral nutrition, and/or implementation of therapeutic/pleasure feedings, potentially leading to a return to oral eating.
    j. The PNMT evaluation(s) should reflect an evaluation of the identified high-risk and medium-risk areas.
    k. The PNMT evaluation process should identify individual-specific triggers that identify the potential onset of illness and are related to an individual's identified high and medium risk indicators. These triggers should be incorporated into the Action Plan.
    l. The PNMT evaluation(s) should document a comprehensive review of an individual's PNMP to determine if staff strategies continue to be adequate to minimize risk factors.
    m. The PNMT Evaluation should document collaborative hands-on assessment with the individual.
    n. The PNMT evaluations should encompass a detailed analysis of clinical evaluation data, which supports the development of recommendations and measurable outcomes to minimize and/or reduce identified risk indicators.
    o. Individual PNMT Action Plans should be integrated, as appropriate, into Nursing Care Plans, PSPs, PNMPs, Trigger Data Sheets, Dining

Plans, and/or Behavior Support Plans.

p. Individual PNMT Action Plans should identify individual-specific objective clinical data through which an individual communicates wellness and/or the onset of illness. The Action Plan should identify appropriate staff to monitor, document, and report on these triggers. These clinical indicators should be integrated into nursing/health care plans.
q. In addition, the Action Plan should incorporate individual-specific behavior triggers for which direct support professionals are responsible for observing, documenting, and reporting. The plan should identify who, what, where, when and how these triggers are to be documented and monitored, as well as the criteria for alerting nursing/medical staff and PNMT members, if these triggers are observed. Any staff training needed for implementation of the process should be defined in the Action Plan.
r. PNMT Action Plans should identify how often the PNMT will conduct a hands-on evaluation to assess an individual's current status and provide data to support the efficacy of Action Plan interventions.
s. PNMT Action Plans should provide comprehensive recommendations to address high-risk indicators.
t. The PNMT Action Plans should support proactive interventions to eliminate and/or minimize Infirmary, emergency room, and/or hospital admissions.
u. PNMT Action Plan recommendations should be implemented with urgency.
v. The PNMT Action Plan interventions/recommendations and measurable outcomes should answer the questions of who, what, where, when, and how.
w. PSPAs should be initiated to discuss the Integrated Risk Rating Form, PNMT Evaluation, and Action Plan. This should be standard practice and supported through Facility policy. (Section O.2)

7. The Facility should develop PNMP procedures to incorporate the following information, at a minimum:
    a. Define the purpose, content and outcome(s) of the PNMP, outline the evaluation process used to provide justification for PNMP strategies (i.e., HOBE evaluation to identify safe elevation range), identify the disciplines' responsibility for development and implementation of the PNMP sections, define the process to integrate PNMPs into the PSP, identify reason(s) for PNMP revision, and describe expectations for competency-based training and performance check-offs, as well as PNMP monitoring.
    b. Non-negotiable staff strategies for individuals at high risk, such as time for an individual to remain upright after a meal, range of safe elevations for wheelchair and alternate positioning, personal care, oral care, bathing/showering, medication administration, etc.
    c. Consideration should be given to identifying an individual's high risk factors on the PNMP. (Section O.3)
8. Therapy and nursing representative's should work in collaboration with the Clinical Pharmacist to review the form of medication(s) being presented to individuals who have been prescribed a modified diet texture and fluid consistency to determine if their current medication(s) support the prescribed diet texture and fluid consistency. (Section O.3)
9. The PNMT should document an individual's status via Integrated Progress Notes to communicate with PST members and provide evidence of the implementation of the PNMT Action Plan. PNMT also should review Integrated Progress Notes to determine an individual's current wellness status and/or identification of the onset of illness, and document their review. (Section O.3)
10. When the PNMT discharges an individual, a PSPA meeting should be held to present and discuss the PNMT Discharge Plan. This plan should continue to support the implementation of staff strategies (e.g., nursing, therapy, and direct support professionals) to minimize identified health risk indicators. (Section O.3)
11. To prevent and address hospitalizations, the PNMT should be involved while an individual is hospitalized, and develop a transition plan to prepare for their return from the hospital to ABSSLC Infirmary, as well as from the Infirmary to their residence. (Section O.3)
12. The Facility should implement an interdisciplinary mealtime safety initiative to ensure staff compliance with mealtime plans for those individuals who eat orally and/or receive enteral nutrition, including the following:
    a. For each residence/dining room, identification of a mealtime supervisor/coordinator to provide oversight before, during, and after the meal;
    b. Implementation of competency-based training for mealtime supervisors/coordinators and monitors. This should include a mealtime

training curriculum with specific learner objectives and competencies to provide foundational knowledge and skills related to ensuring safety at mealtimes in the following areas:
    i. Mealtime position and alignment;
    ii. Diet texture and fluid consistency;
    iii. Presentation techniques to enhance nutritional intake and hydration;
    iv. Care and use of adaptive equipment;
    v. Aspiration and choking precautions and rationale;
    vi. Understanding a swallow study;
    vii. Risk indicators and problem solving; and
    viii. Techniques to promote optimal levels of independence and skill acquisition during mealtimes;
c. Development and implementation of competency-based performance check-offs for mealtime supervisors and monitors to ensure competency with mealtime learner objectives;
d. Establishment of a validation and re-revalidation process for mealtime supervisors and monitors, including auditing mealtime to ensure competency with mealtime indicators;
e. Establishment of protocols for implementation of a mealtime monitoring schedule, and auditing of completed mealtime monitoring forms to formulate corrective strategies to address individual-specific and/or systemic areas of deficiencies for specific indicators. This process should be integrated into the Facility's QA/QI and Risk Management systems;
f. Establishment of compliance benchmarks for mealtime monitoring results to celebrate success. If monitoring results fall below established benchmarks, the Facility should determine what action will be necessary, such as staff re-training and/or an administrative directive to correct deficiencies that appear to be systemic; and
g. Implementation of a heightened mealtime monitoring schedule for individuals identified at high risk, such as individuals at risk for aspiration pneumonia, respiratory concerns, choking, weight, fluid imbalance, etc. (Section O.4)

13. The Director of Rehabilitative Services and lead therapy staff should initiate a comprehensive review of the aspects of new employee orientation related to physical and nutritional supports to determine what revisions and/or additions need to be implemented. The Monitoring Team's previous reports should be reviewed related to foundational curriculum for physical and nutritional supports. (Section O.5)
14. The Facility should develop a detailed task analysis for each of the specific foundational/core competencies related to physical and nutritional supports. Such task analyses should form the basis for a teaching curriculum for instructors, and be used as the core competency performance check-off sheets to test staff competency. (Section O.5)
15. The PNMT should provide individual-specific competency-based training and performance check-offs to document staff competency in implementing PNMT Action Plans. The PNMT Action Plan should describe the purpose and content of the training related to identified risk indicators, identify the staff responsible for conducting the training and performance check offs, state the timeline for completion of training and performance check-offs, and identify which specific staff across shifts are to complete the training and performance check-offs (i.e., nursing, direct support professionals, supervisory staff, etc.). (Section O.5)
16. The Facility should complete a comprehensive analysis of the current multiple monitoring forms to determine if these forms are duplicative and, most importantly, effective in monitoring the provision of effective physical and nutritional supports. (Section O.6)
17. A Facility policy should be developed and implemented 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. Requirement that all monitoring forms 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. Establishment of thresholds for staff re-training. (Section O.6)

18. The PNMT should conduct individual-specific monitoring to document staff compliance with PNMT Action Plans. (Section O.6)
19. 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 QA/QI, Incident Management and Risk Management systems. (Section O.6)
20. PSTs who support individuals with high risk physical and nutritional management difficulties should provide tracking and analysis of action steps to determine the efficacy of their interventions to minimize and/or reduce identified risk indicators. (Section O.7)
21. The Facility should ensure APEN evaluations are completed. (Section O.8)
22. The Director of Rehabilitative Services, in collaboration with lead therapists and the respective PCM from the Quality Assurance Department, should analyze and include data from compliance audits in the POI to substantiate findings related to compliance. However, a focus should be placed on the development of adequate instructions for the audit tools, and procedures should be implemented to ensure inter-rater reliability. (Facility Self-Assessment)
23. Analyses of audit results should track and trend problematic concerns and document actions taken to address problem areas. (Facility Self-Assessment)

| SECTION P: Physical and Occupational Therapy | |
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| 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:<br>▪ **Review of Following Documents**:<br>o Presentation Book for Section P;<br>o Presentation for Section P for Settlement Agreement Monitoring Team; dated August 22, 2011;<br>o The following documents: OT/PT Evaluations, HOBE Evaluation, OT/PT Consultations for the past year, supporting documentation for implementation of direct/indirect therapy programs, PSP and PSPAs for the past year, PNMP with pictures, Dining and Diet Card, PNMP Clinic documentation for the past year, PNMP and individual-specific monitoring, staff competency-based training and performance check offs for staff, daily schedule and wheelchair evaluation for the following 16 individuals: Individual #512, Individual #504, Individual #493, Individual #110, Individual #366, Individual #503, Individual #271, Individual #317, Individual #26, Individual #467, Individual #199, Individual #480, Individual #75, Individual #145, Individual #481, and Individual #513;<br>o OT/PT Evaluations for new admissions for the following four individuals: Individual #121, Individual #125, Individual #107, and Individual #96;<br>o OT/PT Evaluations and Community Living Discharge Plans (CLDPs) for the following two individuals: Individual #130 and Individual #251;<br>o For Individual #484, the following documents: Integrated Risk Rating Form, PST Risk Action Plan, OT/PT/SLP/RD Evaluation, Wheelchair Evaluation, Sign-in sheet for annual PSP on 8/23/11, and PNMP with pictures;<br>o Positioning Tracking Sheet (template), undated;<br>o List of Therapists, dated 7/21/11;<br>o List of Individuals with Adaptive Equipment, undated;<br>o PNM Maintenance Log utilized to track Modifications made to Adaptive/Assistive Equipment, from 9/10 through 6/11;<br>o OT/PT Annual Evaluation (template), dated 9/96;<br>o Seating System Assessment (template), undated;<br>o Eating Evaluation/Nutritional Management Plan (template), revised 2/10;<br>o OT/PT Initial Evaluations for Multiple Individuals, from 2/11 through 6/11;<br>o Tracking Log of completed Assessments, from 3/11 through 7/11;<br>o Wheelchair Seating Assessments (template), undated;<br>o PNMP Clinic Assessments (template), undated;<br>o OT/PT-related Spreadsheets, undated;<br>o Dining Plan Roster, dated 7/18/11;<br>o OT/PT Consults, dated 7/11;<br>o OT/PT Summary Reports, from 1/11 through 3/11;<br>o List of Individuals receiving Direct OT/PT Services and Focus of Intervention, undated; and |

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| | ○ PowerPoint presentation for Aspiration In-Service and Final Test (template), undated.<br>▪ **Interviews with**:<br>○ Bobbie Holden, OT, Director of Rehabilitative Services; and<br>○ Karen Mayfield, Lead PT.<br>▪ **Observations of**:<br>○ In residences and dining rooms in 6521, 6521, 5972, 5971 and 5961. |
| | **Facility Self-Assessment:** Based on a review of the Facility's POI, with regard to Section P of the Settlement Agreement, the Facility found that it remained out of compliance with all of the sub-provisions. This was consistent with the Monitoring Team's findings.<br><br>The POI did not present data to substantiate its findings related to compliance. POI updates, since the last compliance review, did not document regular audits utilizing tools that the State Office had modified based on the Monitoring Teams' review tools. No discussion was included of improvements being made to audit tool instructions, and/or strategies to ensure inter-rater reliability between therapists and Program Compliance Monitors (PCM).<br><br>The Section P Action Plan documented three action steps related to improving the audits designed to ensure staff were competent in implementing OT/PT plans. This was an important action plan for the Facility to implement. However, the Facility was in the initial stages of implementing it. Training for PNMP Coordinators and Therapy Technicians continued to be in process. The development of a monitoring/observation tool had not started. The third action step was to conduct observations/audits quarterly to ensure PNMP Coordinators and Therapy Technicians were competent in the performance of their duties and this initiative had not started.<br><br>Based on the information provided, it was unclear what the Facility viewed as the next steps in its efforts to comply with Section P of the Settlement Agreement. The Director of Rehabilitative Services, in collaboration with the Lead PT, should expand the action plans for Section P to address all sub-components for Section P. During this process it will be imperative to prioritize what will be accomplished during the six-month intervals between compliance reviews.<br><br>The Director of Rehabilitative Services, in collaboration with lead therapists and the respective PCM for Habilitation Therapy Department, should document compliance audits that provide data to substantiate findings related to compliance. There should be a focus on the development of adequate instructions for the audit tools and procedures should be implemented to ensure inter-rater reliability. An analysis of audit results should be initiated to track and trend problematic areas as well as document strategies to ameliorate areas of concerns. The absence of adequate instructions for the monitoring tool and distinct trials to achieve inter-rater reliability between therapists and the PCM will result in audit data that will not be considered reliable and/or valid. |
| | **Summary of Monitor's Assessment:** The Facility had six budgeted positions for OTs and four for PTs. At the time of the review, the Facility had no full-time OTs, but had three part-time contracted OTs. Three full- |

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| | time PTs were employed, with one PT vacancy. Facility Administration and the Director of Rehabilitative Services had recruited an OT with extensive experience, but her salary expectations exceeded state salary ranges. The Facility had submitted a request to the State for hiring approval. These therapy vacancies continued to impact the Facility's ability to achieve compliance with Section P.<br><br>No continuing education documentation was submitted for OTs and PTs. As stated in the previous report, OTs and PTs, who were members of the Core PNMT, should attend State-sponsored webinars, as well as document their involvement with State PNM consultants.<br><br>The current OT/PT evaluation did not provide adequate information to support the person-centered planning process, or plan for future community placement. The OT/PT evaluation process should be critically reviewed to determine what modifications are needed to produce a functional evaluation. These processes should be formalized through Facility policy.<br><br>Direct and indirect therapy interventions were not analyzed during the evaluation and/or update process, or in clinical progress notes to determine if progress was being made, and/or if changes needed to be instituted. Justification for therapy interventions was not outlined in the analysis of findings section of the evaluations to provide a rationale for functional outcomes and recommendations. Therapy plans were not integrated into PSP Action Plan objectives. The PSPs did not provide opportunities integrated throughout the day for an individual to practice newly learned skills.<br><br>The Facility did not have a policy and procedures for the development and implementation of competency-based training and performance check-offs for foundational skill training in physical and nutritional supports, individual-specific PNMP strategies, and strategies to reinforce skill acquisition related to direct therapy plans. The implementation of competency-based training and performance check-offs should be a priority, with individuals identified at high risk for choking, aspiration, respiratory concerns, falls, fractures and skin integrity receiving highest priority.<br><br>The Facility did not have formal policies and/or procedures for the PNMP Clinic to ensure individuals' adaptive/assistive equipment was reviewed annually for fit, availability, function, condition, and effectiveness. |

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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 | Minimal progress had been made with regard to Section P.1, which requires the Facility to identify individuals with therapy needs and complete a comprehensive integrated occupational and physical therapy evaluation, as well as to assess individuals newly admitted to the Facility within 30 days. The evaluation should consider significant medical issues and health risk indicators.<br><br>The Monitoring Team's record sample for Section P was as follows: | Noncompliance |

<table>
<tr><th>#</th><th>Provision</th><th>Summary of Status</th><th>Compliance</th></tr>
<tr><td></td><td>that individuals identified with therapy needs, including functional mobility, receive a comprehensive integrated occupational and physical therapy evaluation, within 30 days of the need's identification, including wheelchair mobility evaluation as needed, that shall consider significant medical issues and health risk indicators in a clinically justified manner.</td><td>
<ul>
<li>Sample P.1 - 10 individuals who had experienced a change in status, including Individual #512, Individual #504, Individual #493, Individual #110, Individual #366, Individual #503, Individual #271, Individual #317, Individual #26, and Individual #467;</li>
<li>Sample P.2 - two individuals who had transitioned to the community, including Individual #130 and Individual #251;</li>
<li>Sample P.3 - four individuals newly admitted to ABSSLC, including Individual #121, Individual #125, Individual #107, and Individual #96; and</li>
<li>Sample P.4 - six individuals, who were receiving direct PT services, including Individual #199, Individual #480, Individual #75, Individual #145, Individual #481, and Individual #513.</li>
</ul>
<u>The Facility provides an adequate number of physical and occupational therapists, mobility specialists, or other professionals with specialized training or experience.</u><br>
According to the current census, 443 individuals were living at ABSSLC. The Facility had six budgeted positions for OT. Three contracted OTs provided an average of 33.75 hours per week, but no full-time OTs were employed. ABSSLC had four budgeted positions for Physical Therapy, and three of these positions were filled.<br><br>
Since the last compliance review, an OT was promoted to the Director of Rehabilitation Services. The Director of Rehabilitative Services, in addition to her administrative responsibilities, was functioning as a PNMT member, and based on documentation provided, her current caseload was the entire census of ABSSLC. Facility Administration, in collaboration with the Director of Rehabilitative Services, reported during the onsite review that a request had been submitted for approval for hiring an OT whose salary request exceeded the state salary range.<br><br>
The following chart represented the current OT's and PT's caseloads:
<table>
<tr><th>Occupational Therapist(s) (OT)</th><th>Current Caseloads and Responsibilities</th></tr>
<tr><td>Contract OT #1</td><td>No caseload assigned</td></tr>
<tr><td>Contract OT #2</td><td>No caseload assigned</td></tr>
<tr><td>Contract OT #3</td><td>No caseload assigned</td></tr>
<tr><td>Six OT Positions</td><td>Vacant</td></tr>
<tr><th>Physical Therapist(s) (PT)</th><th>Current Caseloads and Responsibilities</th></tr>
<tr><td>PT #1</td><td>Lead PT, PNMT member, responsible for PNMT caseload (currently 22 individuals), and supported approximately 147 individuals</td></tr>
<tr><td>PT #2</td><td>PNMT member, responsible for PNMT caseload</td></tr>
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| | (currently 22 individuals), and supported approximately 148 individuals |
| PT #3 | Supported approximately 148 individuals |
| PT#4 | Vacant |

Staffing was potentially one factor that resulted in the inadequate provision of occupational and physical therapy supports to individuals. As is documented throughout this section of the report, individuals were not receiving needed supports. In sum, therapists were not active members of the PSTs, as evidenced by their inconsistent attendance at annual PSP meetings, insufficient provision of direct therapy, the absence of an evaluation update when a change in status occurred, insufficient development and integration of therapy recommendations into formal skill acquisition programs, and the absence of informal strategies to reinforce functional evaluation recommendations and direct therapy plans.

No continuing education documentation was submitted for OTs and PTs. As stated in the previous report, OTs and PTs, who were members of the Core PNMT, should attend State-sponsored webinars as well as document their involvement with State PNM consultants.

<u>All individuals have received an OT/PT screening. If newly admitted, this occurred within 30 days of admission.</u>
Since the last review, seven individuals were admitted to ABSSLC. Sample P.3 included four of these newly admitted individuals. Review of documentation showed that they received an OT/PT evaluation within 30 days of admission. However, these evaluations did not "consider health risk indicators in a clinically justified manner," which had serious potential implications for Individual #96. More specifically:

- Individual #96's OT/PT Evaluation, dated 3/10/11, stated: "[Individual #96] was admitted to AbSSLC… was seen at the [hospital], atypically for this evaluation." The evaluation did not identify her health risk indicators or assess safe ranges of elevation for daily activities. A HOBE evaluation should have been conducted during the evaluation to provide safe elevation ranges during her hospital stay, and the findings should have been integrated into her transition plan back to the Infirmary. On 4/4/11, almost a month after her initial OT/PT evaluation, the PT, SLP, RN and Respiratory Therapist (RT) conducted a HOBE evaluation. Documentation submitted confirmed a conflict between the recommended ranges of elevation derived from the HOBE evaluation and physician orders for elevation. The State Personal Support Plan Process policy stated: "the State Centers must ensure discrepancies in assessments are resolved." The PST should have conducted a PSPA to resolve this conflict.

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| | | <u>All people identified with therapy needs have received a comprehensive OT and PT evaluation within 30 days of identification.</u><br>The ABSSLC OT/PT Annual Evaluation template, dated 9/96, included the following sections with minimal instructional information:<br>▪ General information including active problems, fracture/surgical history, medications, health risk indicators, communication and behavioral considerations;<br>▪ Evaluations including range of motion, upper extremities/fine motor, lower extremities, foot evaluation, posture, abnormal reflexes, transfers/handling, mobility, gait analysis, review of falls, sensory motor functioning, activities of daily living, skin integrity/wound care, and wheelchair;<br>▪ Physical/Nutritional Management Plan, including PNMP focus, physical focus, nutritional focus, revisions, review, positioning, transfers, movement, and relaxation techniques;<br>▪ Nutritional management information, including Nutritional Management Team focus, recommended weight range, current weight, food/liquid texture, mealtime and positioning plans, and review;<br>▪ Assistive/supportive devices; and<br>▪ Recommendations.<br><br>The current OT/PT evaluation did not provide adequate information to support the person-centered planning process or plan for future community placement The OT/PT evaluation process should be critically reviewed to determine what modifications are needed to produce a functional evaluation. These processes should be formalized through Facility policy. The following describes weakness in the current evaluations and offers recommendations to correct these deficiencies:<br>▪ OT/PT evaluations did not provide a description of an individual's preferences, abilities and potentials. Hands-on collaborative evaluation (OT and PT) data should be sufficiently discrete to identity an individual's preferences, interests, current skills, and discovery of potentials for learning and skill acquisition. This should be accomplished through observation, staff interview, record review and clinical evaluation. It should lead to the development of functional outcomes that are meaningful for the individual in the context of everyday living at home, work and leisure activities. Functional outcomes should identify an integrated series of behaviors that allow an individual to achieve important everyday goals.<br>▪ OT/PT evaluations did not document evaluations occurring in multiple natural environments. An OT/PT functional evaluation should occur within an individual's natural environments, including observations of daily routines and activities within the home, activity centers, work sites, community outings, etc. | |

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| | | ▪ OT/PT evaluations did not discuss an individual's high and medium risk indicators and their potential impact on therapeutic interventions. The Health Risk Indicator(s) section instructions should be revised to reflect the current risk evaluation process, including the individual's risk ratings and therapies responsibility within Risk Action Plan(s), including efficacy of interventions.<br>▪ OT/PT evaluations did not provide an analysis of findings to provide justification for recommendations. Evaluation data should be analyzed to identify an individual's strengths, abilities, and potentials for learning and skill acquisition.<br>▪ OT/PT recommendations did not consistently support the attainment of a functional outcome. The analysis of evaluation findings should provide a rationale for functional outcomes and recommendations. The analysis should discuss possibilities for the development of formal programs and informal activities that would support the achievement of PSP action plan training objectives.<br>▪ OT/PT recommendations did not address an individual's preferences. Recommendations should be based on an individual's preferences and needs, and support learning within the home, work, and leisure environments, and in the community.<br>▪ OT/PT recommendations did not identify measurable criteria to enable the OT/PT and other team members to determine the efficacy of the recommendation.<br>▪ OT/PT recommendations were not integrated into PSP plans. This should occur not only through formal action plan training objectives, but informally through multiple informal activities to reinforce and generalize the learning of new skill(s) in multiple environments throughout the 24-hour day; and<br>▪ Documentation should be present to justify initiation, continuation, or discontinuation of direct and/or indirect therapy supports.<br><br>In addition, the Facility should:<br>▪ Determine how the evaluation process will be documented in Integrated Progress Notes;<br>▪ Develop and implement audit protocols to ensure OT/PT Evaluations follow established guidelines;<br>▪ Define in the evaluation policy the report timelines, format and guidelines to be followed; and<br>▪ Delineate a process for implementing changes in an individual's supports when progress is made or a lack of progress is noted. The lack of progress should identify a re-evaluation timeframe.<br><br><u>If receiving services, direct or indirect, the individual is provided a comprehensive OT</u> | |

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| | | and/or PT evaluation every three years, with annual interim updates or as indicated by a change in status.<br>Sample P.1 consisted of ten individuals who experienced a change in status. Two individuals who had transitioned to the community were included in Sample P.2. None of the 12 individuals in Sample P.1 or P.2 (0%) had an OT/PT evaluation and/or update that comprehensively assessed a change in status.<br><br>The following provides a summary of the Monitoring Team's concerns:<br>▪ Individuals who had transitioned to the community (Individual #130 and Individual #251) did not have annual OT/PT evaluation and/or an update to provide adequate information to community providers. For example:<br>o Annual OT/PT evaluations often had months prior to transition, and did not present a picture of the individuals' current status;<br>o Even when addendums were provided, they did not provide an adequate assessment or set of recommendations.<br>o Evaluations did not discuss or address risk factors, such as weight, choking risks, etc. At times, the only interventions included the provision of adaptive equipment, which did not comprehensively address the risk factors identified;<br>o The Activities of Daily Living (ADLs) sections of the assessment did not identify comprehensive lists of strengths, potentials and abilities to assist individuals to transition and experience success in their new homes.<br>o Recommendations related to skill acquisition programs were not justified.<br>▪ When individuals experienced other changes in status, such as a diet downgrade (e.g., Individual #512), choking incident (e.g., Individual #110), diagnosis of aspiration pneumonia (e.g., Individual #366, Individual #503, Individual #271, and Individual #317), fractures (e.g., Individual #467), weight gains for losses that placed them in obese or underweight categories (e.g., Individual #504, and Individual #493), and skin breakdown (e.g., Individual #26), the following issues were noted with regard to OT/PT evaluations and updates:<br>o Current OT evaluations and/or updates were not completed to discuss the need for changes, and/or justify the need for changes made;<br>o HOBE evaluations were not completed as indicated for individuals who experienced aspiration, nor were reviews of the continued appropriateness of individual PNMP strategies.<br>o Individuals with fractures did not have OT/PT evaluation updates to review the appropriateness of their PNMP, and to determine if prescribed strategies were sufficient to minimize the risk of fractures. | |

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| | | o Adequate strategies were not included for obese individuals or for individuals who were underweight;<br>o OT/PT evaluations and updated did not address integration with nursing/health management care plans;<br>o For individuals with skin breakdown, the evaluations and updates did not provide an aggressive approach to address skin breakdown, which places individuals at serious risk for infection and ongoing compromised health status. The OT/PT evaluations did not address a comprehensive evaluation of the reasons for the skin breakdown, leading to collaboration with nursing and medical staff to develop an integrated care plan with aggressive strategies to address skin breakdown.<br><br><u>Medical issues and health risk indicators are included in the evaluation process with appropriate analysis to establish rationale for recommendations/therapeutic interventions.</u><br>None of OT/PT Evaluations and/or Updates for the ten individuals in Sample P.1 (0%) addressed high and medium health risk indicators that had been assigned though the Integrated Risk Rating Form process. The discussion of individual-specific high and medium risk indicators should be an integral component of the functional evaluation process. The comprehensive analysis of evaluation findings should summarize the evaluation data and discuss expectations for change. The analysis should provide justification for recommendations to support wellness, and identify methods of measurement for progress through the achievement of functional outcomes.<br><br><u>Evidence of communication and/or collaboration is present in the OT/PT evaluations.</u><br>Based on review of the records of individuals in Sample P.1, 10 of the 10 OT/PT Evaluations (100%) included signatures of the OT and PT, as well as the date. However, four of these 10 individuals' OT/PT Evaluations were not current: Individual #504, dated 3/28/05; Individual #512, dated 5/29/01; Individual #110, dated of 7/7/03; and Individual #503, dated 10/24/05.<br><br>ABSSLC was not yet in compliance with this provision of the Settlement Agreement. The Facility should continue to recruit OTs and PTs, as well as develop and implement policies to define the OT/PT collaborative comprehensive functional evaluation process. | |
| P2 | Within 30 days of the integrated occupational and physical therapy evaluation the Facility shall develop, as part of the ISP, a plan to address the recommendations of the | Minimal progress had been made with regard to Section P.2 that requires the Facility to develop plans to address the recommendations in the integrated OT/PT Evaluations.<br><br><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> | Noncompliance |

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| | integrated occupational therapy and physical therapy evaluation and shall implement the plan within 30 days of the plan's creation, or sooner as required by the individual's health or safety. As indicated by the individual's needs, the plans shall include: individualized interventions aimed at minimizing regression and enhancing movement and mobility, range of motion, and independent movement; objective, measurable outcomes; positioning devices and/or other adaptive equipment; and, for individuals who have regressed, interventions to minimize further regression. | Per report, 46 of the 443 individuals (10%) were receiving direct PT services. No individuals were receiving direct OT services. Based on a review of ten individuals in Sample P.1, none of these individuals (0%) had a plan that had been developed based on OT/PT recommendations, and integrated into the PSP. The following concerns were noted:<br>• OT/PT evaluations identified individual abilities and potentials for skill acquisition, but no plans had been developed.<br>• OT/PT evaluations recommended training skill programs (e.g., hand cleansing), but no plans had been developed and/or integrated within the PSP.<br>• OT/PT evaluations acknowledged individuals were dependent on staff for activities of daily living, but no plans were developed to provide opportunities for skill acquisition and practice to support an individual's ability to increase independence in dressing, bathing, personal hygiene, grooming, etc.<br>• OT/PT evaluations were not current, and as a result, did not reflect an individual's current preferences and potentials for learning leading to the development of plans to support learning new skills.<br>• Individuals had been identified as significantly overweight, but no plans had been developed to address their overweight status to minimize health risk concerns.<br>• OT/PT recommendations mainly addressed the implementation of service and/or staff objectives, but did not present measurable, functional individual-specific recommendations that should be and performed within a specific timeframe. Plans should be implemented to promote active learning through a variety of experiences and practice within multiple environments. Repetition leads to success in learning and maintaining a new skill. Functional recommendations should lead to the development of formal plans and informal activities providing an individual with multiple opportunities for learning.<br><br>Based on review of six individuals in Sample P.4, who were selected from the submitted list of individuals receiving direct OT and/or PT services, none of the six formal PT plans (0%) were integrated into their PSPs through formal objectives, skill acquisition programs, and/or reinforced through informal activities recommended by the therapist.<br><br>Numerous issues were noted with regard to the evaluation process as it related to defining the therapeutic supports, as well as the provisions of therapeutic supports. These concerns included:<br>▪ Direct and indirect therapy interventions were not analyzed, during the evaluation and/or update process, or in clinical progress notes to determine if progress was being made, and/or if changes needed to be instituted.<br>▪ Justification for therapy interventions was not outlined in the analysis of | |

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| | | findings section of the evaluations to provide a rationale for functional outcomes and recommendations.<br>▪ Therapy plans were not integrated into PSP Action Plan objectives. The PSP should provide opportunities integrated throughout the day for an individual to practice newly learned skills. These activities should be woven through the individual's daily routine.<br>▪ Monthly and/or quarterly documentation was not consistently found to justify the initiation, continuation, and/or discontinuation of programs implemented.<br><br><u>Within 30 days of development of the plan, it is implemented.</u><br>Six of the six individuals within Sample P.4 (0%) who received direct PT had a PT Service Plan date and a subsequent effective date. It was not clear if the "date" signified the date of development or when the plan might have been revised.<br><br>Facility policy should define process that should occur across the 30 days post development of the plan, including, but not limited to ensuring the components of the direct therapy action plan identify and support outcomes that are functional and measurable, and integrating the plan(s) within the PSP, including the plans' outcomes and objectives, as well as, as appropriate formal skill acquisition programs and informal activities into the individual's daily routine.<br><br><u>Appropriate intervention plans are: integrated into the PSP, individualized, based on objective findings of the comprehensive evaluation with effective analysis to justify identified strategies, and contain objective, measurable and functional outcomes.</u><br>Based on documentation provided, none of the six individuals in Sample P.4 receiving direct and/or indirect PT services had their plans integrated into the PSP.<br><br><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><br>None of the records of the six individuals in the Sample P.4, who were identified as receiving formal therapy plans, presented documentation of monthly review by the PT to justify the continuation, revision and/or discontinuation of the formal PT plan.<br><br>ABSSLC was not yet in compliance with this provision of the Settlement Agreement. As discussed above, individuals had identified needs, but did not have plans developed to address their potentials. | |
| P3 | Commencing within six months of the Effective Date hereof and with full implementation within two | Minimal progress had been made with regard to Section P.3 that requires the Facility to provide staff with competency-based training on therapy plans and PNMPs. | Noncompliance |

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| | 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. | Staff implements recommendations identified by OT/PT.<br>Multiple examples are provided above with regard to Section O.4 of the Settlement Agreement with regard to staff not following prescribed PNMP strategies.<br><br>Staff successfully complete general and person-specific competency-based training related to the implementation of OT/PT recommendations.<br>Based on review of individual records, direct support professionals were identified as competent to implement comprehensive OT/PT interventions and supports as outlined in the PNMPs and direct therapy plans for none of 16 individuals (0%) in Samples P.1 and P.4.<br><br>ABSSLC had not yet achieved compliance with this provision. The Facility had not established policy and procedures for the development and implementation of competency-based training and performance check-offs for foundational skill training in physical and nutritional supports, individual-specific PNMP strategies, and strategies to reinforce skill acquisition related to direct therapy plans. | |
| P4 | Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall develop and implement a system to monitor and address: the status of individuals with identified occupational and physical therapy needs; the condition, availability, and effectiveness of physical supports and adaptive equipment; the treatment interventions that address the occupational therapy, physical therapy, and physical and nutritional management needs of each individual; and the implementation by direct care staff of these interventions. | Minimal progress had been made with regard to Section P.4 that requires the Facility to develop and implement a system to monitor and address the status of individuals with OT/PT needs, individual's adaptive/assistive equipment, the OT/PT and PNMP treatment interventions, and direct support professionals' implementation of the interventions.<br><br>System exists to routinely evaluate: fit; availability; function; condition and effectiveness of all adaptive equipment/assistive technology.<br>None of the 16 individuals from Sample P.1 and P.4 (0%) had a 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 concerns were noted:<br>▪ The PNMP Clinic documentation format did not identify medium and high risk indicators that might impact PNMP adaptive and mealtime equipment;<br>▪ No comprehensive list was maintained of individual-specific prescribed PNMP adaptive equipment, mealtime equipment and communication/hearing equipment;<br>▪ The PNMP Clinic format did not document appropriate therapist evaluation/review of prescribed equipment for fit, availability, function, condition, and effectiveness;<br>▪ The PNMP Clinic form did not have signatures for therapists in attendance;<br>▪ Recommendations did not, but should identify the responsible therapist, date of delivery, staff to receive competency-based training and performance check-off, identified staff to conduct training, how often the equipment will be monitored, | Noncompliance |

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| | | and staff to conduct monitoring.<br><br>The Facility did not have a policy to define the review system for prescribed PNMP equipment. This process might occur through multiple levels of review on a daily, monthly, quarterly, and annual basis to ensure an individual's prescribed equipment was available, functioning, continued to be appropriate, and was in good working condition. A therapist's evaluation would need to be completed to ensure the equipment continued to be effective.<br><br>A policy/protocol addresses the monitoring process and provides clear direction regarding its implementation and action steps to take should issues be noted.<br>Systemic issues related to monitoring are discussed above with regard to Section O.6 of the Settlement Agreement.<br><br>On a regular basis, all staff are monitored for their continued competence in implementing the OT/PT programs.<br>Systemic issues related to monitoring are discussed above with regard to Section O.6 of the Settlement Agreement. Multiple monitoring forms were submitted which documented staff non-compliance, but no formal analysis had been completed to address strategies to ameliorate staff non-compliance with individual-specific PNMPs and dining plans, and/or address resolution of systemic concerns.<br><br>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 Settlement Agreement).<br>Systemic and individual-specific issues related to training staff are discussed above with regard to Section O.5 of the Settlement Agreement.<br><br>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 Settlement Agreement).<br>Systemic and individual-specific issues related to monitoring are discussed above with regard to Section O.6 of the Settlement Agreement.<br><br>Safeguards are provided to ensure each individual has appropriate adaptive equipment and assistive technology supports immediately available.<br>As discussed above, adequate safeguards were not in place to ensure each individual had appropriate adaptive and assistive technology supports.<br><br>Person-specific monitoring is conducted that focuses on plan effectiveness and how the | |

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| | | plan addresses the identified needs (as discussed further with regard to Section O.5 of the Settlement Agreement).<br>As is discussed above with regard to Section O.5 of the Settlement Agreement, adequate training and monitoring of staff on individual-specific plans was not being completed.<br><br>Data collection method is validated by the program's author(s).<br>For none of the six individuals (0%) receiving direct PT services was the data collection method validated by the program's author.<br><br>ABSSLC had not yet achieved compliance with this provision. The Facility had not defined a system through policy and procedure to monitor the status of individuals with identified occupational and physical therapy needs; the condition, availability, and effectiveness of physical supports and adaptive equipment; the treatment interventions that address the occupational therapy, physical therapy, and physical and nutritional management needs of each individual; and the implementation by direct care staff of these interventions. | |

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

1. OTs and PTs, who were members of the Core PNMT, should attend State-sponsored webinars as well as document their involvement with State PNM consultants. (Section P.1)
2. The OT/PT Evaluation process should be critically reviewed to determine what modifications are needed to produce a functional evaluation. These processes should be formalized through Facility policy. This should include:
    a. Hands-on collaborative evaluation (OT and PT) data should be sufficiently discrete to identity an individual's preferences, interests, current skills, and discovery of potentials for learning and skill acquisition. This should be accomplished through observation, staff interview, record review and clinical evaluation. It should lead to the development of functional outcomes that are meaningful for the individual in the context of everyday living at home, work and leisure activities. Functional outcomes should identify an integrated series of behaviors that allow an individual to achieve important everyday goals.
    b. An OT/PT functional evaluation should occur within an individual's natural environments, including observations of daily routines and activities within the home, activity centers, work sites, community outings, etc.
    c. Health Risk Indicator(s) section instructions should be revised to reflect the current risk evaluation process, including the individual's risk ratings and therapies responsibility within Risk Action Plan(s), including efficacy of interventions.
    d. Evaluation data should be analyzed to identify an individual's strengths, abilities, and potentials for learning and skill acquisition;
    e. The analysis of evaluation findings should provide a rationale for functional outcomes and recommendations. The analysis should discuss possibilities for the development of formal programs and informal activities that would support the achievement of PSP action plan training objectives.
    f. Recommendations should be based on an individual's preferences and needs and support learning within the home, work, and leisure environments, and in the community.
    g. Recommendations should include criteria that would enable the team to assess and monitor implementation to ensure efficacy of formal program(s).

h. Recommendations should be integrated into an individual's PSP not only through formal action plan training objectives, but informally through multiple informal activities to reinforce and generalize the learning of new skill(s) in multiple environments throughout the 24-hour day; and
i. Documentation should be present to justify initiation, continuation, or discontinuation of direct and/or indirect therapy supports. (Section P.1)

3. In addition, the Facility should:
    a. Determine how the evaluation process will be documented in Integrated Progress Notes;
    b. Develop and implement audit protocols to ensure OT/PT Evaluations follow established guidelines;
    c. Define in the evaluation policy the report timelines, format and guidelines to be followed; and
        a. Delineate a process for implementing changes in an individual's supports when progress is made or a lack of progress is noted. The lack of progress should identify a re-evaluation timeframe. (Section P.1)
4. With regard to the provision of direct and indirect therapy services:
    a. Direct and indirect therapy interventions should be analyzed, during the evaluation and/or update process, as well as in clinical progress notes to determine if progress is being made and/or if changes need to be instituted;
    b. Justification for therapy interventions should be outlined in the analysis of findings section to provide a rationale for functional recommendations, measurable outcomes, and intervention strategies;
    c. As appropriate, therapy plans should be integrated through skill acquisition programs, and reinforced through the use of informal therapy supports throughout the 24-hour day. These supports should be defined in an individual's PSP;
    d. Monthly documentation should justify the initiation, continuation or discontinuation of evaluation recommendations, and reflect the status of measurable outcomes;
    e. Quarterly documentation should be provided for the provision of indirect supports; and
    f. There should be a formal process for implementing changes in an individual's supports, when progress is made and/or a lack of progress is noted, including a timeframe for re-evaluation. (Section P.2)
5. Facility policy should define process that should occur across the 30 days post development of the plan, including, but not limited to ensuring the components of the direct therapy action plan identify and support outcomes that are functional and measurable, and integrating the plan(s) within the PSP, including the plans' outcomes and objectives, as well as, as appropriate formal skill acquisition programs and informal activities into the individual's daily routine. (Section P.2)
6. The Facility should establish a policy and procedures for the development and implementation of competency-based training and performance check-offs for foundational skill training in physical and nutritional supports, individual-specific PNMP strategies, and strategies to reinforce skill acquisition related to direct therapy plans. The implementation of competency-based training and performance check-offs should receive be a priority, with individuals identified at high risk for choking, aspiration, respiratory concerns, falls, fractures, and skin integrity being highest priority. (Section P.3)
7. The Facility should develop a policy and/or procedures for the PNMP Clinic process and form to ensure individuals' adaptive/assistive equipment is reviewed for fit, availability, function, condition, and effectiveness. (Section P.4)
8. The Director of Rehabilitative Services, in collaboration with lead therapists and the respective PCM for Habilitation Therapy Department, should include the results of compliance audits in the POI and provide data to substantiate findings related to compliance. There should be a focus on the development of adequate instructions and criteria for the audit tools, and procedures should be implemented to ensure inter-rater reliability. The Facility should ensure that staff responsible for conducting record audits are provided with necessary training. (Facility Self-Assessment and Section P.4)
9. Analyses of audit results should track and trend problematic concerns and document actions taken to address problem areas. (Facility Self-Assessment and Section P.4)

| SECTION Q: Dental Services | |
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| | **Steps Taken to Assess Compliance:** The following activities occurred to assess compliance:<br>▪ **Review of Following Documents**:<br>o Dental Policy and Procedures, dated 6/9/11;<br>o List of new admissions in prior six months with date of admission assessment: admission-tracking worksheet January to July 2011;<br>o Clinical summary data non-annual exams, from 1/1/11 through 6/30/11;<br>o List of individuals who have refused dental services in past six months: absence-tracking list by date;<br>o List of individuals who have missed an appointment (other than refusals) in the past six months, the date of missed appointment, reason for the missed appointment, and the date of the completed make-up appointment, dated 7/7/11;<br>o List of individuals who in the past six months have had a tooth/teeth extraction: clinical summary data extractions, dated 7/20/11;<br>o List of individuals who within the past six months have been seen for dental emergencies;<br>o List of individuals who within the past six months have had preventive dental care: Clinical summary data preventive January to June 2011, dated 7/18/11;<br>o List of individuals who within the past six months have had restorative dental care: Clinical summary data restorative January to June 2011, dated 7/18/11;<br>o List of individuals who within the past six months were due for annual exams, whether they have had exams, and whether the dentist was able to complete those exams: completed annual exam report, dated 7/19/11;<br>o Most recent comprehensive exams for one individual from each residence (copy of dental office record and copy from active record for same visit): Individual #178 on 7/11/11, Individual #424 on 3/14/11, Individual #305 on 5/12/11, Individual #151 on 7/7/11, Individual #480 on 6/16/11, Individual #4 on 4/6/11, Individual #506 on 11/24/10, Individual #228 on 5/4/11, Individual #13 on 5/12/11, Individual #81 on 10/26/10, Individual #481 on 4/11/11, Individual #48 on 4/5/11, Individual #526 on 2/14/11, Individual #212 on 1/12/11, Individual #286 on 12/30/10, Individual #330 on 6/13/11, Individual #268 on 12/2/10, Individual #285 on 1/5/11, Individual #149 on 5/13/11, Individual #547 on 4/6/11, Individual #273 on 9/29/10, Individual #284 on 10/6/10, and Individual #177 on 6/8/11;<br>o Copy of any oral surgery consults and progress notes in the past six months for the following: Individual #20, Individual #163, Individual #105, Individual #32, Individual #81, Individual #505, Individual #425, Individual #313, Individual #523, and Individual #98, Individual #510;<br>o List of abbreviations used in all dental records/reports;<br>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: medical services monitoring tool: dental services, revised 8/2/10;<br>o Attendance tracking sheet for dental appointments for the past six months: Absence |

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| | tracking 2011 by month, dated 7/7/11;<br>o List of refusals for the past six months per date of refusal (list reason for appointment): Absence Tracking 2011 by month –refusals, dated 7/7/11;<br>o List of those who have not seen dentist in one year and reason: annual exam report, 2010, 2011 dated 7/7/11;<br>o List of those who have outstanding need for dental x-rays, according to current professional standards, and type of x-ray that is needed to fulfill required recommendation;<br>o List of those who were edentulous at time of last visit, and those who have become edentulous since that time: Chart: residents recently without teeth, dated 7/15/11, Chart: residents without teeth dated 7/15/11;<br>o List of other reasons for missed appointments per date for past six months (include reason for appointment): Table: Absence Tracking by month non-refusal January to June 2011, dated 7/15/11;<br>o List of no shows/missed appointment per building per month for last six months: tables of missed appointments 2011 per month per residence January to June 2011 with memo to QDDP concerning missed appointments per individual;<br>o List of refusals per building per month for the last six months: Absence tracking 2011 by residence by month, dated 7/19/11;<br>o List of interventions per individual for missed appointments (follow-up appointment scheduled, whether follow up completed, etc.): missed appointment list with interventions for residences #6350, #6710 January to June 2011;<br>o QMRP, IDT minutes that review, assess, develop and implement strategies for dental visit refusals and no shows last six months: PSP addendums for following individuals: Individual #440, dated 6/21/11; Individual #26, dated 6/24/11; Individual #375, dated 6/21/11; Individual #422, dated 6/24/11; Individual #479, dated 6/21/11; Individual #303, dated 6/21/11; Individual #505, dated 6/21/11; Individual #286, dated 6/21/11; Individual #425, dated 6/21/11; Individual #495, dated 6/24/11; Individual #469, dated 6/21/11; and Individual #527, dated 6/24/11;<br>o For five most recent emergency exams, integrated progress notes from start of emergency to closure, and copy of Dental Department evaluation and treatment for following individuals: Individual #437, Individual #169, Individual #397, Individual #238, and Individual #504;<br>o Appointment schedule for those undergoing general anesthesia/conscious sedation;<br>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, consult reports, pre-operative checklist or evaluation, and post-operative checklist, or monitoring forms, etc. for following individuals with date of operative procedure: Individual #451, dated 12/7/10; Individual #32, dated 3/25/11; Individual #505, dated 1/21/11; Individual #168, dated 1/21/11; Individual #144, dated 5/20/11; and Individual #51, dated 3/25/11;<br>o For the past six months, copies of any correspondence concerning restraint and sedation |

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| | use for office visit (to QMRP, team, psychologist, etc.);<br>o Dental records for following: Individual #163, Individual #480, Individual #184, Individual #105, Individual #26, Individual #228, Individual #509, Individual #283, Individual #286, Individual #42, Individual #226, Individual #149, Individual #273, Individual #204, Individual #169, Individual #98, Individual #383, Individual #136, Individual #133, Individual #326, Individual #409, Individual #193, Individual #357;<br>o Most recent ten dental pre-treatment sedation assessments: Individual #178, dated 6/28/11; Individual #242, dated 6/10/11; Individual #276, dated 6/8/11; Individual #505, dated 6/2/11; Individual #168, dated 6/9/11; Individual #495, dated 3/30/11; Individual #486, dated 6/22/11; Individual #469, dated 6/10/11; and Individual #527, dated 6/7/11;<br>o For 10 individuals given dental pre-treatment sedation, copies of progress notes from record and dental office from start of sedation in residence to release from monitoring: Individual #178, dated 1/28/11 and 6/28/11; Individual #440, dated 3/16/11; Individual #321, dated 2/8/11; Individual #455, dated 1/11/11; Individual #198, dated 2/23/11; Individual #486, dated 6/22/11; Individual #189, dated 3/3/11; Individual #469, dated 6/10/11; Individual #527, dated 6/7/11; and Individual #69, dated 2/24/11;<br>o Current list of HRC Approved dental Medical Restraint with Sedation;<br>o Copy of any restraint and sedation tracking list/system used by the Dental Department: restraint and sedation all data (including type, reason, drug, effectiveness, procedure) 2011;<br>o In last six months, per month, percentage of individuals utilizing general anesthesia/IV sedation for dental exam and treatment;<br>o In last six months, per month, percentage of individuals utilizing oral sedation for dental visits;<br>o In last six months, per month, percentage of individuals utilizing mechanical restraints for dental visits;<br>o Copy of dental extraction records in past six months for following individuals: Individual #20, Individual #105, Individual #32, Individual #81, Individual #505, Individual #425, Individual #313, Individual #523, Individual #98, and Individual #510;<br>o For those completing annual exams in the past six months: oral hygiene rating in each exam listed per individual and date of exam;<br>o Quarterly oral hygiene ratings;<br>o List of those who receive suction tooth brushing treatment;<br>o Copy of annual dental assessments completed in last 30 days and for the prior year for these same individuals: Scheduling annual exam and recall date range table, dated 7/15/11;<br>o List of annual assessments completed in last six months, and the date of previous annual assessment;<br>o Most recent annual dental summary provided for the PSP for the following individuals: Individual #178, dated 7/11/11; Individual #151, dated 7/7/11; Individual #6, dated 7/12/11; Individual #371, dated 7/7/11; Individual #237, dated 7/7/11; Individual #434, |

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| | dated 7/7/11; Individual #410, dated 7/8/11; Individual #56, dated 7/7/11; Individual #312, dated 7/12/11; Individual #468, dated 7/12/11;<br>o The most recent/current Facility oral hygiene data (percent good, fair, poor rating);<br>o Dental Department PowerPoint presentation entitled: "What is aspiration?"; and<br>o Presentation Book for Section Q.<br>▪ **Interviews with**:<br>o Jerry Griffin, DDS, Staff Dentist. |
| | **Facility Self-Assessment:** The Facility determined it remained out of compliance with both subsections of Section Q. This was consistent with the findings of the Monitoring Team.<br><br>The Facility provided a substantial amount of helpful narrative information in the POI to describe efforts it made to move towards compliance with the provisions of this section. Some data was included to substantiate progress made. For example, the Facility was completing monitoring using a new oral hygiene monitoring tool. Although it did not address all of the components of Section Q of the Settlement Agreement, it identified whether or not residences were properly equipped to address the oral hygiene needs of the individuals who lived there (e.g., toothpaste and tooth brushes present, cleanliness of supplies, etc.). In addition, references were made to tracking systems (e.g., tracking of dental exams and dental procedures, numbers of individuals with oral hygiene programs, etc.). However, specific data for specific timeframes were not provided to substantiate the Facility's compliance findings. In addition to developing and implementing more comprehensive monitoring tools to review for example, the quality of dental supports provided, the Facility should include existing data in its POI in the future to substantiate its findings (e.g., timeliness of assessments, emergency care, etc.).<br><br>Action plans had been developed to address the development of desensitization plans, and improve the timeliness with which consents were obtained for dental work. These were important priorities. |
| | **Summary of Monitor's Assessment:** The Dental Department has progressed in both subsections of Section Q, but remained out of compliance. Much creativity had been used in the development of a mock office to be used for desensitization plans. Review and improvement of the environments in the residences to increase cooperation with oral hygiene, as well as researching better tasting toothpastes also had increased compliance with tooth brushing. The oral hygiene rating scores indicated less "good" as well as less "poor" ratings, and more "fair" ratings. With the drop in the "good" rating, the Dental Department should explore the potential reasons, and develop a strategy to improve the oral hygiene index scores across the campus.<br><br>Missed appointments and refusals were tracked through a detailed database. Some of the reasons for missed appointments were correctable, and if addressed, would potentially improve attendance. The missed appointment rate for general anesthesia appointments remained problematic.<br><br>Closure was noted for individuals seen in the dental office for dental problems. |

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| | Better tracking of pain or lack of pain, and pain management, as well as monitoring of vital signs before and after a dental procedure were areas requiring better documentation.<br><br>Desensitization programs now had some success stories in the Dental Department. However, the number of participants (18) involved in this programming was small compared to the need at ABSSLC. |

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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. | The Dental Department included two staff dentists, two dental assistants, two dental hygienists, and a dental clerk.<br><br><u>Annual Assessments</u><br>There were ten individuals newly admitted to ABSSLC during the time period between 12/30/10 and 6/16/11. Of these 10 (100%) had completed a comprehensive dental evaluation within 30 days of admission. Of these, eight of the comprehensive exams were completed within the first 14 days.<br><br>All individuals were examined in the prior year (i.e., all individuals saw a dentist in the past calendar year). Additionally, according to the Dental Department, for the period 1/1/11 through 6/30/11, all residents seen during that time had required/ recommended x-rays according to current professional standards.<br><br>A list of all those that had completed an annual exam was submitted for the years 2010 and 2011. According to the POI, timeliness was interpreted as completion of the annual within the anniversary month of admission or the last annual exam. Based on this, compliance was 229 out of 230 individuals (representing the individuals for whom annuals had been completed in the prior six months). However, based on an updated guideline similar to the Medical Department that the annual exam should be completed within 365 days of the prior annual, compliance was 130 out of 230 (57%).<br><br>Separately, copies of the annual dental assessments that had been completed in the most recent 30-day period, as well as copies of the prior annual dental assessment were submitted. Compliance with completion of the dental annual exam within 365 days of the prior annual dental examination, compliance was 25 out of 52 (48%).<br><br>One individual became edentulous since the Monitoring Team's last visit. A list of those who were edentulous totaled 168 individuals. This was 38% of the population residing at ABSSLC. That only one individual became edentulous in the prior six months suggested a decline in new cases with this condition. The dental peer review should determine an average percentage across the state and determine a future goal for edentulousness. With more attention to dental hygiene, as well as access to conscious | Noncompliance |

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| | | sedation/general anesthesia and restorative care, individuals new admitted should have an increased opportunity to preserve the teeth that remain.<br><br><u>Oral Hygiene</u><br>Data was submitted addressing the oral hygiene levels at ABSSLC. In 2010, for which a full year of data was available, 67% of the individuals were rated as having good oral hygiene, 19% as fair, and 14% as poor. In 2011, for which six months of data was reviewed, 64% had good oral hygiene, 26% had fair, and 10% had poor. The percentage in the "good" oral hygiene category did not improve, but declined slightly. The category of "fair" increased, and the category of "poor" oral hygiene decreased.<br><br>Separately, data was submitted, compiling the oral hygiene rating from each annual exam completed in the six months prior to the Monitoring Team's visit. Data was submitted from January 2011 through June 2011. A total of 194 individuals had completed annual dental exams and had oral hygiene scores available. Of these, 71% had good, 25% had fair, and 4% had poor hygiene. This data was considerably improved from the prior information presented, and the reason for the discrepancy was not available. To ensure the accuracy of oral hygiene ratings across facilities, dental peer review should consider this an area of importance. It should set a number or percentage of individuals for a dentist from another facility to examine for oral hygiene scores. Based on this data, the dental hygienists then could compare their scores for inter rater reliability and validity of the score.<br><br>The Dental Department continued to make progress in the area of oral hygiene. An innovative program included transforming the appearance of the oral hygiene areas in the residences. From data submitted from a 6/1/11 review, it was found that 100% of vacuum brushing units were functional, clean, and stored properly; 75% of the toothbrushes were clean and in place; 90% of the tubes of toothpaste were not labeled with identification; 80% of the boxes were clean and labeled correctly; and 85% of the caps for toothbrushes were missing. This had led to improved interest in the residences, and improved compliance, as the tooth brushing equipment had become more accessible to the individuals and better organized. Out of the 23 residences, 16 residences met the goal for storage, condition, availability, and labeling of toothbrushes and toothpaste. The other seven residences were not compliant due to limitations of space. The Dental Director discussed potential options in resolving this concern in these seven residences, but it remained unclear how this would be accomplished. The Dental Department is encouraged to meet with Facility Administration in resolving the environmental barriers in providing an appropriate system for toothbrush storage and availability in these seven residences. However, in the 16 residences, this appeared to have improved focus and interest in completing tooth brushing and implementing tooth brushing skills. | |

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| | | To also improve compliance, the Dental Department had researched and made available some choices in flavors for toothpaste that were more appealing to the individuals, and which also had contributed to increased compliance with tooth brushing.<br><br>Additionally, the Dental Department would soon start training individuals using the Murdock system, which broke down oral hygiene skills into individual steps. Reportedly, this would then be personalized to each individual.<br><br>As part of direct support professional in-service training, the Dental Department members participated in a PowerPoint presentation entitled: "what is aspiration." This presentation was developed in collaboration with the Occupational/Physical Therapy Director. Emphasis was placed on correct oral hygiene techniques and positioning.<br><br>A number of individuals were considered unsafe for routine tooth brushing. These individuals were identified as at risk for aspiration, had a history of aspiration, or had silent aspiration. Other criteria used in determining if an individual was at risk for aspirating while tooth brushing included individuals that could not manage thin liquids safely, individuals that were unable to spit, and individuals that could not use the toothbrush independently. From these criteria, 158 individuals were identified that had orders for suction tooth brushing.<br><br><u>Preventive, Restorative, Emergency Dental Services</u><br>At the time of the review, all dental cleanings were completed in the dental office.<br><br>The Dental Department implemented an improved tracking system for consents, annual dental exams, and all dental procedures. Information was updated in the computer database within 24 hours. Consents were often obtained in both verbal and written format. As the consent was mailed, the family/guardian was called, and the consent also was obtained verbally, with the additional instructions to complete and return the signed copy.<br><br>The dentists wrote closure notes, and reflected the findings of a follow-up visit or follow-up information.<br><br>The Dental Department offered a wide variety of dental services. For the first six months of 2011, 1107 appointments and dental procedures were completed. This was in addition to the 443 admission and annual dental exams completed.<br><br>A list of individuals completing preventive dental care was submitted. The list totaled 778 appointments for the time period from January 2011 through June 2011. Prophylaxis was accomplished during several types of visits that were listed (annual, | |

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| | | recall, special request, admission, and discharge). It was noted that recall visits for prophylaxis had a varied schedule, depending on the oral health needs of the individual. Routine recall visits were generally made at a frequency of two weeks to six months.<br><br>The Dental Department continued to provide restorative dentistry. From January 2011 through June 2011, 59 individuals underwent dental restoration.<br><br>A list of extractions completed was submitted. It is recommended that a second opinion be obtained for extractions. These are currently obtained for those undergoing oral surgery off campus, but might not be completed when done in the dental office.<br><br>Information on restraint usage during dental procedures was submitted. The following summarizes this information:<br>▪ From January 2011 through June 2011, only one mechanical restraint was used during a dental procedure, and that was in January. No mechanical restraint use was recorded from February 2011 through June 2011.<br>▪ A list of those receiving oral sedation also was submitted. From January 2011 through June 2011, 21 individuals received oral sedation (the title of the record indicated oral sedation restraint and the actual table heading listed mechanical). If this was accurate, 21 individuals received oral sedation out of 1119 dental appointments. This was an oral sedation usage rate of approximately 2%. There was variation between this data, and data included in another record in which all chemical restraint use was listed for dental appointments. The number documented from January 2011 through June 2011 was 26 chemical restraints in this second record.<br>▪ Another record was submitted in which the heading indicated oral sedation restraint use by month, but the actual record heading indicated general anesthesia. If that is the correct interpretation of the table, 30 individuals received general anesthesia from January 2011 through June 2011. However, a separate data submission indicated 34 individuals received general anesthesia during this time.<br>▪ Additionally, from January 1, 2011 through June 2011, seven physical restraints were recorded during dental appointments.<br><br>The Dental Department submitted 10 records for individuals that had been given pre-treatment sedation. The following summarizes the review of these records:<br>▪ In all ten records (100%), documentation was present to show monitoring of pulse, and either pulse oximetry or blood pressure, or both. For one individual, Individual #455, the pulse was typographically written in error.<br>▪ Additionally, all (100%) had a post-operative IPN completed. The IPN was a typed form with boxes checked for completion and clarity. It provided thorough | |

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| | | information to the residential staff.<br>▪ For nine out of the 10 (90%), start and stop times were recorded. For Individual #455, no start and stop time was noted for the procedure.<br>▪ For one individual, Individual #178, the date of the anesthesia and clinical record (1/28/11) did not match the progress record submitted (6/28/11).<br><br>Separately, nine records were submitted with information concerning intraoperative monitoring during dental procedures for those that received oral sedation prior to the appointment. The following summarizes the results of this review:<br>▪ Eight out of nine (89%) had a copy of the monitor strip recording pulse, blood pressure, and or pulse oximetry. For one individual, there was no recording on the monitor strip due to movement. However, there was an oxygen saturation and respiratory rate recorded on the anesthesia and clinical record, suggesting a manual measurement. Additionally, one of the monitor strips had a date not consistent with the appointment date listed on the anesthesia and clinical record form (Individual #242).<br><br>For those requiring general anesthesia/conscious sedation, ABSSLC contracted with a dental anesthesiologist to assist in providing general anesthesia. Over a seven-month time period from January 2011 through July 2011, 44 appointments were scheduled for general anesthesia/conscious sedation. Of these, 10 were cancelled for many different reasons, a cancellation rate of 23%. The Dental Department should consider reviewing the reasons for cancellations to determine if any innovative systems processes could be implemented to reduce this cancellation rate.<br><br>Documents were submitted for six individuals that had undergone general anesthesia/conscious sedation to determine quality of care and quality of documentation. The following summarizes this review:<br>▪ In six records reviewed (100%), consent was completed, the intraoperative record was completed, a dictated operative record was completed, a recovery room record was completed, a dental note was written in the record the day of the procedure, a post procedure note was written, and an Infirmary stay note was written.<br>▪ Anesthesia provided a written preoperative evaluation in three (50%).<br>▪ Four (67%) were prescribed pain medication. It was not clear if the remaining two individuals had pain or were pain free. It is recommended for those situations in which pain medication would be prescribed, but the individual was without pain, that a note indicating there was no discomfort be written.<br><br>Documents were submitted for those individuals completing oral surgery in the prior six months, including integrated progress notes. Eleven records were reviewed. Five of | |

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| | | these individuals had general anesthesia, and vital sign monitoring was not submitted, as it was located in other documents than those requested. For one individual, only a minor procedure was needed in removing a loose tooth. For the other five individuals, six teeth were extracted which required six office visits. For one individual, Individual #98 during office visit on 3/29/11, no post procedure set of vital signs was recorded. For the other five tooth extractions (83%), pre and post procedure vital signs were recorded.<br><br>The Dental Department separately submitted a list indicating that 28 individuals completed 31 appointments for dental extractions. The number of extractions varied from one tooth extracted at a visit to one full mouth extraction of 26 teeth (i.e., for an individual who had bruxism, and had ground his teeth down and exposed pulp, which could have resulted in abscess formation. A second opinion confirmed the teeth were not restorable). At 17 appointments, individuals had one tooth extracted. At nine appointments, two teeth were extracted. There were two appointments in which four teeth were extracted.<br><br>Separately, 10 records were submitted for individuals that had undergone dental extractions. Three of these required general anesthesia and oral surgery consultation. Two of these were completed at the regional hospital. For the other six individuals, all had one tooth extracted per dental appointment. One of the six individuals had two appointments, in which one extraction was done at each appointment. For these six individuals, seven teeth were extracted.<br>▪ All seven (100%) dental appointments had a set of pre-procedure vital signs recorded.<br>▪ Six (87%) had a post-procedure set of vital signs recorded.<br>▪ Six (87%) had a follow up IPN note.<br>▪ All seven (100%) had documentation of pain management post-operatively.<br><br>A submitted list indicated there were 54 emergency dental visits from January 1, 2011 through June 30, 2011. Documents were submitted for five individuals that completed an emergency dental visit. These occurred between 4/15/11 and 6/30/11. When there were acute dental concerns, the individual was seen in the dental office the same day or the next day. Of these five, two had behaviors that were the reason for the visit. One had a broken tooth, and one had occlusal decay. One had a medical reason other than dental disease identified (sinusitis). There was documentation of comfort and pain medication for two individuals. A third had documentation of no pain. One had oral hygiene concerns and was provided instructions. The other was referred back to the residence, as there were no dental findings. In summary, all five (100%) had quick response for requests for dental examination, all (100%) had documentation of exam, all (100%) had an x-ray completed, and all 100%) had pain management, when indicated. | |

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| | | Separately, 23 dental records were reviewed, one from each residence. Focus was on dental care and documentation from January 1, 2011 to July 2011. The following summarizes this review:<br>▪ Of these, 23 (100%) had at least one prophylactic treatment. Some had as many as eight prophylactic visits.<br>▪ All (100%) had annual dental examinations completed during the prior year. However, there was no form 8509 for Individual #286 or Individual #409 (the annual exam was documented, but the form was not completed or not submitted). It was documented as completed for Individual #286 at the time of the annual assessment on 12/30/10, but it was not submitted. For Individual #409, it was hand written in the IPN on 9/3/10.<br>▪ All (100%) had x-rays completed during the prior year.<br><br>The Dental Department had made great progress in many areas. They were up-to-date on dental x-rays and examinations. However, annual exams needed to be completed within 365 days of the prior one. In addition, efforts were needed to sustain good and fair oral hygiene ratings across the campus, second opinions should be sought for extractions, improvements were needed with regard to pre and post op vital sign monitoring, and efforts should be made to improve attendance rate at general anesthesia appointments. Emergencies also should be tracked for timeliness from initial complaint to time they the dentist saw them, and the problems resolved. | |
| Q2 | Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement policies and procedures that require: comprehensive, timely provision of assessments and dental services; provision to the IDT of current dental records sufficient to inform the IDT of the specific condition of the resident's teeth and necessary dental supports and interventions; use of interventions, such as desensitization programs, to minimize use of sedating medications and restraints; interdisciplinary teams to review, | This section of the report includes a number of sub-sections that address the various requirements of this provision of the Settlement Agreement. These include the development of dental policies and procedures, provision of dental records to PSTs, refusals and missed appointments, tracking of use of sedating medications and restraints, and interventions to minimize the use of sedating medications.<br><br><u>Provision of Dental Records to PSTs</u><br>For one individual from each residence, the Dental Department submitted a copy of the most recent comprehensive annual exam and IPN that was available in the dental office. Also submitted was a copy of the information that was available in the residence's record. Dental records for 23 individuals were provided, representing 23 residences. All records had identical information in the residence record and the dental office record. The Form 8509 was missing from both the dental office and active record for one record. For 22 out of the (96%), this indicated that the PSTs had full access to the dental records.<br><br>For each annual PSP, a copy of the annual Dental Examination record was provided. Included in the record were missing and unerupted teeth, extra oral exam, oral exam, radiographs ordered, whether periodontal disease or dental caries existed, degree of | Noncompliance |

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| | 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. | gingivitis and periodontitis, oral hygiene level, degree of cooperation/behaviors, and oral hygiene instruction. It is recommended that brief recommendations/comments be noted on this record concerning any outstanding needs, as well as ongoing needs for transition to the community. Additionally, if the individual requires sedation, or would benefit from improved cooperation, recommendations for a desensitization program, or consideration of medication choices and dosage for sedation depending on prior effectiveness, would guide the team's discussion and conclusions. For instance, Individual #6 was listed as being very uncooperative, but no information was provided about whether he was sedated in the past or if a desensitization program was being implemented, or whether the dental office would recommend continuation or development of such a program. If no sedation had been used, that would be important information to record.<br><br><u>Refusals/Missed Appointments</u><br>For the time period from 1/1/11 through 6/30/11, 67 refusals were documented. Of these, 62 had a subsequent appointment that was kept. The main reasons for the refusals were recorded as "refusal to leave the home," and "behavioral concerns." The reason for the visit that was missed also was tracked. For 37 out of 67 refusals, the appointment was for dental prophylaxis and topical fluoride. Eight appointments were for annual dental examinations. Four appointments were for chlorhexidine gluconate dental rinse.<br><br>Each month a letter was sent out to each of the QDDPs/case managers, listing those individuals on their respective caseloads that had missed appointments for the prior month. The request was to contact the Dental Department to set up a PST meeting to discuss the pattern of refusals. A sample of PSP addendums was submitted as examples of PST discussion and recommendations. Action steps listed included a recommendation for a desensitization plan, staff discussing good dental care (hygiene and prevention) with the individual, determining favorite staff to accompany the individual, offering a reinforcer, changing the time of day the appointment was offered, and using verbal prompts.<br><br>Progress in tracking refusals to attend Dental Department appointments also had advanced. The Dental Department had found that calling the residence three to four times in the days before the appointment, as well as on the day of the appointment was instrumental in compliance. The Dental Department had documented a decrease in refusal rates. However, this was because accuracy of the reason for the missed appointment had improved. Staff in the residence could no longer simply state a missed appointment was due to refusal, so the correct reason was beginning to be identified. These other reasons had often been much easier to resolve than an individual with | |

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| | | repeated refusal patterns.<br><br>Appointment refusals also were tracked per month. For January 2011, there were 12 refusals; in February 2011, eight refusals; in March 2011, nine refusals; in April 2011, 10 refusals; in May 2011, five refusals, and in June 2011, 10 refusals. During this six-month time period, no trend was noted of decreased refusals. It was noted that 16 individuals were responsible for 34 of the refusals. This information would assist the Facility to identify a target group of individuals needing behavioral expertise, and potentially desensitization programs for some of these individuals.<br><br>The Dental Department submitted information for missed appointments from 1/1/11 through 6/30/11. Reasons were identified for each missed appointment. During this time period, 54 missed appointments (non-refusals) were documented. The reasons included the following: the individual was ill (14 missed appointments), the appointment was not scheduled on the residence's calendar (13 missed appointments), equipment needed repairing (two missed appointments), the Facility or the department cancelled the appointment (seven missed appointments), there were medical restrictions on the residence (seven missed appointments), the individual was on furlough or off campus (two missed appointments), schedule conflicts (five missed appointments), and a staff shortage (four missed appointments). This information provided areas that could be corrected through increased communication with the residences and the PSTs. Ultimately, this would lead to a reduction in numbers of missed appointments.<br><br>Missed appointments also were tracked per month. For January 2011, there were seven missed appointments; in February 2011, 18 missed appointments; in March 2011, five missed appointments; in April 2011, seven missed appointments; in May 2011, five missed appointments; and in June 2011, 12 missed appointments. During this six-month period, no consistent decrease was noted in missed appointments. The Dental Department now had a database that listed the reason for the missed appointment, the procedure that was to be completed during the appointment, and whether the appointment was subsequently rescheduled and completed. In 53 out of 54 missed appointments, a rescheduled appointment was completed. The only individual for whom a rescheduled appointment was not completed was due to a serious illness. The data collection had noticeably improved. In January and February 2011, several missed appointments had no reason listed, but from April onward, each missed appointment had a reason recorded.<br><br>The Dental Department submitted a list of interventions for those individuals that had missed appointments. The list did not include all those with missed appointments or refusals, but provided information describing action steps that were taken when missed | |

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| | | appointments occurred. These included rescheduling with general anesthesia, rescheduling with the residence, rescheduling with sedation, rescheduling with favorite staff, admitting to the Infirmary, rescheduling with staff explaining the procedure, and requesting a PSPA meeting. It was not clear the reason for the incomplete list (it did not include all 54 missed appointments or 67 refusals), and only two residences were represented (residence # 6350 and residence #6710).<br><br><u>Interventions to Minimize the Use of Sedating Medications</u><br>For desensitization, the dental office was in the process of creating a mock dental office. It was located in a separate building. At this point, partitions had been constructed to ensure privacy and to prevent access to equipment that another department used.<br><br>To date, 18 desensitization plans were created. The Dental Director's opinion was that significant improvement had been seen in four individuals' cooperation in the dental office, and some improvement for another three to four individuals. Cooperation had occurred with dental cleaning, and less use of mechanical and physical restraint was needed in the office. For restorative care, pre-treatment sedation was still required in these seven to eight cases.<br><br>Although desensitization has been implemented for 18 individuals, the dental office had no data to determine actual progress. It is recommended that periodic meetings be held with the Psychology Department to obtain this information and the analysis of the information. This information sharing would allow feedback to be shared with both departments to improve the individualized desensitization programs and provide the opportunity to further success.<br><br><u>Dental Policies and Procedures</u><br>The current department policies and procedures were reviewed and revised serially over the past six months, recorded as 2/2/11, 3/11/11, 4/11/11, 6/1/11, and 6/9/11. The policies appeared to be complete, and incorporated areas such as Dental Department attendance at the PSTs.<br><br>Compliance in this area will require additional focus on missed appointments that are preventable, as well expansion of the dental desensitization program. Progress had been made in both these areas. | |

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

1. The Dental Peer Committee should determine the average percentage of those individuals who are edentulous throughout the SSLC system, and identify an appropriate outcome measure with the goal of reducing the numbers of individuals who become edentulous. (Section Q.1)

2. The Dental Peer Committee should conduct external reviews to other SSLCs to provide independent oral hygiene scores to ensure inter-rater reliability and validity to the data. (Section Q.1)
3. The Dental Department is encouraged to meet with the Facility Administration in determining approaches to provide more space in some of the residences for dental hygiene storage and use. (Section Q.1)
4. Second opinions should be obtained for extractions with priority given to those with multiple extractions. (Section Q.1)
5. The dental office should review the cause of the relatively high cancellation rate for those scheduled for general anesthesia. (Section Q.1)
6. For postoperative dental procedures/emergencies, there should be documentation of pain and pain management, or documentation that there was no pain. (Section Q.1)
7. As recommended previously, a system should 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. (Section Q.1)
8. The Dental Department should track the time period from initial emergency complaint to resolution/treatment by the dentist. (Section Q.1)
9. As recommended previously, 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. (Section Q.1)
10. As recommended previously, 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. (Section Q.1)
11. The annual dental exam record should include a brief entry concerning outstanding needs, as well as requirements for adequate dental care in preparation for potential transition to the community. (Section Q.2)
12. The annual dental exam record should include a recommendation for desensitization if appropriate, or changes in sedation given prior to the appointment, if indicated depending on the effectiveness of prior sedation. (Section Q.2)

| SECTION R: Communication | |
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| 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:<br>▪ **Review of Following Documents**:<br>o Presentation Book for Section R;<br>o Presentation for Section R, dated August 22, 2011;<br>o The following documents: SLP Evaluation, SLP Communication Therapy Program, Supporting documentation for implementation of direct/indirect SLP communication program, therapy progress notes for communication program, PSP and PSPAs for past year, Behavior Support Plan, SLP consultations for the last year, competency-based training for communication device/program, individual-specific communication monitoring for the past two months, Communication Dictionary, person-specific monitoring for communication systems, and Daily Schedule for the following 16 individuals: Individual #387, Individual #92, Individual #455, Individual #160, Individual #83, Individual #409, Individual #464, Individual #235, Individual #435, Individual #485, Individual #533, Individual #383, Individual #242, Individual #425, Individual #390, and Individual #293;<br>o Speech Evaluation for new admissions for the following four individuals: Individual #121, Individual #125, Individual #107, and Individual #96;<br>o SLP Communication Services Policies, undated;<br>o Continuing education completed by SLPs since last visit, from 2/11 through 7/11;<br>o List of SLP and Audiology Staff, undated;<br>o List of Individuals with Alternative or Augmentative Communication (AAC) Devices, dated 7/11;<br>o Communication Master List, undated;<br>o AAC Evaluation and Speech-Language Assessment (templates), undated;<br>o Five samples of Speech-Language Evaluations, from 4/11 through 7/11;<br>o Tracking Log of Completed Assessments, from 3/11 through 7/11;<br>o Monitoring Tools for AAC and SLP programs (template), revised 12/10;<br>o Completed monitoring forms for AAC and Electronic Aids to Daily Living (EADL) equipment, dated 6/11;<br>o Communication Report Summary, revised 12/10;<br>o Analysis of Monitoring of Speech (AAC) Equipment, dated 7/27/11;<br>o AAC and EADL Equipment Spreadsheet and Monitoring List, dated 7/11;<br>o List of Individuals receiving Direct Speech Services and Focus of Intervention, from 9/10 through 5/11;<br>o List of Individuals with Behavioral Issues and coexisting severe Language Deficits, dated 6/11; and<br>o List of Individuals with PBSPs and Replacement Behaviors related to Communication, 6/11.<br>▪ **Interviews with**:<br>o Bobbie Holden, OT, Director of Rehabilitative Services; and |

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| | ○ Cheryl Balanay, MA, CCC/SLP, Lead SLP.<br>▪ **Observations of**:<br>○ Residences and dining rooms in 6521, 5972, 5971 and 5961=. |
| | **Facility Self-Assessment:** Based on a review of the Facility's POI, with regard to Section R of the Settlement Agreement, the Facility found that it remained out of compliance with all of the sub-provisions. This was consistent with the Monitoring Team's findings.<br><br>Since the Monitoring Team's last review, the POI updates did not document regular audits utilizing tools that the State Office had modified based on the Monitoring Teams' review tools. To ensure the validity and reliability of the data, a focus should be placed on the development of adequate instructions for the audit tools, and procedures should be implemented to ensure inter-rater reliability. An analysis of audit results should be initiated to track and trend problematic areas as well as document strategies to ameliorate areas of concerns. The Facility should include the results of these audits and analyses in its POI to substantiate its findings related to compliance.<br><br>The one Section R action plan documented the completion of six action steps dealing with revisions to the Facility Speech Language policy. Based on the information provided, it was unclear what the Facility viewed as the next steps in its efforts to comply with Section R of the Settlement Agreement. The Director of Rehabilitative Services, in collaboration with the lead SLP, should expand the action plans for Section R to address all the sub-components. During this process it will be imperative to prioritize what will be accomplished during the six-month intervals prior to onsite compliance reviews. |
| | **Summary of Monitor's Assessment:** The Facility had five full-time SLPs and a SL Assistant. However, a review of individual records did not substantiate adequate involvement of SLPs in individuals' programs. Based on a review of 16 PSPs for individuals revealed that SLPs attended only five of the 16 PSP meetings (31%). In addition, only two percent (2%) of ABSSLC individuals were receiving direct therapy. An absence was noted of development and integration of therapy recommendations into formal PSP action plan objectives; as well as of development of instructional programs to reinforce direct therapy plans formally and informally.<br><br>SLPs attended a three-day workshop on the behavioral approach to teaching communication skills to children with autism and other developmental disabilities. Since the Monitoring Team's last review, no documentation was submitted for SLP participation in state-sponsored seminars. To build capacity for SLPs who may in the future have responsibilities on the PNMT, and/or have individuals on their caseloads with significant physical and nutritional support needs, it is recommended that SLPs attend state-sponsored webinars.<br><br>The current SLP evaluation did not provide adequate functional evaluation data to support the annual person-centered planning process, or planning for future community placement. SLPs should view the attainment of functional communication skills for all individuals as non-negotiable. The SLP evaluation process should be critically reviewed to determine what modifications are needed to produce a functional |

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| | evaluation that leads to the development of formal skill acquisition programs and/or action plan training objectives. Such objectives should support the achievement of functional communication skills. They should include informal activities that provide multiple opportunities to practice new and learned communication skills. PST members will need the direct support and guidance from SLPs to ensure functional communication becomes fully integrated within the PSP.<br><br>No competency-based training and performance check-offs were completed to demonstrate staff competency with generic and/or individual-specific AAC system(s).<br><br>A document entitled "Analysis of Monitoring of Speech Equipment," dated 7/27/11, summarized monitoring from January to May 2011 related to the availability and use of generic and individual-specific communication equipment. The lowest level of monthly compliance was 14% and the highest was 26%. An action plan was submitted, but it was not significantly different from the previous action plan. Additions had been made to have SLPs prioritize speech equipment to be monitored, and to integrate speech equipment monitoring with Habilitation Therapies. The Monitoring Team recommends that the action plan steps be modified to identify who, what, where, when, and how these action steps will be actualized. This is necessary to support a more aggressive approach to ensure staff compliance with the use of generic and individual-specific AAC systems. |

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| 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 professionals, with specialized training or experience demonstrating competence in augmentative and alternative communication, to conduct evaluations, develop and implement programs, provide staff training, and monitor the implementation of programs. | The Monitoring Team's record sample for Section R was as follows:<br>▪ Sample R.1 - six individuals who received direct SLP services, including Individual #387, Individual #92, Individual #455, Individual #160, Individual #83, and Individual #409;<br>▪ Sample R.2 - six individuals who were identified as Priority 1 in the Master Communication Plan, including Individual #464, Individual #235, Individual #435, Individual #485, Individual #533, and Individual #383;<br>▪ Sample R.3 - four individuals newly admitted to ABSSLC, including Individual #121, Individual #125, Individual #107, and Individual #96; and<br>▪ Sample - four individuals with Behavior Support Plans, including Individual #242, Individual #425, Individual #390, and Individual #293.<br><br><u>The Facility provides an adequate number of speech language pathologists or other professionals [i.e., Assistive Technology (AT) specialists] with specialized training or experience. Training should include augmentative and assistive communication.</u><br>Based on interview, four budgeted SLP positions were available, and these positions were filled. The Lead SLP was not counted as one of the four budgeted SLP positions. A SLP Assistant (SLPA) provided support to the SLPs. The following chart illustrates the caseloads and responsibilities of the SLPs: | Noncompliance |

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| Current SLPs | Current Caseloads and Responsibilities |
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| SLP | Lead SLP and supported 71 individuals |
| SLP #1 | PNMT member and supported 124 individuals |
| SLP #2 | Supported 105 individuals |
| SLP #3 | Supported 79 individuals |
| SLP #4 | Supported 68 individuals |

As stated in the previous report, therapists were not active members of the PSTs as evidenced by the SLPs' absence from annual PSP meetings. For example, based on Samples R.1, R.2, and R.3, the SLP attended only five of the 16 annual PSPs (31%). In addition, a minimal number of individuals were provided direct therapy. Only two percent of individuals residing at ABSSLC were receiving direct speech services. A lack of development and integration of therapy recommendations into formal skill acquisition programs was noted, as well as a lack of development of instructional programs to reinforce direct therapy plans for staff, and insufficient development of informal strategies to reinforce evaluation recommendations and measurable outcomes.

The SLPs attended a variety of continuing education courses and conferences, including:

- Four SLPs attended Teaching Communication Skills to Children with Autism and other Developmental Disabilities Three-day Introduction to Verbal Behavior;
- Five SLPs attended a Dynavox Technology Update;
- One SLP and the PNMT Chairperson attended Vitamin D and Calcium Concepts and Controversies;
- One SLP attended Assistive Technology and EADLs, Positioning for Access, and the TSHA [Texas Speech Language Hearing Association] 2011 Annual Conference.

No Certificates of Completion and/or continuing education agendas or handouts were presented as documentation of completion of these courses. No documentation was submitted for SLP participation in state-sponsored seminars that had been presented since the Monitoring Team's last review. As stated in the previous report, the SLP who is the PNMT Coordinator should attend State-sponsored webinars. To build capacity for other SLPs who might in the future have responsibilities on the PNMT, and/or have individuals on their caseloads, it is recommended that additional SLPs attend state-sponsored webinars.

Communicative Aides and Speech Generating Devices (SGDs) (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.

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| | | Six individuals in Sample R.2 were identified as Priority 1 in the Master Communication Plan. Individuals' evaluations were scheduled and tracked following a priority design. Priority 1 individuals were identified by four criteria: 1) individuals with expressive communication devices as primary need; 2) individuals who were non-verbal with BSPs for aggressions/SIB; and 3) school-aged individuals and individuals in therapy.<br><br>Based on a review of Sample R.2, three individuals (Individual #464, Individual #235, and Individual #485) (50%) received a SL evaluation during 2011, but no SL supports were recommended related to AAC systems (0%). The initial recommendation in these three evaluations stated: "In view of the above Clinical Impressions, Speech-Language therapy is not indicated as his/her needs can best be addressed in the context of daily living." Two of these individuals had BSPs (Individual #464 and Individual #235) for aggressive behavior. These individuals had been evaluated with documented communication needs, but were not recommended to receive any level of SLP support for AAC.<br><br>The remaining three individuals within Sample R.2 did not have current SL evaluations (Individual# 533 with an SL Evaluation dated 4/11/06, Individual# 383 with an SL Evaluation dated 5/31/00, and Individual# 435 with an SL Evaluation dated 12/6/00).<br><br>The SL template had been revised to incorporate recommendations from the Monitoring Team's last report, but a review of individuals' SL evaluations within sample R.1 identified concerns with individual SL evaluations:<br>• SL evaluations did not provide adequate functional evaluation data to support the annual person-centered planning process, or planning for future community placement. For example, multiple evaluation recommendations state: "In view of the above Clinical Impressions, Speech-Language therapy is not indicated as [his/her] needs can best be addressed in the context of daily living activities." The SLP evaluation process should continue to be reviewed to determine what modifications are needed to produce a functional evaluation that leads to the development of formal skill acquisition programs and/or action plan training objectives. Such objectives should support the achievement of functional communication skills. They should include informal activities that provide multiple opportunities to practice new and learned communication skills. PST members will need the direct support and guidance from SLPs to ensure functional communication becomes fully integrated within the PSP.<br>▪ The SL evaluation was not completed in collaboration with the OT and PT disciplines. Hands-on collaborative functional evaluations between an individual's OT, PT, and SLP should be encouraged. A collaborative evaluation might expand beyond these clinicians. The composition of the collaborative evaluation should be driven by the individual's needs. For example, the | |

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| | | evaluation of an individual with significant behavior challenges should include the psychologist, or the evaluation for an individual with multiple high-risk indicators should include nursing.<br>▪ The current evaluation continued to not be sufficiently discrete to identify an individual's preferences, interests, current skills, and discovery of potentials for learning and functional communication skill acquisition. This should occur through observation, staff interview, record review, and clinical evaluation. The evaluation should lead to the development of functional outcomes that are meaningful to the individual in the context of everyday living at home, and work, as well as during retirement activities, leisure interests, and community outings. Functional outcomes should identify an integrated series of behaviors (hence, the importance of a collaborative evaluation) that allow an individual to achieve important everyday goals.<br>▪ The SL template incorporated an observation section, but multiple SL evaluations did not document observations within multiple natural environments. A functional evaluation should occur within individuals' natural environments, and include observations of daily routines and activities within the home, activity centers, work sites, leisure activities, etc.<br>▪ The SL evaluation format was revised to incorporate information from the Medical Problem list and the impact that information might have on SL functioning. The revision did not address a review of the individual's current high and medium risk factors that might have an impact on their communication ability.<br>▪ The SL Evaluations did not include an analysis of findings. Evaluation data should be analyzed to identify an individual's strengths, abilities, and potentials for learning and skill acquisition. The analysis of evaluation findings should provide a rationale for functional outcomes and recommendations. The analysis should discuss possibilities for the development of formal programs, as well as informal activities that would support the achievement of functional outcomes and recommendations.<br>▪ Recommendations did not include measurable outcomes. Recommendations should include criteria that would enable the team to assess and monitor implementation to ensure efficacy of formal program(s).<br>▪ SL Evaluations included Communication/Active Treatment Recommendations for the individual and staff, but these recommendations were not integrated consistently into the individual's PSP. Recommendations should be integrated into an individual's PSP not only through formal skill acquisition programs, but informally to reinforce the learning of new skill(s) in multiple environments throughout the 24-hour day.<br><br>Based on staff report, 11 of the 443 individuals residing at ABSSLC (2%) were receiving | |

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| | | direct SLP services. Review of Sample R.1 did not substantiate that these individuals were receiving adequate direct SL services, including the development and implementation of programs to support direct therapy, provision of competency-based staff training and performance check-offs, and individual-specific monitoring to determine the efficacy of the programs and AAC system(s). In addition, the following concerns were noted:<br>▪ SL Evaluations for individuals receiving direct SL supports were not adequate as described above. SL Evaluations for individuals receiving direct SL supports should integrate the recommendations offered.<br>▪ SL Evaluations for school-aged individuals did not discuss and/or integrate information from their Individual Education Plans (IEP) related to functional communication. The SL evaluation for school-aged individuals should review and integrate educational goals with recommendations.<br>▪ No protocols were in place for auditing SL Evaluations to ensure consistency with established policy and procedures. The Facility policy should define the process for auditing SL evaluations.<br>▪ Direct therapy plans were not consistently integrated into PSPs, nor were PSP policy guidelines followed. Direct therapy service plans should be integrated into PSP Action Plans, and adhere to the established guidelines for action plans and monitoring. SLPs did not report progress for direct therapy on a monthly basis. Documentation protocols for direct therapy plans should be established to support compliance with the Personal Support Plan Process policy. Direct therapy progress notes also should provide justification for the initiation, continuation, or discontinuation of direct therapy. A process should be delineated for implementing changes in an individual's supports when progress is made or a lack of progress is noted. No documentation for staff competency-based training and performance check-offs was provided to confirm staff competency in assisting individuals with the utilization of AAC systems in a variety of environments.<br>▪ Monthly SL equipment monitoring forms were provided but these forms did not provide resolution to problems identified, such as missing equipment or staff non-compliance with generic and individual-specific AAC system use.<br><br>ABSSLC was not in compliance with this provision of the Settlement Agreement, and minimal progress had been made. Multiple individuals reviewed did not have adequate SLP evaluations. An absence was noted of the development and implementation of programs to support AAC systems. Competency-based staff training was not being provided, nor was individual-specific monitoring occurring to determine the efficacy of prescribed AAC system(s). | |
| R2 | Commencing within six months of | <u>All individuals in need of AAC are identified as being in need of AAC.</u> | Noncompliance |

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| | the Effective Date hereof and with full implementation within three years, the Facility shall develop and implement a screening and evaluation process designed to identify individuals who would benefit from the use of alternative or augmentative communication systems, including systems involving behavioral supports or interventions. | Despite identified needs related to communication as identified in their SL evaluations, none of the six individuals in Sample R.2 (0%), who were identified as Priority 1 in the Master Communication Plan, were provided ongoing direct support by an SLP to facilitate functional communication.<br><br>Since the Monitoring Team's last review, the ABSSLC SL Evaluation Master Plan priority levels had been revised to include:<br>▪ Priority Level 1: individuals with expressive communication devices as a primary need; non-verbal with BSPs for aggression/SIB (low frequency/low severity behaviors may be bumped to priority 3); who are school-aged; and receiving direct therapy (evaluate yearly);<br>▪ Priority Level 2: individuals with input communication device; functionally verbal but have clarification AAC devices; Electronic Aids to Daily Living (EADL) only; and BSP who have limited verbal skills (evaluate every 3 years); and<br>▪ Priority Level 3: everyone else will be re-evaluated as indicated by change of status or referral (no evaluation time frame established).<br><br>The ABSSLC Evaluation Master Plan identified the following priority levels for the 443 ABSSLC individuals:<br>▪ Priority Level 1 - 137 individuals;<br>▪ Priority Level 2 - 108 individuals; and<br>▪ Priority Level 3 - 198 individuals.<br><br>A review of the Evaluation Master Plan revealed that SLP evaluations had been completed for 49 of 108 individuals (45%) identified as Priority Level 1. In addition to conducting a critical review of the SL evaluation process, the Director of Rehabilitative Services and the Lead SLP should initiate a review of the current status of the SLP evaluation completion rates for individuals within the priority levels to assess compliance with the timelines included in the Settlement Agreement.<br><br><u>All people have received a communication screening or evaluation within 30 days of admission, readmission or change in status.</u><br>Since the last review, seven individuals had been admitted to ABSSLC. Based on a review of Sample R.3, all four had received a communication screening and evaluation. However, none of these four newly admitted individuals (Individual #121, Individual #125, Individual #107, and Individual #96) (0%) had received an adequate comprehensive functional SL evaluation. The initial recommendations for each of these four individuals was as follows: "In view of the above clinical impressions, Speech-Language therapy is not indicated as [his/her] needs can best be addressed in the context of daily living activities," and "The following communication strategies are provided. These should be included in his PNMP and integrated into daily programming | |

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| | | as possible." The SL evaluations did not recommend SL involvement for individuals who would benefit from the use of alternative or augmentative communication systems.<br><br>Programs, goals and objectives related to the acquisition or improvement of speech or language are written by the SLP.<br>SL service plans for direct therapy were reviewed for the individuals within Sample R.1. Individual service plans did not identify an author, nor was a SLP's signature present. Individual #387 had a service plan objective, but his evaluation did not recommend direct therapy.<br><br>For persons receiving behavioral supports or interventions, the Facility has a screening and evaluation designed to identify who would benefit from AAC. Note: this may be included in the PBSP.<br>A list entitled "Individuals with Positive Behavior Support Plans (PBSP) with Coexisting Several Language Deficits/Replacement Behaviors Related to Communication/Risk Level for Challenging Behaviors," updated 6/11, and was utilized to identify four individuals with BSPs in Sample R.4. The following concerns were noted.<br>▪ All of the individuals within the sample had been rated high for challenging behaviors, but were assigned different priority levels for the SL Evaluation Plan:<br>o Individual #242 and Individual #390 - Priority 1;<br>o Individual #425 - Priority 2; and<br>o Individual #283 - Priority 3.<br>The SL Evaluation Communication Plan criteria for priority levels should incorporate high and medium risk ratings for challenging behavior.<br>▪ SL Evaluations did not consistently describe how communication systems would support individual BSPs. Presentation Book R presented examples of individual SL evaluation statements to document BSP integration. However, these examples were not sufficient for the following reasons:<br>o The SL evaluations did not document specific collaboration between the SLP and psychologist.<br>o It was not clear if the collaboration led to the development and implementation of communication strategies to be integrated in the PSP, BSP, direct therapy plans, indirect activities in daily schedules.<br>o The evaluations' analysis of findings sections did not provide justification for functional recommendations related to the development and implementation of formal treatments and programs, as well as informal activities to support acquisition of functional communication skills.<br>SLPs and psychologists should collaborate on how to successfully integrate evaluation findings and recommendations within their respective discipline's work products (i.e., PNMPs, BSPs, direct therapy plans, PSP action plan | |

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| | | objectives, etc.).<br><br>Additional guidelines for individuals with a BSP were integrated into the ABSSLC SL Facility policy. The following comments are provided with regard to this policy:<br>▪ The policy indicated that the SLP would collaborate with the psychologist for integration of communication supports. Each person with BSP was to be reviewed at least yearly for integration and associated communication needs via their Behavior Support Committee (BSC). A review of individual SL evaluations and BSPs did not consistently document collaboration between the SLP and the psychologist. The SL Department should audit SL evaluations and BSPs to determine if the policy revisions were sufficient to ensure the collaboration between SLPs and psychologists was adequately documented, and that the recommended communication strategies and BSPs were sufficiently integrated.<br>▪ Every individual at ABSSLC was to have a communication dictionary. It was unclear why every individual at ABSSLC needed a communication dictionary, particularly if they were able to effectively communicate verbally. The SL department should evaluate the need for every individual to require a communication dictionary.<br>▪ Their BSP and SL evaluations were to be reviewed and communication dictionaries were to be updated prior to their PSP. The communication dictionary would be reviewed during the annual PSP for any additional changes. A review of individual communication dictionaries and BSP replacement behaviors did not show adequate integration of the communication dictionary with the BSP.<br>▪ Documentation of integration was to be present in the BSP, signature sheets from BSC meetings, and the SLPA tracking sheet of BSP integration. Review of individual records did not consistently document integration. As stated above, an audit of completed SL evaluations and BSPs should assist in determining if policy guidelines were being implemented and/or if additional information needed to be added to the SL policy.<br><br>For none of the four individuals with BSPs in Sample R.4 (0%) was collaboration between the psychologist and SLP in the development of the PBSPs documented in the SL evaluation. Such collaboration is necessary to provide relevant evaluation information to integrate communication strategies into the development of a BSP and the PSP. For example:<br>▪ Review of BSPs did not consistently document integration with the SL.<br>▪ SL Evaluations were not current, and did not discuss strategies for integration within the BSP.<br><br><u>Policy exits that outlines evaluation schedule and staff responsibilities.</u> | |

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| | | In addition to adherence to the state policy (Communication Services), the ABSSLC Specific Policy/Procedure for Speech-Language Pathology included revisions, including that referrals to SL could be initiated by the PST or concerned individuals; changes in criteria for Evaluation Master Plan priority levels; requirements for documentation to support SLP and psychologist collaboration with BSPs; expectations that SLPs were to participate in PNMP clinic; revisions related to monitoring; and expectations that eating evaluations were to be completed in collaboration with OT. The SL policy revisions were positive, but the SL Department should conduct SL evaluation audits to determine if policy guidelines are being followed, particularly with regard to the documentation of collaboration between SLPs, psychologists, and OTs. In addition, a review of should be conducted to determine if evaluations are being completed per the established priority levels in the Evaluation Master Plan. This is essential to determine if Settlement Agreement timelines will be met.<br><br>Review of individual records documented that SLPs were not consistently following policy directives. If it is determined that directives cannot be implemented immediately, then Facility Administration should define a phase-in process for policy directives. Formal in-service training should be completed on new policies, and include the following:<br>▪ Training roster as evidence of therapist attendance;<br>▪ Training agenda to identify what specific policy revisions and/or procedures were trained;<br>▪ Date of the training in-service;<br>▪ Projected completion date for therapists that were not able to attend to participate in training.<br><br>Throughout Section R, the Monitoring Team has made recommendations with regard to needed policy changes.<br><br>ABSSLC was not yet in compliance with this provision of the Settlement Agreement, and no progress had been made. As noted above, individuals had not been appropriately screened or evaluated. In addition, individual records did not support collaboration between the SLP and the psychologist in the development of BSPs. | |
| R3 | Commencing within six months of the Effective Date hereof and with full implementation within three years, for all individuals who would benefit from the use of alternative or augmentative communication systems, the Facility shall specify in | <u>Communication information is not only present in the PSP, but integrated into the daily schedule.</u><br>None of the six individuals in Sample R.1 (0%), who received direct therapy, had formal skill acquisition programs and informal communication activities integrated into their PSP Action Plans and daily schedules. Two of the six individuals (Individual #92 and Individual #83) did not have a daily schedule. | Noncompliance |

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| | the ISP how the individual communicates, and develop and implement assistive communication interventions that are functional and adaptable to a variety of settings. | None of the six individuals in Sample R.1 who would benefit from AAC systems received direct support from a SLP to develop and implement communication programs to integrate the use of these devices into their PSPs and daily schedule.<br><br>Rationales and description of interventions regarding use and benefit from AAC are clearly integrated into the PSP.<br>For none of the six individuals in Sample R.1 had the SL service plan goals been integrated into the PSP Action Plans. Direct therapy plans should not be implemented in an isolated environment. The goal of direct therapy plans should be discussed with PST members to ensure the plan is functional and meaningful for the individual, and supports the individual's preferences. Direct therapy plans should be integrated and reinforced through inclusion in PSP action plan objectives; schedules within the home, activity centers, and/or work; PNMPs; BSPs; nursing care plans; and community outings to support multiple learning opportunities for the use of AAC systems.<br><br>AAC devices are portable and functional in a variety of settings.<br>None of the six individuals in Sample R.1 (0%) had PNMPs or daily schedules that provided staff strategies for the use of their AAC devices in multiple environments, such as during mealtime, community outing, or leisure time, or at the work, the activity center, or home.<br><br>AAC devices are individualized and meaningful to the individual.<br>None of the SL service plans of the six individuals within Sample R.1 (0%) defined how their individualized communication systems would be generalized beyond the direct SL sessions to ensure these devices were meaningful and functional for the individual. No formal communication programs had been developed and implemented with individualized strategies for staff to implement to reinforce what was being learned in direct speech therapy. Such programs were necessary to ensure the devices were functional and meaningful to the individual.<br><br>Staff are trained in the use of the AAC device.<br>None of the records of the six individuals within Sample R.1 substantiated that staff had received individual-specific competency-based training and performance check-offs to evaluate staff competency with individual's AAC devices.<br><br>ABSSLC was not in compliance with this provision of the Settlement Agreement, and no progress had been made. Individuals were reviewed who would benefit from the use of an AAC system(s), but did not receive SL support to develop and implement assistive communication interventions. Individual PSPs did not integrate SL service plans for those individuals who received direct SL support. The lack of integration for direct services within the PSP did not ensure AAC system(s) were functional for the individual. | |

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| 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><br>On a positive note, the ABSSLC SL policy for monitoring guidelines was revised to incorporate the following:<br>▪ Equipment to be monitored monthly for presence, condition and function;<br>▪ AAC devices recommended in SL evaluations to be monitored monthly during a 20-minute snapshot;<br>▪ Monitoring results to be charted with a trend line and results shared with Facility administration, Unit Directors, and Home Supervisors.<br><br>For none of the six individuals within Sample R.1 (0%) was evidence found of a system that monitored all AAC communication systems. Monthly SL equipment monitoring had occurred, but the following concern and recommendations were noted:<br>▪ Communication/Hearing Equipment listed in the SL evaluation and the PNMP were not consistently reflected on the monitoring form. The SL equipment monitoring form should monitor all communication equipment.<br>▪ Communication equipment was not monitored in a variety of environments. The form should be modified to document monitoring in multiple environments.<br>▪ Monitoring forms indicated that a system was "not working" or "missing," but no resolution was documented on the form and/or on a subsequent monitoring form. The form should be modified to provide documentation of problem resolution, including how the problem was resolved, date of resolution, and signature from the prescribing therapist. In addition, if a system was "not working" or was "missing," monitoring guidelines should provide specific directions, including timelines describing expectations for the process of problem resolution.<br><br>The Facility had made revisions to the protocol identifying the prioritization of and timelines for the completion of SL equipment work orders. Timelines appeared to be lengthy and could extend up to 90 days. An absence of a communication system for three months would not meet the requirements of the Settlement Agreement.<br><br>The Monitoring Team recommends a detailed tracking system for work orders to determine the possibility of work order timelines being shortened.<br><br>The Monitoring Team commended the Facility for continuing to work to increase compliance levels for monitoring speech equipment, but additional work remained to be done. A document entitled "Analysis of Monitoring of Speech Equipment," dated 7/27/11, presented a chronology of events documenting the results of speech equipment monitoring. The Campus Communication Usage 2010/2011 bar graph, undated, | Noncompliance |

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| | | revealed the following compliance percentage average:<br>▪ January 2011 - 16% compliance<br>▪ February 2011 - 17% compliance;<br>▪ March 2011 - 26% compliance;<br>▪ April 2011 - 17% compliance; and<br>▪ May 2011 - 14% compliance.<br><br>The SL analysis documented the overall percentage of use had increased campus wide from 4four percent in July 2010 to 14% in May 2011. However, the monitoring scores from January to May 2011 showed no sustained increase in staff usage. An action plan was presented to increase compliance that did not differ significantly from the previous action plan with the exception of two additional steps. First, SLPs were to separate AAC equipment from lower priority equipment and Electronic Aids to Daily Living (EADLs) to prioritize monitoring of AAC equipment. Second, speech equipment monitoring was to be integrated with Habilitation Therapy Department monitoring.<br><br>The implementation of the previous action plan did not produce the desired outcome of increasing monitoring scores for staff compliance with speech equipment as illustrated by the low monitoring scores. It was unclear how the addition of the two new action steps would elicit the desired outcome of increasing staff compliance with AAC systems. The Director of Habilitation Therapies and the Lead SLP should review these action steps, in collaboration with Assistant Director of Programs, Director of Behavioral Services, and other staff as appropriate to identify what additional barriers might be contributing to staff non-compliance with the use of SL equipment. Action steps should be developed and implemented to resolve these barriers. In addition, the SL department should provide competency-based training and performance evaluations to document staff competency with individual-specific communication systems. The SLPs also should review AAC systems to determine if these systems continue to be appropriate and functional for the individual. The action plan should incorporate steps and outcomes that are measurable (for example, establish the desired compliance level to be achieved), identify who will be responsible, establish timeframes for completion, and define what documentation will be required to validate completion of an action step.<br><br>The Facility Speech Language monitoring policy should incorporate the following as recommended in the previous report:<br>▪ Monitoring forms that include instructions for individual monitoring indicators to support consistency and inter-rater reliability;<br>▪ Identification, training, and validation process for monitors to achieve accurate scoring and a high level of inter-rater reliability;<br>▪ Formal schedule for monitoring to occur; | |

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| | | ▪ Auditing process of completed monitoring forms to identify forms completed accurately, and analysis of individual-specific concerns and systemic issues; and<br>▪ Feedback loop identified in which deficiencies are noted and shared with appropriate supervisory staff to ameliorate deficiencies.<br><br><u>Monitoring covers the use of the AAC during all aspects of the person's daily life in and out of the home.</u><br>As stated above, the monitoring form needed revision to document monitoring in a variety of environments (home, activity center, work sites, leisure activities, mealtimes, etc.).<br><br><u>Validation checks are built into the monitoring process and conducted by the plan's author.</u><br>There was no evidence that validation checks were built into the monitoring process and conducted by the plan's author.<br><br>ABSSLC was not in compliance with this provision of the Settlement Agreement, and minimal progress had been made. | |

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

1. The Director of Rehabilitative Services and the Lead SLP should review the current SLP evaluations to ensure SLPs assess and identify individuals who would benefit from AAC systems, including recommending the development of programs to support AAC systems as appropriate. (Section R.1)
2. The following recommendations are made regarding the evaluation process:
    a. Hands-on collaborative functional evaluations between an individual's OT, PT, RD and SLP, should be encouraged. The composition of the collaborative evaluation should be driven by the individual's needs.
    b. The evaluation process should identify an individual's preferences, interests, current skills, and discovery of potentials for learning. This should occur through observation, staff interview, record review, and clinical evaluation. The evaluation should lead to the development of functional outcomes that are meaningful to the individual in the context of everyday living at home, and work, as well as during retirement activities, leisure interests, and community outings. Functional outcomes should identify an integrated series of behaviors (hence, the importance of a collaborative evaluation) that allow an individual to achieve important everyday goals.
    c. Recommendations should include measurable criteria that would enable the SLP and the team to assess and monitor implementation to ensure efficacy of formal program(s).
    d. Recommendations should be integrated into the PSP not only through formal Action Plan objectives, but informally to reinforce the learning of new skill(s) in multiple environments with suggested activities throughout the 24-hour day.
    e. SL evaluations for school-age individuals should integrate information from their Individual Education Plans (IEP) related to functional communication. SL recommendations should reinforce IEP goals and support these educational interventions, and be integrated in the PSP through Action Plans.
    f. Direct therapy protocols should be established to support compliance with the Personal Support Plan Process policy. (Section R.1)

3. The Director of Rehabilitative Services and the Lead SLP should initiate a review of the current status of the SLP evaluation completion rates for individuals within the priority levels to assess compliance with the Settlement Agreement timelines. They also should review evaluations that have been completed thus far to determine if these evaluations meet the Settlement Agreement requirements. (Section R.2)
4. The SL Evaluation Communication Plan criteria for priority levels should incorporate high and medium risk ratings for challenging behavior. (Section R.2)
5. Functional communication recommendations should be integrated formally through skill acquisition programs/action plan objectives, and informally reinforced through integration into daily activities. (Section R.2 and Section R.3)
6. Additional guidelines should be added to the SL policy related to the collaboration between the SLP and the psychologist in conducting SL evaluations, and PSP development. (Section R.2)
7. Competency-based training and performance check-offs for staff should be implemented to document staff competency with generic and individual-specific AAC system(s). (Section R.3)
8. To address low compliance ratings with the use of AAC, the Facility's Action Plan steps be modified to identify in greater detail who, what, where, when, and how these action steps will be actualized. The resulting plans should support a more aggressive approach to ensuring staff compliance with the use of generic and individual-specific AAC systems. (Section R.4)
9. The Facility Speech Language monitoring policy should incorporate the following as recommended in the previous report:
    a. Monitoring forms that include instructions for individual monitoring indicators to support consistency and inter-rater reliability;
    b. Identification, training, and validation process for monitors to achieve accurate scoring and a high level of inter-rater reliability;
    c. Formal schedule for monitoring to occur;
    d. Auditing process of completed monitoring forms to identify forms completed accurately, and analysis of individual-specific concerns and systemic issues; and
    e. Feedback loop identified in which deficiencies are noted and shared with appropriate supervisory staff to ameliorate deficiencies. (Section R.4)
10. To ensure the validity and reliability of the Facility's compliance audit data, a focus should be placed on the development of adequate instructions for the audit tools, and procedures should be implemented to ensure inter-rater reliability. An analysis of audit results should be initiated to track and trend problematic areas as well as document strategies to ameliorate areas of concerns. The Facility should include the results of these audits and analyses in its POI to substantiate its findings related to compliance. (Facility Self-Assessment)

| **SECTION S: Habilitation, Training, Education, and Skill Acquisition Programs** | |
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| 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:<br>▪ **Review of Following Documents**:<br>o Presentation for Section S at the entrance meeting, dated 8/22/11;<br>o Section S Presentation Book: Plan of Improvement, dated 8/12/11, including Teaching People with Developmental Disabilities PowerPoint presentation and participant's guide; handout on Training Objectives; Meeting Agenda and accompanying handouts (Personal Support Plans, Personal Focus Assessment, Third Quarterly Review, Action Plans, and Risk Terminology) for training of Qualified Developmental Disabilities Professionals by State Consultants;<br>o Updated guidelines for developing training objectives;<br>o Training objectives: Individual #387 (sign language training), and Individual #150 (fewer target behaviors in community);<br>o Skill Acquisition Program, sample from Brenham SSLC, PSP date 12/17/11;<br>o Engagement Monitoring Form, revised 8/16/11;<br>o Personal Focus Assessments for: Individual #387, Individual #61, Individual #300, Individual #478, Individual #228, Individual #108, Individual #187, Individual #533, Individual #109, Individual #405, and Individual #376;<br>o Positive Assessment of Living Skills (PALS) for: Individual #387, Individual #424, Individual #61, Individual #300, Individual #478, Individual #228, Individual #108, Individual #425, Individual #187, Individual #398, Individual #533, Individual #109, and Individual #376;<br>o Personal Support Plans for: Individual #387, Individual #23, Individual #267, Individual #424, Individual #163, Individual #207, Individual #123, Individual #61, Individual #534, Individual #95, Individual #300, Individual #478, Individual #228, Individual #108, Individual #81, Individual #505, Individual #545, Individual #48, Individual #526, Individual #337, Individual #425, Individual #502, Individual #107, Individual #187, Individual #135, Individual #121, Individual #398, Individual #313, Individual #533, Individual #125, Individual #109, Individual #405, Individual #444, Individual #323, Individual #287, Individual #469, Individual #131, Individual #205, Individual #133, Individual #132, and Individual #376;<br>o Training Documentation Reports for: Individual #87, Individual #424, Individual #207, Individual #123, Individual #95, Individual #300, Individual #478, Individual #228, Individual #108, Individual #425, Individual #187, Individual #398, Individual #533, Individual #109, Individual #405, Individual #486, Individual #444, Individual #323, Individual #287, Individual #132, and Individual #376;<br>o Vocational Services Evaluations for: Individual #424, Individual #2, Individual #434, Individual #247, Individual #398, Individual #486, and Individual #363; and<br>o Vocational Assessment, State Supported Living Center: template and completed form for |

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| | Individual #30.<br>▪ **Interviews with**:<br>o Kristin Wyrick, QDDP Coordinator; Jeff Branch, Active Treatment Coordinator; Ron Manns, Director of Behavioral Services; Jolene Willis, Assistant Director; Hailey Sibley, Program Compliance Monitor; Ric Sibley, DADS Consultant; and Bill Davis, DADS SSLC QDDP and Programs Coordinator, on 8/25/11;<br>o Candi Hallford, Vocational Services Director, and Bill Davis, DADS SSLC QDDP and Programs Coordinator, on 8/24/11;<br>▪ **Observations of**:<br>o 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;<br>o Activity Center 5921, Activity Center 5922, Activity Center 5923, Activity Center 6340, and Activity Center 6700;<br>o Workshop 657, Workshop 662, and Workshop 680;<br>o Facility Incident Report Team, on 8/22/11;<br>o Unit II Daily Incident Monitoring Meeting, on 8/23/11; and<br>o Personal Support Plan Meeting for Individual #146, on 8/23/11. |
| | **Facility Self-Assessment:** A review of the Facility's Plan of Improvement, dated 8/12/11, indicated that it remained out of compliance with all requirements of Section S of the Settlement Agreement. This finding was consistent with that of the Monitoring Team.<br><br>The Facility had adapted a monitoring tool similar to that used by the Monitoring Team. However, without accompanying documentation or indicators of inter-rater reliability, it was difficult to determine the accuracy of the data. While an overall compliance rating was provided in January of 2011, it was unclear how this score related to individual components of Section S. The Facility is encouraged to look at each requirement of the Settlement Agreement provisions, and then determine compliance based upon objective and reliable data. Samples of completed monitoring tools, along with copies of the documents reviewed, will prove helpful in the future.<br><br>With regard to Section S, the Facility included one action plan in its POI related to the development of skill acquisition goals. This was an important priority, and the Facility's progress in this regard is discussed below in further detail. |
| | **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. 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 |

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| | 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.<br><br>Although the Facility remained out of compliance with all provisions outlined in Section S of the Settlement Agreement, several actions had occurred that deserve commendation. First, staff had received additional training in the Personal Support Plan process that should result in improved and enhanced services to the individuals served. Two new instruments were being introduced with plans to complete annual comprehensive assessment of functional skills, and more specifically, vocational skills, interests, and needs. Steps also had been taken to improve the teaching format and techniques applied to effect enhanced skill development and independence. The Monitoring Team looks forward to future visits to review the progress made with these new initiatives. |

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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 41 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. Thirty of these 41 PSPs (73%) had been developed after January 2011. Individual #323 had had his PSP meeting held the week before the Monitoring Team's visit. Therefore, his plan from 2010 was reviewed. Staff should carefully review plans to ensure accuracy and clarity. A few specific concerns are identified below.<br>▪ Plans for school-aged individuals (Individual #387, Individual #163, Individual #81, and Individual #135) residing in one particular residence included a review of rights restrictions due to an unidentified individual's concealment of weapons. It was unclear in each of the four PSPs whether the specific individual had engaged in this behavior. This is important information that should be clarified.<br>▪ As noted in previous reports, some plans referred to the individual by another name or by the wrong gender (Individual #387, Individual #81, Individual #505, and Individual #135).<br>▪ For Individual #23, eating was identified as one of his preferences and a top priority. As eating is a necessary activity for life, its inclusion in a list of preferences and priorities was questionable, unless something particular about eating could be identified to assist the team in providing supports from a person-centered perspective. | Noncompliance |

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| | | In 25 of the 41 PSPs (61%), assessments used to determine needs were identified by discipline or, more clearly, by specific title or name. By identifying the assessment used and the date it was completed, the PSP Team can best ensure ongoing and appropriate assessment of need.<br><br>Prior to the PSP meeting, the Team was expected to complete the Personal Focus Assessment (PFA) for the individual. Twelve PFAs were provided for review. Ten of these 12 (83%) had been completed within the nine-month period prior to the Monitoring Team's visit. The PFA for Individual #108 was completed in 2009 and the PFA for Individual #376 was not dated. There was a degree of variation among the 10 current assessments with regard to detail and scope of the information provided. The PFAs for Individual #478, Individual #533, and Individual #109 were examples in which information was provided in all areas noted, summaries were fairly specific, and necessary assessments were identified along with the responsible person and due date. Examples in which this information was incomplete or missing were the PFAs for Individual #424, Individual #61, and Individual #300. As noted in the most recent training provided to the QDDP staff, the PFA is the "foundation of the entire PSP process." Without in-depth information about the individual's preferences, strengths, and needs, one cannot develop a comprehensive plan for habilitation.<br><br>A range of one to 13 training objectives had been identified for each of the 41 individuals for whom the PSP was reviewed. This resulted in an average of 6.32 annual objectives per individual. The concerns noted in the last Monitoring Team Report remained relevant.<br>▪ The skills to be trained were clearly identified in 12 of the 41 PSPs reviewed (29%). For the great majority of plans, the objective was identified in one to two words resulting in an inadequate identification of the observable and measurable skill the individual was expected to learn. Examples include Individual #61 (eating, medication training, shaving skill), Individual #300 (work, money skills, calendar use), Individual #545 (bathing, recreation), Individual #48 (responsible behavior, cooking), and Individual #533 (dressing, self-medication).<br>▪ Two school-aged individuals (Individual #387 and Individual #135) had only one training objective each, both of which were scheduled to occur weekly. Although their Individualized Educational Plans should address some needed skills, adequate habilitation services cannot be achieved when an individual is provided training only one time per week on one single skill. There are numerous hours outside of school when training should occur.<br>▪ The scheduling of activities was not always sufficient for learning. Individual #534, Individual #95, Individual #300, Individual #228, Individual #108, Individual #121, Individual #313, and Individual #405 all had schedules that | |

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| | | identified training was to occur monthly. The training schedules for Individual #61, Individual #131, and Individual #376 were identified as "ongoing." For habilitation services to be effective, training must be offered frequently enough to ensure skill acquisition.<br>▪ For at least one individual (Individual #287), no information as included regarding scheduling of training, start dates for training, person responsible, or location.<br>▪ Individual #398 had seven training objectives included in his PSP developed on 4/12/11. However, five of these objectives had been initiated three years earlier.<br><br>It is important to recognize the additional training that had been conducted on the entire Personal Support Plan process. Consultants hired by the State had trained Qualified Developmental Disabilities Professionals, and other team members over two days in early August. Training focused on the Personal Support Plan meeting, with an emphasis placed on identifying personal preferences and goals, a completion of the individual's risk assessment incorporating supporting documentation, identification of barriers to community integration, and the use of assessments and data to develop action plans. It also was stressed that current PSPs should be "significantly different" from previous PSPs and should be highly individualized.<br><br>The results of this training were evident in the PSP meeting for Individual #146 that a member of the Monitoring Team attended. One QDDP facilitated the meeting, while the QDDP assigned to the individual recorded pertinent information. The individual and his guardian were present and were actively engaged in discussion, as were several members of the team. All disciplines were represented. At the start of the meeting, a booklet, including an agenda and risk assessment criteria, was distributed to all those present. Team members skillfully addressed parental and individual concerns regarding community placement, but encouraged continued exploration of community options. When developing action plans, team members often suggested involvement in community-based activities, including adult literacy classes. When the individual expressed an interest in exploring other work options, the PST indicated they would work with the individual to assess his skills, needs, and interests. Team members also reviewed steps that had been taken to minimize dental appointment difficulties (e.g., more frequent, but shorter dental visits, home visits to encourage good oral hygiene), to address improved management of skin and circulation problems, and to assist the family with concerns related to night toileting.<br><br>With regard to staff training, the presentation entitled "Teaching People with Developmental Disabilities" proved to be a good introduction to this topic. A few areas for the Facility to consider are reviewed below: | |

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| | | ▪ One overhead indicated that the teacher was to provide an instruction for each skill. However, not all skills should require an instruction from another. Staff are encouraged to consider natural discriminative stimuli that set the occasion for a response to occur. For example, if one's shoelaces are untied, this is a natural discriminative stimulus to stop and re-tie the laces. If one is hungry or thirsty, this is a natural discriminative stimulus to obtain or ask for food or drink. Many behaviors should be taught with consideration given to the natural discriminative stimuli that occasion behavior from people who perform skills independently. The goal is to avoid dependence upon another to engage in desired behaviors or perform adaptive skills.<br>▪ The Facility should consider using a different example when providing a sample of a Training Skills Format. The example provided referred to teaching an individual to wait for two minutes after he/she asked for a preferred food item. While waiting is a good skill for individuals to develop, this example could lead participants to try this with individuals with whom they work without giving consideration to the potential for increasing undesired behaviors, if the skill is not introduced gradually and effectively. Putting a highly preferred item in front of someone and then telling him/her to wait while the teacher stands looking at his/her watch, might actually evoke undesired behavior, because the individual might not understand why he/she must wait.<br>▪ An example of a teaching sequence was provided in which "Mr. Doe" was learning to request a keyboard in response to an instruction posed by the teacher. Consideration should be given to teaching independent communication skills in which the learner develops the ability to communicate his/her wants without waiting for another to ask a question.<br>▪ Staff should provide a number of examples of good behavioral objectives in which the following criteria are met: a) the conditions under which the behavior will occur are described; b) the response is described in observable and measurable terms; and c) the criteria for determining skill acquisition is clearly identified.<br><br>The Monitoring Team was asked to review a sample training objective that had been obtained from Brenham SSLC. The goal was to help an individual become more independent in using the telephone. The objective outlined the instruction and the observable response. The conditions under which the behavior was to occur (e.g., when brought to the office and told it is time to call ___), and clear criteria to determine mastery were missing. Specific instructions were provided, but although backward chaining was noted, this was not clearly explained in the teaching steps. It appeared that only one opportunity for the behavior to occur was scheduled each week. Staff were directed to record the level of prompting required to complete the last step in the task analysis. If this plan followed a carefully described backward chain, the data should reflect whether | |

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| | | the individual performed the skill or skill sequence as described in the identified step of the teaching sequence. The scoring should be a simple correct (i.e., as described) or incorrect. As noted above, training objectives or skill acquisition programs will need to be written so that the behavioral objective is clear, teaching guidelines are comprehensive enough to ensure precise and consistent implementation, there are sufficient opportunities for the behavior to occur, and there is planning for the maintenance and generalization of the newly acquired skill.<br><br>With 90 individuals, or 20% of the population of ABSSLC, identified with visual impairment, it is recommended that the Facility either hire or contract with an orientation and mobility specialist, and/or teacher of the visually impaired to ensure that all staff are trained in appropriate supports for these individuals. While care is taken to address the needs of individuals who have physical disabilities or other sensory impairments through physical, occupational, and speech/language therapies, it appeared that no special considerations were provided for those who experienced blindness or limited vision. Specialized supports are appropriate and would contribute to ensuring that adequate habilitation services are provided to these individuals.<br><br>A total of 149 Training Documentation Reports for 21 different individuals were reviewed. Task analyses were provided for 53% of the sample. The following summarizes the results of this review:<br>▪ As behavioral objectives were not provided in any of the reports (0%), 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.<br>▪ While training schedules were noted, these did not specify the number of trials to be 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 one to three times per week, indicated that the time spent addressing habilitation goals was severely limited.<br>▪ Additional concerns were raised when the consequences for correct responding were reviewed. For 134, or 90%, of the sample, praise was the identified reinforcer. In eight of the training documents (5%), the reinforcer was not identified. The remaining seven training objectives (5%) listed praise and access to an item or activity as the 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. As reported, the psychology staff had begun | |

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| | | completing formal preference assessments with specific individuals. The results of these assessments should be communicated to all team members and incorporated into habilitation programs.<br>▪ 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.<br>▪ None of the plans (0%) identified consequences for incorrect responding.<br>▪ In addition, there were no plans (0%) for ensuring the maintenance and generalization of skills learned.<br><br>In sum, it is important that training guidelines provide clear and comprehensive information that includes 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.<br><br>Review of the data contained within these reports resulted in the same concerns noted previously.<br>▪ Opportunities for the skill to occur were significantly limited.<br>▪ Measures were not included to ensure that training programs were implemented with a high degree of integrity.<br>▪ Materials were not always available for the completion of the training program.<br>▪ Some objectives had been initiated several years earlier, yet it appeared that no changes had been made to the teaching program to address slow or limited progress.<br>▪ Data was often missing, in some cases due to an absence of training documentation sheets.<br>▪ Several individuals exhibited frequent refusal to participate in a training program, yet this did not appear to trigger a review of the program.<br>▪ Occasionally steps in a training program were suddenly changed without an apparent review of the individual's progress or lack thereof.<br><br>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 with 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. | |

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| | | Engagement Measures<br>As reported previously, measures of engagement or Planned Activity Checks (PLACHECKS) were collected during the first four days of the Monitoring Team's visit. PLACHECKS were collected in residences, activity centers, and workshop areas. The following summarizes the results:<br>▪ Thirty-five PLACHECKS were collected in the residences. The percentage of individuals actively engaged ranged from 0% to 100%, with a mean of 40% engagement.<br>▪ Nineteen PLACHECKS were collected across the activity centers. The range of engagement was 0% to 100%, with a mean of 13.6% of individuals engaged.<br>▪ In the workshops, eight PLACHECKS were collected. As has been reported previously, the workshop areas reflected the highest levels of active engagement, with a range of 29% to 100%, and a mean of 83.4% engagement.<br><br>The concerns noted previously remained relevant. In the residences, individuals were frequently observed without materials that offered varied and age-appropriate activities. Staffing patterns in the residences often prohibited habilitation training or active treatment, because too few staff were present to attend to and teach too many individuals (e.g., a ratio of 3:20). The following provides some examples of observations made:<br>▪ During a morning visit to one residence, the majority of the individuals were observed sitting or lying on the floor with little attempt made to find a more appropriate or comfortable seating arrangement.<br>▪ During an observation later in the day, another individual entered his residence without shoes on his feet and with his hand in his pants. No attempt was made to find him shoes or to engage him in a more appropriate activity.<br>▪ Individual #123 was again observed in his bedroom, wrapped in a sheet on his bed, with his clothing on the floor. When staff were asked how often he was checked, the Monitoring Team was told every 15 minutes. The staff member could not report where these checks were documented. The document provided at a later time indicated that checks were conducted every half hour.<br>▪ Individual #246 was again observed outside of his residence in the dirt, in spite of temperatures that exceeded 100 degrees.<br>▪ In one residence, a television played as two individuals manipulated objects that also produced sounds. This created a very chaotic and loud environment with no apparent attention given to individual preferences.<br>▪ On only two occasions were individuals observed participating in meal preparation activities. In one residence, two individuals were helping to set the tables. In another residence, a staff member was guiding the individuals to serve themselves food and drink, and to apply condiments to food where appropriate. | |

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| | | Engagement in the activity centers was noticeably more limited than during the last visit. The following provides examples of these observations:<br>▪ Groups of individuals were observed seated with nothing to do.<br>▪ One individual was standing as a staff member played maracas and sang.<br>▪ In another setting, staff played a game of UNO as individuals sat idly around a table.<br>▪ On at least four occasions, groups of individuals were observed seated in their wheelchairs in Snoozelen rooms. There was no attempt made to engage these individuals in operating CD players, visual displays, or other materials used to provide sensory stimulation. In fact, these individuals were simply sitting.<br>▪ One incident observed and reported to supervisory staff was an interaction between a staff member and Individual #156. The individual was being allowed to move the staff member's hand so that it approximated the staff member slapping himself in the face. The staff member was stating: "Don't hit myself, I think I've learned my lesson," as the individual laughed. Clearly the staff member was engaging in what he thought was a humorous game, but which certainly was inappropriate particularly because this individual had a behavior support plan designed to enhance pro social behavior.<br>▪ Activity Center 6700 contained a variety of age-appropriate games, exercise machines, and music equipment. The Monitoring Team was informed that the individuals served also had grown a garden and were learning to make recipes that included their produce. While this center reflected an improvement in age-appropriate and varied activities, it was regrettable that visits to this center were made when no individuals were present.<br><br>The workshops remained areas where engagement was consistently better. The work remained limited with the majority of individuals sorting, folding, or stacking laundry. A few other individuals were shredding. The Vocational Services Director did report an expansion of jobs on campus, with one individual making copies of needed training documents, another taking new employee identification photos, and one other helping the maintenance staff in the morning with grounds work. A pilot project was being introduced with one residence that would allow the individuals to attend a workshop in the early evening, because this appeared to be a preferred time to work. Staff should continue to explore a broader range of vocational opportunities that address the specific needs and interests of the individuals served.<br><br>The Monitoring Team was asked to review a proposed monitoring tool for measuring engagement. The directions indicated that the group of individuals should be observed for three minutes, following which data regarding engagement was to be recorded. PLACHECK data found in the literature typically describes the use of a momentary time sample in which the individuals in the group are observed at a specific moment (often | |

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<tr><td></td><td></td><td>the end) of a prescribed interval of time. By extending the observation of the group to three minutes, the recording of engagement becomes less clear. For example, if an individual is engaged for one minute, but then off task for two, how is engagement scored. It would be advisable to follow the guidelines for a momentary time sample, while gathering more frequent, repeated measures of engagement during one observation. While the instructions offered some good descriptors of engagement, staff should not to score engagement based upon staff behavior (e.g., “staff attempts to engage the person in an activity”). It also would be helpful to describe appropriate engagement while “waiting for a turn.” Criteria might include awake and orientated towards the activity, and the absence of stereotypic responding. The second part of this form listed 12 standards regarding materials and staff interactions. Each of these standards should be described in sufficient detail to ensure inter-observer agreement. For example:<ul><li>Material availability must be sufficient for the number of individuals present;</li><li>An environment conducive to learning should be described and might differ depending upon the activity and the individual;</li><li>Staff were expected to interrupt and redirect “maladaptive” behavior, yet this might not be what is described in the individual’s behavior support plan; and</li><li>Staff were advised to provide positive reinforcement, yet due to the individual specific nature of reinforcers, this might more clearly be referencing praise or positive verbal feedback.</li></ul>Staff should revise this form to ensure that engagement measures utilize a momentary time sample, the definition of engagement is clear and comprehensive, the standards in part II are clearly described, and finally, that constructive feedback can be provided immediately to the staff.</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 13 individuals. Four of these assessments were not dated. The Facility indicated that a PALS or other assessment of adaptive behavior was not available for Individual #405. 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 were relevant for the individuals served at ABSSLC. The table below provides a summary of the specific skill areas assessed for each of the 13 identified individuals:<table><tr><th>Skill Areas</th><th>Individuals</th></tr><tr><td>Self-determination</td><td>Individual #300</td></tr><tr><td>Dressing</td><td>Individual #228, and Individual #533</td></tr><tr><td>Undressing</td><td>Individual #228</td></tr></table></td><td>Noncompliance</td></tr>
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| Grooming | Individual #387, and Individual #533 |
| Bathing | Individual #387, Individual #424, Individual #478, Individual #425, and Individual #187 |
| Shaving | Individual #61, and Individual #425 |
| Toileting | Individual #387, and Individual #187 |
| Menstrual Care | Individual #376 |
| Dental Hygiene | Individual #387, Individual #424, Individual #300, Individual #478, Individual #108, and Individual #398 |
| Oral Hygiene with Edentulous Care | Individual #187 |
| Adaptive Equipment Care | Individual #109 |
| Receptive Language | Individual #109 |
| Expressive Language | Individual #387, and Individual #109 |
| Sensory Characteristics | Individual #376 |
| Personal Management | Individual #478, and Individual #108 |
| Social Skills | Individual #300, Individual #187, Individual #533, Individual #109, and Individual #376 |
| Personal Possessions Care | Individual #109 |
| Cleaning and Organization | Individual #300 |
| Laundry/Clothing Care | Individual #61, Individual #425, and Individual #398 |
| Dining Room Skills | Individual #387, Individual #424, Individual #61, Individual #108, and Individual #109 |
| Food Storage and Preparation | Individual #478 |
| Kitchen Skills | Individual #187 |
| Leisure Skills | Individual #478, Individual #228 |
| Leisure Preference | Individual #228, Individual #425, Individual #187, and Individual #376 |
| Money Management and Shopping | Individual #387, Individual #424, Individual #61, Individual #300, Individual #478, Individual #228, Individual #108, Individual #425, Individual #187, Individual #398, Individual #533, Individual #109, and Individual #376 |
| Numbers | Individual #425 |
| Community Leisure | Individual #398 |

The number of skill areas assessed for each individual were as follows:

- Four for Individual #424, Individual #61, Individual #108, Individual #398, and Individual #533;

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| | | ▪ Five for Individual #300, Individual #228, and Individual #376;<br>▪ Six for Individual #478 and Individual #425; and<br>▪ Seven for Individual #387, Individual #187, and Individual #109.<br><br>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.<br><br>In six (46%) of the 13 PALS assessments, the results were briefly summarized with recommended training objectives to address areas of need. The best example of this outcome of the assessment process was evident in the PALS for Individual #478. In the other seven PALS assessments (54%), it was unclear whether the information gained had been used to develop appropriate objectives for habilitation.<br><br>The Facility was introducing a new tool to assess each individual's adaptive behavior across a range of domains. The "Functional Skills Assessment" consisted of 13 broad areas, including: dressing skills, restroom skills, hygiene and grooming, communication, social skills, domestic skills, dining skills, academic skills, leisure, campus/community awareness, telephone skills, adaptive equipment, and community living. The plan was to complete this assessment in full for each of the individuals residing at ABSSLC. Further, to ensure reliability in completion of the assessment, a limited number of staff would be trained on the assessment process. Six Active Treatment Coordinators would be assigned to assess the strengths and needs of the 443 individuals currently living at the Facility. While this was an admirable undertaking, the demands of completing a thorough assessment for, on average, 74 individuals might prove too great a task for this number of staff.<br><br>As planned, the assessor was to note the level of prompting required for the individual to complete each of the identified tasks. While on site, the Monitoring Team made a recommendation to the Facility to simplify this process by restricting the scoring to indicate whether or not the individual could perform the task independently. As independence is the ultimate goal of habilitation, the level of prompting to perform a skill is not relevant. What is relevant is whether the individual can engage in the skill or activity without assistance from another. The type of prompt necessary to teach independence should be addressed in the teaching plan, in which a careful plan should be included for fading of all prompts.<br><br>When employing the results of this assessment to determine goals for the individual, staff should consider the most functional and appropriate outcome for that individual. For | |

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| | | example, early dressing skills assess whether the individual can identify different types of clothing. If the individual cannot perform this skill, it will be more important for him/her to learn to dress independently than to identify clothing. Similarly, it would be wise to consider an individual's ability to make purchases, even with supervision, rather than spending extensive time trying to teach the individual to name various coins and bills. Staff should not focus on what might be considered missing prerequisite skills, but rather consider those identified absent skills that will help the individual become more capable and independent in his/her daily life.<br><br>Seven vocational evaluations were reviewed. The vocational evaluation format included a review of the individual's current work schedule, a list of his/her achievements and/or abilities, recommendations for future vocational services, the date of the individual's behavior support plan (if applicable), and his/her estimated earning for the previous six months. This assessment format was not sufficient to provide teams with the information necessary to develop adequate vocational programs, or ensure that individuals were engaged in meaningful work in as integrated a setting as appropriate to meet their needs.<br><br>In addition, vocational staff should work with the PST when progress is impeded, particularly when the individual consistently refuses to attend work. In the case of Individual #486, his work schedule was reduced to one hour each week due to work refusals. Perhaps collaboration with psychology and other disciplines would have resulted in a better solution to this problem be it in the form of more interesting or preferred work, changes to the work environment, enhanced incentives, or better staff support and training.<br><br>As the Vocational Services Director explained, a new vocational assessment had been identified and will be completed with all individuals residing at ABSSLC. This should offer a more comprehensive profile of the individual's skills and interests, that will in turn, lead to a greater range of work opportunities for those served. | |
| S3 | Within three years of the Effective Date hereof, each Facility shall use the information gained from the assessment and review process to develop, integrate, and revise programs of training, education, and skill acquisition to address each individual's needs. Such programs shall: | | |
| | (a) Include interventions, | As noted above with regard to Section S.1 of the Settlement Agreement, the assessment | Noncompliance |

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| | 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 | process remained flawed at the time of the visit. Needed assessments were often not identified in the PSP, full psychological evaluations were quite dated (as discussed with regard to Section K.6), and assessment of adaptive behavior was often incomplete. As a result, it was unclear how assessment information had been used to develop meaningful goals and objectives. The result was habilitation programs that were quite limited in scope. Skill acquisition programs remained poorly written with limited understanding of the observable and measureable behavior the individual was expected to learn, the conditions under which learning was to occur, and the criteria used to determine skill acquisition. Opportunities for instruction remained severely limited, reinforcement for correct responding was not individualized, and there were no plans for ensuring maintenance and generalization of the newly learned skill. This component of the Settlement Agreement requires that assessment information be used to develop, integrate, and revise programs to address the individual's needs. These identified deficiencies will need to be corrected for the Facility to comply with the Settlement Agreement.<br><br>Actual teaching of skills was not observed during the review of the Facility. A review of the activities observed among individuals residing at ABSSLC was provided above in regard to Section S.1. It remained that many of the activities observed were limited in variety, were often not age-appropriate, and were not functional for the individual. Rather than providing truly individualized services that would lead to greater independence and expansion of one's abilities, group activities were often the norm.<br><br>Based upon a review of work assignments, 148 of the 443 individuals (33%) residing at ABSSLC were employed. The majority of these individuals (109, or 74%) were restricted to working in one or more of the three workshops. This work consisted primarily of sorting, folding, or bundling different laundry items. Hours of work ranged from a low of half an hour per week, to a high of 31.25 hours per week.<br><br>As noted in the past, it is essential that consideration be given to the Principle of Normalization or Social Role Valorization when considering an individual's access to integrated settings. This should be applied when considering acceptable public behaviors, age-appropriate activities, work/learning/home/recreational environments, and appearance. While touring the Facility, individuals were observed wearing poorly fitting clothing or presenting with inadequate hygiene, engaging in behaviors that would not be acceptable among individuals without disabilities, and being encouraged to engage in activities that were developed for very young children. As just a few examples, Individual #444 was observed wearing a shirt with his nametag sewn to the outside of the front collar. Individual #409 was observed exiting her school bus with her belongings in a plastic bag on which the words "Patient's Belongings" were written. These conditions will severely limit the individual's ability to integrate within the greater | |

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| | | community, and were not "practical and functional in the most integrated setting consistent with the individual's needs." | |
| | (b) Include to the degree practicable training opportunities in community settings. | The Facility provided a list of the number of individuals who had attended at least one off-campus activity between the months of January and June of 2011. Access to the community is essential, however, 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.<br><br>Of the 41 PSPs and 149 Training Documentation Reports reviewed, none (0%) specified training in the community. When a request was made for a list of training activities that had occurred in the community during the previous six months, the Facility responded that such a list was not available. As the new PSP process is implemented, it will be important to examine solutions to barriers to inclusion in the community and expand individuals' opportunities to learn new skills in environments outside of ABSSLC. | Noncompliance |

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

1. As the Personal Support Plan is the guiding document to ensure adequate habilitation services, it is essential that this be based on comprehensive and current assessment. The Personal Focus Assessment should be completed to ensure that the individual's strengths, preferences, and needs are clearly identified. (Section S.1 and S.2).
2. The Facility should implement its new functional skills and vocational assessments. (Section S.1 and S.2).
3. Skills identified for training following comprehensive assessment should be functional, age-appropriate, and matched to the individual's preferences. Skill development should span a range of adaptive behavior domains, including self-care skills, communication skills, social skills, domestic skills, leisure skills, academic skills, vocational skills, and community skills. (Section S.1).
4. 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. (Section S.1 and Section S.3).
5. 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, incorporating the results of formal preference assessments;
    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. (Section S.1).

6. Staff should be provided ongoing competency-based training to ensure their understanding and application of all training programs. (Section S.1)
7. All data collected on skill acquisition programs should be presented graphically, and reviewed at a minimum of once a month. This would allow for ongoing monitoring with program revisions completed in a timely manner. (Section S.1).
8. 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. (Section S.1, Section S.2, and Section S.3).
9. A plan should be developed to ensure inter-observer agreement measures are collected on all skill acquisition programs. (Section S.1).
10. The Facility should expand its therapeutic services to include orientation and mobility services for those individuals who experience visual impairment. (Section S.1).
11. A system for monitoring and increasing overall engagement rates is strongly recommended. This would afford administrative and support staff the ability to identify areas of need, and would allow for constructive feedback to the staff who provide the day-to-day programming. Recommended changes to the proposed PLACHECK tool include: use of a momentary time sample, inclusion of a clear and comprehensive definition of engagement, descriptors of each additional standard of the environment and staff behavior, and description of a process for constructive feedback to be provided immediately to the staff. (Section S.1)
12. As recommended previously, staff should expand the variety of home, leisure, and vocational activities available to the individuals served. (Section S.1).
13. When employing the results of the new "Functional Skills Assessment" to determine goals for the individual, staff should consider the most functional and appropriate outcome for that individual. Staff should not focus on what might be considered missing prerequisite skills, but rather consider those identified absent skills that will help the individual become more capable and independent in his/her daily life. (Section S.2)
14. 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. (Section S.3).
15. As the Facility's self-assessment process develops, additional guidelines should be provided to ensure the validity of the results, staff responsible for conducting the audits should be trained, and inter-rater reliability established. Once data is collected, it should be analyzed, and used to identify areas in which corrective actions are needed. The Facility's POI should include data related to specific indicators of compliance. (Facility Self-Assessment).

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. (Section S.3)
2. Consideration should be given to reducing the number of individuals residing together in a single residence, and increasing staffing ratios to allow increased opportunities for skill acquisition. (Section S)

| SECTION T: Serving Institutionalized Persons in the Most Integrated Setting Appropriate to Their Needs | |
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| | **Steps Taken to Assess Compliance:** The following activities occurred to assess compliance:<br>▪ **Review of Following Documents**:<br>o DADS Policy Number 018.1, entitled "Most Integrated Setting Practices", dated 3/31/10;<br>o ABSSLC Policy #018.1, entitled "Most Integrated Setting Practices," dated 8/18/11;<br>o Presentation Book for Section T;<br>o List of all individual referred for community placement, undated;<br>o Updated list (at time of onsite review) of individuals referred to the community, undated;<br>o List of individuals requesting community placement with no recommended movement, dated 7/19/11;<br>o Since the last review, list of all individuals who have not been referred solely due to Legally Authorized Representative (LAR) preference, undated;<br>o List of individuals transferred to community, since 2/14/11;<br>o List of individuals who have had a Community Living Discharge Plan (CLDP) developed since the last review, undated;<br>o In response to request for list of individuals discharged pursuant to an alternate discharge, note stating: "No alternative discharges since last visit," undated;<br>o In response to request for a list of individual who have transferred to other SSLCs, note stating: "No transfers from AbSSLC to any other SSLC since Feb.," undated;<br>o Response to request for list of alleged offenders: "No alleged offenders currently residing at ABSSLC," undated;<br>o In response to request for description of how Facility assesses individual for placement: excerpt from State Office policy on Personal Support Plan Process related to Living Options Discussion, dated 7/30/10;<br>o For the last 12 months, list of individuals who have been assessed for placement, date of assessment, and resulting recommendations, undated;<br>o In response to request for list of individuals who have returned from a community placement since 1/1/10: "There have been no community placements returned since 2/14/11";<br>o In response to request for list of all deaths if any that occurred following transition to the community: "There have been no deaths of individuals who have been community placed since 2/14/11";<br>o Community Placement Report, dated 7/21/11;<br>o ABSSLC Tour Activity, dated 7/21/11;<br>o For the last 12 months, list of educational opportunities provided to individuals and families/LARs, undated;<br>o Self-advocacy meeting invitation, agenda, sign-in sheets, and follow-up email for 5/10/11 meeting;<br>o Outline for Community Placement Preferences, Obstacles and Determination of |

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| | Professionals for Placement Training, with sign-in sheets, various dates;<br>o Community Provider Tours, with indication of employees who participated, from February through July 2011;<br>o Active Employee Course Participation Report for Supporting Visions: Personal Support Plan Introduction, from 2/1/11 through 7/21/11;<br>o Maple Street Messenger, dated May/June 2011;<br>o Community Placement Obstacles, dated 7/21/11;<br>o In response to request for analysis of obstacles: "Quarterly reviews of obstacles have not started as of 7/21/2011. Initial plan is for APC to review obstacle data with QA/QI committee on a quarterly basis and develop facility plan at the 4th quarterly review";<br>o In response to request for any Facility-wide needs assessment related to the provision of community services to people with developmental disabilities and obstacles to such placement: "Do not have," undated;<br>o Personal Support Plans (PSPs), Sign-in Sheets, Assessments, Personal Support Plan Addenda, (PSPAs), Personal Focus Assessments (PFAs), and skill acquisition and teaching programs for: Individual #187, Individual #538, Individual #469, Individual #383, Individual #20, Individual #150, Individual #95, Individual #357, Individual #405, Individual #361, Individual #25, and Individual #504;<br>o CLDP, any associated assessments, and most recent PSPs for the following: Individual #357, Individual #438, Individual #130, and Individual #251;<br>o Draft Community Living Discharge Plan for Individual #258, dated 8/25/11, as well as any associated assessments, and most recent PSP;<br>o Since last review, a list of all post-move monitoring visits including the dates for each of the completed visits and due dates for upcoming visits for: a) individuals who transitioned from this Facility and receive post-move monitoring from this Facility; b) individuals who transitioned from this Facility and receive post-move monitoring from another Facility, specifying which Facility; and, c) individuals who transitioned from another sending Facility, specifying Facility, and receive post move monitoring from this Facility;<br>o Pre- and Post-Move Monitoring Checklists for the following individuals: Individual #132, Individual #130, Individual #58, Individual #251, Individual #438; Individual #12; and Individual #357;<br>o Last 10 Section T quality assurance monitoring tools completed by the Admissions Placement Coordinator (APC), and last 10 completed by the QA Department;<br>o In response to request for all individuals who transitioned to the community since the last review, any PSPAs related to the post-move monitoring results, the following: "No information available for this request.<br>▪ **Interviews with**:<br>o Laura Wilford, Admissions/Placement Coordinator;<br>o Kerry Loveland, Post-Move Monitor;<br>o Kristin Wyrick, QDDP Coordinator;<br>o Pat Smith, Quality Assurance Director;<br>o William Whitaker, Program Compliance Monitor; |

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| | o Donnie Wilson, State Office Continuity Services Coordinator; and<br>o Eileen Short, State Office Continuity Services staff member.<br>**Observations of**:<br>o Community Living Discharge Planning Meeting for Individual #258; and<br>o Post-Move Monitoring Visit for Individual #357. |
| | **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 four of the 17 indicators. The only inconsistency between the Facility's and the Monitoring Team's findings was with regard to the Section T.2.a, which relates to post-move monitoring. The Facility found it was in compliance. However, as detailed with regard to this section of the Settlement Agreement, the Monitoring Team identified issues related to both the thoroughness of the reviews, and the follow-up action taken when issues were identified.<br><br>As is described in further detail below with regard to Section T.1.f of the Settlement Agreement, the Admissions Placement Coordinator and the QA Department continued to conduct regular audits utilizing tools that the State Office had modified based on the Monitoring Teams' review tools. Inter-rater reliability had not yet been established, and the Facility had not yet developed adequate instructions for the audit tools. As a result, the data could not be considered reliable or valid.<br><br>The Facility's POI included minimal data from the internal audits. When it was included, it did not consistently address the quality of the supports provided. For example, with regard to Section T.2.a, for which the Facility found itself in compliance, the only data cited related to the timeliness, not the quality of the monitoring.<br><br>The Facility included two action plans in its POI. One was related to the education of individuals and their families/guardians about community options, and the other addressed the identification and analysis of obstacles to community transition. These plans are discussed in further detail below. They were important priorities, but as illustrated in the report that follows, in order to comply with this Section of the Settlement Agreement, other action plans needed to be developed and implemented, particularly with regard to the quality of CLDPs., and the assessments used to develop them. |
| | **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.<br><br>At the time of the review, although assessments prepared for annual PSP meetings had begun to include the assessor's recommendation regarding transition to the community, individuals' PSPs generally did not include a summary or conclusion with regard to the professional team members' determination with regard to whether or not community placement was appropriate. Such recommendations should be |

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| | 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.<br><br>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. No aggregate reports were yet available.<br><br>ABSSLC continued 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. However, concerns continued to be noted with the CLDPs, including:<br>▪ 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.<br>▪ The CLDPs reviewed included essential and non-essential supports. However, it appeared that the Facility continued to be struggling with 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.<br><br>Post-move monitoring had been completed in a timely manner for 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). However, some concerns were noted with the thoroughness and/or completeness of the monitoring for some individuals.<br><br>In addition, the post-move monitoring identified some issues with regard to the provision of services at the community sites. Not all of these items were addressed in a thorough or timely manner. |

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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 | As reported in previous reports, on 3/31/10, DADS issued a revised policy entitled "Most Integrated Setting Practices." 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." | Noncompliance |

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| | 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. | 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.<br><br>With regard to the availability for funding 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.<br><br>At the time of the review, although some of the assessments prepared for annual PSP meetings had begun to include the assessor's recommendation regarding transition to the community (e.g., the OT and PT and/or nursing assessments completed for Individual #361, and Individual #25), individuals' PSPs generally did not include a summary or conclusion with regard to the professional team members' determination with regard to whether or not community placement was appropriate. For three of the 11 PSPs reviewed (27%) (i.e., Individual #538, Individual #469, and Individual 383), teams had documented a determination of the professionals regarding whether or not transition to the community was recommended. However, it did not appear that these teams had used the process that the State had set forth in which each assessor would make a recommendation, and provide a list of supports the individual would need if he/she transitioned to the community. As was discussed at the parties' meeting in June, in addition to assessors providing recommendations in each of their assessments, the determination of the professionals on the team should be documented clearly in the PSP. The professionals' recommendation 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 | Since the last review, the Facility had added a Facility policy entitled "Most Integrated Setting Policies," dated 8/18/11. However, it was anticipated that the State Office was going to issue an updated policy related to Most Integrated Setting in the near future, which likely would require modifications to be made to Facility policies. The three Monitoring Teams submitted comments on the DADS draft policy for the State's consideration. | Noncompliance |

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| | processes. Such policies, procedures, and practices shall require that: | 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. | As noted above with regard to Section F of the Settlement Agreement, ABSSLC had continued to make efforts to improve PSPs. The PSP format included a section entitled the "Optimistic Living Vision for…" This section included discussion regarding the individual's and his/her LAR's awareness of community options, their preferences for a specific living option, obstacles identified by the PST, and the supports and services the individual needed in various areas. A review was conducted of a sample of 12 PSPs. The findings related to this review are discussed below with regard to the two requirements included in this provision, including: 1) the identification in the PSP of 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; and 2) identification of the major obstacles to the individual's movement to the most integrated setting, and identification and implementation of strategies to overcome such obstacles.<br><br><u>Identification in PSPs of Needed Protections, Services, and Supports</u><br>As was discussed with regard to Section F of the Settlement Agreement, individuals' PSPs did not consistently identify all of the protections, services, and supports that needed to be provided to ensure safety and the provision of adequate habilitation. Some of these issues were due to the fact that thorough and adequate assessments were not being completed (e.g., nursing, psychiatry, physical and nutritional management, and communication), services and supports were not being adequately integrated with one another (e.g., psychology and psychiatry, and psychology and dental/medical), and/or adequate plans not being developed to address individuals' preferences, strengths and needs (e.g., nursing, psychiatry, psychology and habilitation, physical and nutritional supports, and communication).<br><br>As has been reiterated since the baseline review, 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 | Noncompliance |

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| | | 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. As is clear from review of recent transitions, when all of the necessary protections, supports, and services are not outlined in the PSP, it is much more difficult to ensure the individual's safe transition.<br><br>Based on a review of 12 PSPs, 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. PBSPs, PNMTs, health care plans, psychiatric treatment plans, communication plans, etc.) continued to result in incomplete PSPs. Previous reports have provided detailed examples of concerns related to PSPs. The Facility is encouraged to review the Monitoring Team's previous reports in relation to Sections F and T of the Settlement Agreement, as well as to critically analyze recent transitions to the community, and identify supports that were missing from PSPs and CLDPs.<br><br><u>Identification of and Plans to Overcome Obstacles to Transition to Community</u><br>As noted above, the PSP format included a section on obstacles identified by the PST. In addition, the State Office has standardized a list of obstacles/barriers to community transition to assist in the analysis of information collected from PSTs throughout the SSLC system. Shortly before the Monitoring Team's visit, the Admissions Placement Coordinator had provided training to PSTs on obstacles, and their identification in PSPs, as well as related action plans.<br><br>In reviewing the sample of 12 PSPs, some obstacles were identified. Of the 12 PSPs reviewed, 11 should have had obstacles defined. The remaining individual had been referred for transition to the community. Of the 11 remaining plans, three (27%) (i.e., Individual #504, Individual #383, and Individual #538) included an adequate list of obstacles. The problems associated with the obstacles in the remaining plans included the following:<br>▪ Many did not conform with the State Office's standardized list (e.g., Individual #187, and Individual #150);<br>▪ Many were not adequately justified (e.g., Individual #361, Individual #538, and Individual #20 not being able to access 24-hour nursing supports in community except in nursing home); | |

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| | | ▪ Some identified the individuals' needs as obstacles, as opposed to supports or services not being available in the community to support such needs (e.g., Individual #405's behavioral and psychological needs, and Individual #187's medical and behavioral problems); and<br>▪ When guardians or individuals objected, adequate inquiry did not occur with regard to specifically what their concerns were (e.g., Individual #187, Individual #383, Individual #20, Individual #150, Individual #361, and Individual #469);<br>▪ At times, the team did not identify any obstacles existed, but the individual was not referred for transition (e.g., Individual #25).<br><br>Moreover, action plans to overcome the obstacles identified generally were not present, and the few that had been developed were not adequate. Of the 11 PSPs, three (27%) (i.e., Individual #504, Individual #383, and Individual #20) included an action plan to overcome obstacles identified. Concerns related to these plans included:<br>▪ They did not address the obstacles identified in an individualized manner. For example, a plan might have been included for an individual to visit a home, but no individualization was included in the plan to address the individual's specific needs or concerns about transition.<br>▪ Other plans only addressed one obstacle when more than one had been identified.<br><br>The Monitoring Team has provided numerous examples in previous reports regarding the concerns related to the identification of obstacles, and the lack of plans to overcome them. The Facility is encouraged to review the previous reports.<br><br>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. | Since the last review, ABSSLC had developed an action plan to address education for individuals and their families/guardians about community options. This had resulted in the Facility adding some new activities to the ones it had been consistently completing. The new activities included:<br>▪ Articles were featured in the last two volumes of the "Maple Street Messenger," ABSSLC's newsletter. The articles nicely described two individuals' transitions to the community, and highlighted some of the positive experiences they had had since moving, including being able to spend more time with their families, working, and enjoying community activities.<br>▪ In May 2011, the Admissions Placement Coordinator had been an invited | Noncompliance |

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| | | speaker at the Self-Advocacy meeting. During the meeting, she described different community options, and fielded a number of different questions from meeting participants.<br>▪ On a quarterly basis, the Admissions Placement Coordinator had begun to attend one of each unit's morning meetings to educate PSTs more about community options, particularly for individuals who had been identified as potential candidates for transition.<br>▪ In response to the need for families to be able to attend a Provider Fair, the Facility was planning to offer a Saturday or Sunday fair in March 2012.<br><br>Some of the activities that ABSSLC had previously completed, and continued to complete included:<br>▪ On 9/23/10, a provider fair was held. Another was planned for this fall.<br>▪ 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.<br>▪ Visits to community group homes and day programs continued to occur on approximately two Fridays per month. Based on documentation between 2/18/11 to 7/15/11, nine such visits occurred. None occurred in April 2011. Approximately 53 individuals from approximately 17 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 options available in the community. ABSSLC is encouraged to continue offering regular visits to community homes and day programs.<br>▪ 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.<br>▪ As noted in previous reports, ABSSLC was fortunate to have a number of staff, including the Admissions Placement Coordinator who had experience working in the community system. This allowed staff to assist in answering questions about the community that individuals, families/LARs, or other staff might have.<br><br>As discussed in previous reports, 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 12 PSPs was reviewed. For nine of these individuals, additional education was indicated. Of the nine plans that identified a need for further education (Individual #25, Individual #361, Individual #405, Individual #150, Individual #20, Individual #383, Individual #469, Individual #538, and Individual #187), none (0%) included an adequate written action plan. Generally, the problems included: | |

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| | | ▪ The narrative of plans often mentioned exposing an individual and/or his/her guardian or family further to community options, but no corresponding action plans were found to ensure this occurred (e.g., Individual #187, Individual #405, Individual #361, Individual #25, and Individual #150).<br>▪ Obstacles listed included the individual and/or guardian resistance. However, the reasons for this were not explored, and, as a result, no actions were developed to individualize information provided to attempt to specifically address guardian concerns (e.g., Individual #469, and Individual #383).<br>▪ Even when specific concerns related to an individual or guardian's resistance were noted, and an action plan developed to provide further education, the action plan was not individualized to address the stated concerns (e.g., Individual #20).<br><br>The Facility is encouraged to continue offering a variety of educational options to individuals and families, as well as its efforts to expand these options to creatively meet the needs of various individuals and guardians. For example, it was very positive that as individuals successfully transitioned to community settings, with their and their guardians' permission, newsletter articles had begun to highlight such success stories. The Facility staff are commended for these efforts, and encouraged to continue them. In addition, as has been recommended previously, efforts could be made for individuals from the Facility to visit their peers 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.<br><br>The Facility was continuing to complete some of the basic activities related to education, and had begun to creatively implement other options. The Facility is encouraged to continue to expand these options. The area in which particular focus was needed in order for compliance to be achieved, was with regard to individualizing the process, particularly through action plans included in individuals' PSPs. The Admissions Placement Coordinator, as well as the Post-Move Monitor, who have knowledge about community programs and successful transitions should play a key role in working with teams to individualize these action plans. The individualization of this process is key to ensuring that individuals and their guardians have been provided education that allows them to make an informed choice, as required by the Settlement Agreement. | |
| | 3. Within eighteen months of the Effective Date, each Facility shall assess at least fifty percent (50%) of | 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 July 2010 through July 2011, of individuals who had annual PSP meetings, the recommendation, if any regarding | Noncompliance |

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| | 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. | a move, the individual's preference and the LAR/Primary Correspondent/Family's preference. 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 copy of the Living Options Discussion section of the DADS policy on PSPs.<br><br>As is discussed above with regard to Section T.1.a of the Settlement Agreement, the individuals' PSPs reviewed generally did not document an independent assessment or determination by the professionals on the team of the individuals' appropriateness for transition to the most integrated setting appropriate to meet their needs.<br><br>The Facility had begun to implement the State Office's plan to have each professional member of the PST document his/her recommendation regarding the individual's ability to transition to the community in the assessments completed prior to annual PSP meetings. These assessments also were to identify supports that the individual would need in a community setting. As noted earlier, a few of the assessments for some of the PSPs reviewed included recommendations related to community transition.<br><br>As was discussed at the parties' meeting in June, in addition to assessors providing recommendations in each of their assessments, the determination of the professionals on the team should be documented clearly in the PSP. It was early in the implementation of this new process, and, as would be expected, the PSPs reviewed did not yet include such documentation. Based on discussions with staff, this new initiative had been communicated to PST staff. It was anticipated that for PSP meetings held beginning on August 1, 2011, these summary statements would be included. | |
| 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: | At the time of the last review, the Facility had just begun to implement the revised CLDP process. Although progress had been made, the CLDPs continued to need significant improvement.<br><br>In the previous compliance report, the Monitoring Team made a number of recommendations regarding the revised CLDP format. Based on discussions with Facility and State Office staff, it appeared that the State Office, working in conjunction with the SSLCs, was in the process of making additional changes to the format. The recommendations previously made will not be repeated here, but can be referenced in the last report.<br><br>Community Living Discharge Plans were reviewed for four of the five individuals who had transitioned from the Facility to the community since the Monitoring Team's last onsite review, representing 80% of this group of individuals. The Monitoring Team's pre-review document request asked for copies of any CLDPs developed between the time | Noncompliance |

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| | | of the initial document request and the onsite review. However, the fifth CLDP was not provided. The CLDPs reviewed were for Individual #357, Individual #438, Individual #130, and Individual #251. In addition, a member of the Monitoring Team observed a planning meeting related to Individual #258's transition, and reviewed a draft of his CLDP.<br><br>With regard to the timeliness of the Community Living Discharge Plans, all four (100%) included documentation to show that they were developed sufficiently prior to the individual's transition. This was determined based on the narrative, and the information included in the CLDP regarding the team's deliberations and discussions, for example, regarding essential supports. Based on this information, it appeared the four individuals' planning had occurred over a sufficient period of time. As noted previously, 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. Documentation, either in the CLDPs or in PSPAs, also should be maintained to show the details of the ongoing development of the CLDPs between the time of referral and the individual's transition.<br><br>With regard to the timeliness of the development of CLDPs, the Facility had made significant progress. However, as is detailed in further detail below, the Facility was not yet in compliance with developing and implementing adequate 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. However, none of the four plans reviewed (0%) clearly identified a comprehensive set of specific and measurable steps that Facility staff would take to ensure a smooth and safe transition, and when such steps were identified, they often were not sufficiently detailed or measurable. Some examples of the general concerns noted across all plans included:<br>▪ Many of the plans identified the need for training for community provider staff. However, none of them defined which community provider staff needed to complete the training (e.g., direct support professionals, management staff, clinicians, day and vocational staff, etc.), and/or what level of mastery of the information was required (e.g., demonstration of competence).<br>▪ Plans also did not specify the method of training, for example, if it would be necessary for community provider staff to shadow ABSSLC staff, and/or show competency in actually implementing a plan, such as a PBSP, PNMP, etc. For some individuals, specific components of their PSPs should be targeted for more intensive training of community provider staff prior to the individual's transition (i.e., an essential support), or, at a minimum, evidence that the community provider staff have the competencies necessary to safely support the individual.<br>▪ Missing from all of the plans was any requirement that collaboration occur between the Facility clinicians currently working with the individual and the | Noncompliance |

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| | | community clinicians who would assume responsibility for supporting the individual (e.g., medical staff, nurses, therapists, psychologists, etc.). For many individuals, this would be necessary to ensure ongoing coordination of care.<br>▪ Similarly, no coordination was specified as needing to occur between current and future residential or day/vocational staff.<br>▪ None of the plans described ABSSLC's staff's involvement in evaluating potential sites at which individuals would be served (e.g., Habilitation Therapies staff to ensure adequate accessibility and/or equipment, Behavioral Services Department staff to determine if safety issues could be addressed in specific settings, and/or if modifications needed to be made to existing plans to address changes in environment).<br>▪ None of the plans addressed any role that ABSSLC staff or community provider staff might play in assisting the individual to make the transition. For example, there appeared to be no consideration about the need for ABSSLC staff to follow the individual into the community for any period of time (e.g., the first day or longer), or to check in by telephone or in-person on occasion. Likewise, no action steps were provided in any of the CLDPs for community provider staff to visit the individual at ABSSLC. Different individuals have different reactions to transitions. However, teams should be cognizant of the stress that transition can cause, and should build mechanisms into CLDPs to reduce this to the extent possible.<br><br>As is described in further detail in the section of this report that addresses Section T.1.e of the Settlement Agreement, the CLDPs also did not consistently identify the essential supports required by the individuals. The Facility remained out of compliance with this provision. | |
| | 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 provided at the new setting. | Based on review of four CLDPs, three (75%) included documentation that the plans had been reviewed with the individual and/or the LAR, as appropriate. The CLDP for Individual #438 did not include the guardian's signature on the sign-in sheet. However, this appeared to be a documentation issue. A member of the Monitoring Team had observed this meeting, and the mother/guardian participated. The Facility was found to be in substantial compliance with this provision.<br><br>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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| | | 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. | This requirement of the Settlement Agreement includes two components, including the timeliness of assessments (i.e., within 45 days of the individual leaving the Facility), and the comprehensive nature of the assessment. Although the Facility had made progress with regard to obtaining timely assessments, the quality (i.e., comprehensiveness) of the assessments was significantly lacking.<br><br>As noted in the previous report, it appeared that a process had been put in place to improve compliance with the timeliness of assessments. 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 all four of the individuals' CLDPs reviewed, it appeared that assessments had been updated within the 45-day timeframe.<br><br>However, the quality of these assessments was lacking. None of the four CLDPs reviewed (0%) were based on adequate assessments. In particular:<br>▪ Most of the assessment formats were not designed to provide a summary of relevant facts related to individuals' stays at the Facility. Although it is understandable that an individual's full history cannot be included in a discharge summary, it is important that the Facility provide community providers with a summary of, for example, treatments or plans that have particularly successful or unsuccessful, and important milestones during the individual's stay at the Facility.<br>▪ In addition, assessments frequently were inadequate to assist teams in developing a comprehensive list of protections, supports, and services in a community setting. They did not describe or recommend the protections, treatments, and supports that needed to be provided (e.g., implementation of plans, staffing supports, training for staff, specific staff qualifications, etc.), and/or the specific clinical supports required (i.e., qualifications of clinical staff, the frequency and level of their involvement, etc.).<br>▪ Moreover, assessments did not identify supports that might need to be provided differently or modified in a community setting, and/or make specific recommendations about how to account for these differences. For example, nursing assessments for individuals who had nursing care/health management plans at the Facility did not include recommendations about their continuation and/or any modifications that needed to be made to accommodate community | Noncompliance |

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| | | settings that might not have nurses available at all times. Similarly, psychology/behavioral assessments did not identify differences (e.g., environmental, staffing, training of staff on protective holds, etc.) that could impact the implementation of the PBSP in place at the Facility, and/or make recommendations about needed modifications. These provide a few examples, but this was a pervasive problem across all assessments.<br>▪ In addition to specific issues related to transition, as is discussed in other sections of this report, the underlying assessments were not of adequate quality.<br>▪ Finally, as has been recommended in previous reports, 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.<br><br>The Facility remained out of compliance with this provision of the Settlement Agreement. A focus on improving the quality of assessment is necessary. | |
| 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. | The CLDPs reviewed included essential and non-essential supports. Although progress definitely was being made, the Facility continued to struggle with this process. On a positive note, efforts were underway to improve PSPs to more effectively describe individuals' needs for supports, and define how such supports were to be provided at the Facility. If done correctly, this should greatly assist teams when it is time to plan for an individual's transition to the community. Given the current inadequacies of PSPs, teams had to identify these supports after the individual was referred for transition, which made it more difficult due to the generally short timeframes from referral to transition.<br><br>At the time of the current review, 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. Moreover, the plans did not consistently identify preferences of the individuals that might affect the success of the transition. This made it difficult to ensure individuals' successful transitions, and for thorough and meaningful monitoring to occur prior to and after the individual's transition to the community. Likewise, teams did not consistently identify non-essential supports or do so in measurable ways.<br><br>In none of the four plans reviewed (0%) was a comprehensive set of essential and non-essential supports identified in measurable terms. The Monitoring Team has provided many examples of concerns in previous reports. The following summarizes the general | Noncompliance |

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| | | concerns noted:<br>▪ Generally, teams were not visualizing the individual with no supports at all, and then identifying each and every support that was needed to assist the individual to be successful in a particular community environment(s). Due to the current inadequacies of the PSPs, teams needed to start at the beginning, and describe the full array of supports the individual needed and wanted. Once these were listed, the CLDP needed to identify how they would be provided in the community, by whom, when, with what frequency, and for how long. This could only be accomplished by reviewing current assessments, which, as noted above, were inadequate, and then asking each team member what they did for the individual hourly, daily, weekly, monthly, quarterly, and annually. Based on this knowledge, the foundation for the CLDP could be built.<br>▪ Although some clinical services (e.g., psychology/behavior, psychiatry, therapy, etc.) were sometimes now referenced in the CLDPs, the intensity of the supports was not identified, nor were the qualifications or the roles of clinicians clearly defined. Supports defined as "psychologist will review BSP," or "dental services" were inadequate. Teams were not clearly identifying what these supports entailed for the individual at ABSSLC, and then defining in the CLDP how functionally equivalent supports could be provided in the community.<br>▪ In addition, many clinical supports that ABSSLC was providing, based on assessment information, were not included in the CLDPs, and no justification was provided for not identifying a functionally equivalent support. For example, nursing care/health management plans often were not referenced in CLDPs. Likewise, for individuals with weight issues, dietary supports that ABSSLC was providing were not included in CLDPs as required supports.<br>▪ In removing any support that the individual utilized at the Facility from the array of supports that would be provided in the community, teams should justify why the support is not needed in the community. For example, for one individual, the PNMP was discontinued "because can't be carried out in community," but no substitution for the PNMP was identified, and adequate justification was not provided for discontinuing it.<br>▪ Teams were not factoring in modifications that needed to be made to current programs or plans, and writing this into the essential or nonessential supports. For example, when an individual has to begin consistently attending a day/vocational program, when this has not been the expectation at the Facility, the team should consider steps to take prior to the individuals' transition (i.e., increasing expectations at the Facility), as well as any modifications to the PBSP or other treatment programs for implementation once the individual transitions to the community.<br>▪ Often plans required that community staff be trained on existing plans. As noted above, concerns existed with regard to the lack of expectations for the quality or | |

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| | | outcomes of this training.<br>▪ Although some improvements had been seen, particularly with regard to PBSPs, few plans identified an essential or nonessential support for other plans to be implemented (e.g., nursing care plans, health management plans, PNMPs, diets, exercise programs, etc.).<br>▪ Many of the individuals reviewed had specific health care indicators that needed to be monitored and reported (e.g., constipation, input/output, seizures, weight, meal refusals, psychiatric symptoms, etc.). However, few, if any supports were included in the CLDPs to ensure that specific staff were responsible for monitoring such indicators, and when specific criteria were met, reporting these to health care staff.<br>▪ None of the plans identified crisis intervention plans, and/or how the current methods for dealing with crises at the Facility needed to be modified in a community setting.<br>▪ Direct support staffing ratios and requirements were sometimes, but not always specified. When they were specified, they often did not provide specific guidance regarding the individual's staffing requirements. For example, "24-hour awake staff" was not helpful in ensuring the individual who was the subject of the transition plan received adequate staffing supports. Depending on the ratio and other staff responsibilities, "24-hour awake" staffing in no way guarantees that the individual will remain safe, and be adequately supervised. In specifying staffing supports, teams should identify specifically the individual's staffing needs in relation to others supported in the home or day/vocational program (e.g., if an individual requires line-of-sight supervision, and other individuals live in the home, the team should consider this in describing an appropriate ratio), as well as in different situations (e.g., in the home, in the community, at a day or work site, at night, etc.), as well as the qualifications of staff (e.g., specific training requirements for staff, competencies or certifications needed, etc.).<br>▪ In reviewing assessments, albeit incomplete, many recommendations were not specifically addressed in CLDPs (e.g., SPL, and OT/PT therapy recommendations, adherence to weight reduction programs, etc.).<br>▪ Generally, day and vocational supports were not well defined.<br>▪ Supports that needed to be provided across day and vocational programs, as well as residential programs (e.g., nursing, psychology, therapy, etc.) generally were not included as part of the day/vocational component.<br>▪ Issues continued to be noted with regard to the measurability of supports identified. Although this had improved significantly, the issue was not completely resolved.<br><br>It should be noted that the CLDPs were showing some improvements. After each of the | |

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| | | Monitoring Team's reviews, it was clear that efforts were made to better define essential and nonessential supports. This was evidenced in the meeting for Individual #258 that a member of the Monitoring Team observed. The team attempted to break down the individuals' needs, how those needs were met at the Facility, and what supports needed to be provided in the community. However, although the team identified a number of supports that needed to be added to the draft CLDP, the resulting document did not adequately set forth the full array of protections, supports, and services that Individual #258 required. Many of the items listed above as concerns related to other CLDPs also applied to Individual #258's plan (e.g., lack of definition of ABSSLC's therapists' role in evaluating new environments to ensure his safety; lack of clear criteria for day program, including hours, staffing, expectations with regard to engagement and activities, community integration, as well as clinical supports or oversight that might need to be provided; identification of only some of the clinical indicators that required monitoring and reporting to medical staff should they occur; omission of team's discussion of wheelchair and follow-up needed by provider; insufficient definition of which staff required training and which training required a competency-check of community provider staff; no definition of staffing ratios or requirements; lack of integration of all existing health management plans and/or the full PNMP into required services or provision of justification for not including them; issues related to measurability of supports, particularly when many were included within one support; etc.).<br><br>With regard to Monitoring by the MRA or other means to ensure essential supports were in place prior to an individual's transition, the MRA's review 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 appeared 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.<br><br>However, the Facility had begun to implement the process of having the Post Move Monitor conduct a pre-move site visit designed specifically to determine if the essential supports were in place. A review was conducted of five individuals' pre-move site visit | |

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| | | documentation. Three (60%) appeared thorough, and included each essential support listed in the individual's CLDP. These three identified the evidence that had been reviewed to determine that the essential support was in place. They also appeared to have been completed in a timely manner, generally on the date of the individual's transition. For the remaining two (i.e., Individual #251 and Individual #130), the forms did not appear to have been completed. Answers to questions were missing, and/or day program supports were not reviewed.<br><br>Although the process of having the Post-Move Monitor complete pre-move site visits showed promise, thorough completion of the process is essential. It also should be noted that the process will become more complicated as more essential supports are appropriately identified in individuals' CLDPs.<br><br>Overall, a finding of noncompliance was made for this component of the Settlement Agreement. Although progress was noted with regard to the pre-move confirmation of essential supports, these were not being consistently thoroughly completed. In addition, substantial work was still needed in adequately delineating the essential and non-essential supports in individuals' CLDPs. | |
| 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. | Progress had been made and/or sustained with regard to the implementation of quality assurance processes that identify and remediate problems to ensure that CLDPs are developed and the Facility implements the portions of Section T of the Settlement Agreement for which it is responsible. Positive developments included:<br>▪ At the time of the last review, the Facility had begun using the monitoring tools that had been modified based on the Monitoring Teams' audit tools. At the time of this most recent review, the Facility continued to conduct audits using these tools. The QA Department, as well as the Admissions Placement Coordinator conducted reviews of the Living Options Discussion, CLDPs, and the Post Move Monitoring Process.<br><br>Areas in which continued efforts needed to be made included:<br>▪ As noted above, minimal amounts of the data was being incorporated into the Facility's self-assessment/POI.<br>▪ Inter-rater reliability had not yet been established, nor had the accuracy of the monitoring data. The Facility had recognized this need based on the varied results of the auditing that had been completed thus far. As is discussed with regard to Section E, the procedures being used to establish inter-rater reliability needed modification. It was positive, however, that the QA Department had a plan to meet monthly with the Department staff with one goal being to attempt to resolve discrepancies in monitoring. A standard inter-rater reliability methodology should be used statewide, and focus should be placed on ensuring | Noncompliance |

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| | | that not only were the results of the monitoring similar, but that also they were accurate. In other words, if both auditors were incorrect in their assessment of an indicator, high inter-rater reliability would be present, but the data still would not be valid.<br>▪ As detailed in the Monitoring Team's report on Austin SSLC, dated 7/7/11, the Monitoring Team continues to have concerns about the adequacy of the guidelines provided to reviewers. Efforts to improve these are necessary to ensure accuracy in monitoring as well.<br>▪ As a result of inadequate instructions or criteria for auditing, many of the completed review tools that the Facility submitted for review did not appear to have captured relevant issues, particularly with CLDPs. Many of them found compliance with close to 100 percent of the indicators, which was inconsistent with the Monitoring Team's findings related to CLDPs it reviewed. It is important to note that now that more clear criteria had been established for the obstacle categories that teams could consider, more critical review was seen in this section of the Living Option reviews.<br>▪ Analysis of the data, and development of appropriate corrective action plans had not yet occurred to the extent necessary. The Admissions Placement Coordinator shared an action plan to address Section T.1.g, related to the Facility's obstacles report, but this did not appear to be based on the results of the Facility's own internal auditing. This was an important area in which to focus. However, as identified through the Facility's own monitoring, the Monitoring Team's findings, as well as the concerns identified for individuals who transitioned to the community, corrective action plans needed to be developed to address other areas, including but not limited to the adequate development and implementation of CLDPs.<br><br>Although progress had been made in this area, the Facility was continuing to develop and implement quality assurance processes necessary to assess its implementation of Section T. The Facility should continue to expand its monitoring activities in this area, including modifying, as appropriate, the monitoring tools, particularly to improve the guidance provided to auditors; training staff who will conduct the monitoring on the review tools and their implementation; ensuring the reviews accurately evaluate quality as well as the presence or absence of items; 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 | Although some progress was being made in this area, the State and Facility were still in the beginning stages of implementing this provision of the Settlement Agreement. The | Noncompliance |

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| | identified obstacles to individuals' movement to more integrated settings, consistent with their needs and preferences. On an annual basis, the Facility shall use such information to produce a comprehensive assessment of obstacles and provide this information to DADS and other appropriate agencies. Based on the Facility's comprehensive 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. | Facility had not yet generated an annual report to State Office. The obstacle data ABSSLC submitted to the Monitoring Team was extremely limited. It included data related to 22 individuals who had stated a preference for community transition, but had not been referred. This data showed the obstacles identified for 50 percent of the individuals being LAR choice, 49% being behavior/psychiatric, 23% being medical, nine percent being the MRA was not present at the meeting, and for nine percent, community options were being explored, which did not appear to be an obstacle.<br><br>Progress that had been made included:<br>▪ The State had developed a list of standard obstacles that teams would be asked to utilize. On 5/16/11, the Monitoring Panel provided the State Office with comments on the draft revised Most Integrated Setting policy, including the list of obstacles. In general, though, this list should assist in standardizing the data collected, which in turn should provide the State Office with better information about protections, supports, and services that should be enhanced in the community, as well as concerns that individuals and LARs have regarding transition to the community.<br>▪ ABSSLC had drafted an action plan to address Section T.1.g. It appeared to set forth a reasonable plan for complying with this provision, and the Facility had begun to implement it. For example, the Facility provided documentation of training on the new obstacles categories that the Admissions Placement Coordinator had provided to PST members. Data entry staff also had been trained on entering information gained through PSP and PSPA meetings.<br>▪ The Facility indicated: "Quarterly reviews of obstacle reports have not started as of 7/21/2011. Initial plan is for APC to review obstacle data with QA/QI committee on a quarterly basis and develop facility plan at 4th quarterly review.<br><br>Although ABSSLC remained out of compliance with this provision, activities were underway to achieve compliance. It will be essential for PSTs to be provided ongoing technical assistance on the proper identification of obstacles in order for these efforts to be successful. | |
| 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 | In response to a document request, the Facility submitted to the Monitoring Team a Community Placement Report. For the time period between 2/18/11 and 7/21/11, the report listed:<br>▪ Current Referrals: 12 individuals were included on this list. At the time of the review, one of these individuals had transitioned to the community.<br>▪ Community Placements: Four individuals were included on this list.<br>▪ Rescinded Referrals: Two individuals were included on this list. The reasons for the referrals being rescinded were IDT Decision: "Individual/Family," and "IDT | Substantial Compliance |

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| | ISP process, that they can be appropriately placed in the community and receive community services; and those individuals who have been placed in the community during the previous six months. For the purposes of these Community Placement Reports, community services refers to the full range of services and supports an individual needs to live independently in the community including, but not limited to, medical, housing, employment, and transportation. Community services do not include services 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. | Decision: Other Reasons."<br><br>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. For meetings occurring between 9/1/10 and 7/21/11, the report listed:<br>▪ Individual Prefers Community, Not Referred – LAR Choice: This list included two individuals.<br>▪ Individual Prefers Community, Not Referred – Other Reasons: This list included 10 individuals. However, three of these individuals were either on the list of individuals who had already transitioned, or who had been referred.<br><br>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 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 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 | <u>Timeliness of the Checklists</u><br>Post-move monitoring documentation was reviewed for seven individuals (Individual #12, Individual #58, Individual #438, Individual #251, Individual #130, Individual #357, and Individual #132). For these individuals during the time period reviewed, the ABSSLC Post-Move Monitor should have conducted 14 reviews. Of the 14 required visits, 14 (100%) had been documented as having been completed on time.<br><br>The Facility continued to ensure that visits had been made to both the residential and day sites of the individuals, and that 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 | Noncompliance |

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| | 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. | sometimes noted that a visit had been made to the community provider's office to review paperwork, and/or interview staff.<br><br><u>Content of Checklists</u><br>With regard to the content of the checklists, since the previous review, ABSSLC had begun to use the new format that the State Office had developed for post-move monitoring activities, which had been modified a second time in May 2011. Only one report (i.e., for Individual #132) used the newest format.<br><br>Each of the items on the checklists reviewed had been addressed. Particularly in the reports using the less recent version of the form, efforts clearly were being made to add additional information regarding the interviews conducted, the documents reviewed, and the observations made. However, it should be noted that the newest format (i.e., the May 2011 version) seemed to result in less specific information being provided to demonstrate adequate review of each essential and non-essential support. More specifically, although the seven-day monitoring report for Individual #132 stated what evidence had been reviewed, this generally consisted of a short phrase, such as "viewed tracking sheets for behavior," or "appointment consult form." Some narrative was provided in the "Additional Comments" section, but the narrative did not consistently address each essential and nonessential support and describe the findings of the review. As a result, the thoroughness of the review was difficult to determine. The Facility should add narrative to the "Evidence reviewed to determine supports are in place" column to justify its findings of whether or not each essential and non-essential supports is in place.<br><br>It should be noted that the newest version included a column to identify specifically whether or not the essential or nonessential support had been provided adequately. This was an improvement over the previous form.<br><br>The checklists reviewed generally were completed thoroughly. However, some concerns were noted with regard to ensuring and/or documenting that each essential and non-essential support was in place in a timely manner. More specifically:<br>▪ In other instances, the Post-Move Monitor did not comment on specific supports that should have been in place (e.g., Individual #251's routine supervision was not addressed, nor was follow-up noted on the finding in the 45-day report that the PCP had changed his diet with no reason cited and no specific plan for follow-up, or Individual #130's use of floatation device while swimming due to a seizure disorder;); and<br>▪ At times, a support that was categorized as an "essential support," but was ongoing in nature, was reviewed initially, but not during each of the subsequent reviews. | |

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| | | Use of Facility's Best Efforts to Ensure Supports Are Implemented<br>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. The following summarizes the findings of the review of post-move monitoring documentation:<br>▪ Of the seven individuals reviewed, four of them (57%) had needs identified for follow-up to be conducted to ensure supports were implemented. The individuals who required follow-up activity included: Individual #357, Individual #438, Individual #130, and Individual #58.<br>▪ Of the four individual for whom follow-up was indicated, documentation was present to show that for one individual (25%), adequate follow up had occurred (i.e., Individual #357). It should be noted for this one individual, the follow-up required at her seven-day visit was fairly minimal. During the week of the review, additional follow-up needs were noted at her 45-day review. Because, this was in the process of being completed, a conclusion could not be drawn with regard to its adequacy.<br><br>The following summarizes the general concerns related to the follow-up activities the Facility undertook:<br>▪ In some cases, individuals experienced significantly negative outcomes during their initial 90 days of transition, but the Facility's PSTs either did not taken action to review and address these issues, or the action taken was not timely and/or inadequate (e.g., Individual #58 who had police contact, was banned from a local store, and had left his home without informing staff on a number of occasions; and Individual #130 who had police contact on a community outing, and subsequently was hospitalized in a psychiatric unit).<br>▪ In at least one instance, the expectations set forth in the CLDP were modified, without any documentation that this had been a PST decision, or that adequate justification was present to modify the requirement (i.e., Individual #130's nonessential support that a referral be made to the Department of Assistive and Rehabilitative Services).<br>▪ At times, providers' explanations for failures to provide supports appeared to be accepted without further advocacy to ensure supports were provided timely (e.g., Individual #130 had an active seizure disorder, but provider stated the neurologist only saw their "clients" one day per month; despite significant behavioral issues, Individual #58's provider could not get appointment with psychologist due to lack of Medicaid card and staff then forgot to bring him to appointment when scheduled; although little progress in identifying appropriate job for individual #58, and little follow-up noted by Facility until after 90-day period; and Individual #438's documentation showed little follow-up related to | |

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| | | overdue/missing OT/PT evaluation and ophthalmology appointments)<br>▪ PSPAs were requested related to post-move monitoring activities. At the time of the review, it was the Monitoring Team's understanding that PSTs would review post-move monitoring results, and determine if further action was necessary. In response to this request for documents, the Facility provided a statement reading: "No information available for this request."<br><br>In the Monitoring Team's previous report a finding of substantial compliance was made for this provision. However, as was noted in that report, because CLDPs continued to include minimal requirements, the Post Move Monitor's job was expected to grow exponentially as the CLDPs began to include more of the necessary essential and nonessential supports. As a result, to sustain compliance in this area, considerable effort would be necessary to confirm the existence of these protections, supports, and services, and to take action to correct deficiencies identified. The finding of noncompliance for this provision is reflective of this increase in teams' identification of essential and nonessential supports. As would be expected, the need increased for follow-up to ensure the provision of such supports using the Facility's best efforts. Although reviews generally were thorough, adequate follow-up efforts were not documented. | |
| 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 onsite review, a member of the Monitoring Team accompanied the Post-Move Monitor on a post-move monitoring visit for Individual #357. Also in attendance were the Admissions Placement Coordinator, the Program Compliance Monitor, and the State Office Continuity Services Coordinator.<br><br>The Post-Move Monitor followed the format, asked many good questions, reviewed documentation, and conducted observations. The review for Individual #357 consisted of visits to the individual's day program and home.<br><br>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 at ABSSLC to clarify issues or obtain additional information. For example, the community psychiatrist had written an order for the "as needed" use of a psychotropic medication in gel form. The Post Move Monitor indicated she would follow-up with the SSLC team to obtain their recommendations.<br><br>The Monitoring Team appreciates that the Post Move Monitor quickly completed the report for this review. In reviewing the report, a couple of discrepancies were noted with regard to the Post Move Monitor's findings and the information gained through the onsite review. One issue related to the description of the community provider's concern regarding counseling supports being provided to Individual #357, and the quality of | Noncompliance |

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| | | counseling offered (i.e., play therapy). The Post Move Monitor's write-up focused more on the fact that the counselor was not soliciting the provider's feedback, which also was a stated concern. However, the issues related to quality were not documented. The second issue related to Individual #357's behavior. Specifically, the PMM did not document the discussion about Individual #357's problem with getting to work on time. The significance of these issues not being fully discussed in the report relates to documentation of the thoroughness of the review, as well as the corrective actions that were identified and implemented. For example, given the provider's concerns about the quality of counseling supports, action should have been taken to either confirm the provider's concerns or identify different counseling supports. The fact that Individual #357 said she liked and felt comfortable with her counselor did not substantiate that the counseling services were of adequate quality. Further inquiry and/or action was necessary to confirm the support was in place. Likewise, the ABSSLC team should have reviewed the issues related to timely day program attendance, and made recommendations, as appropriate. | |
| **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-required discharge planning procedures, rather than the provisions of Section T.1(c),(d), and (e), and T.2, for the following | 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." For example, reasons such as a LAR choosing to discharge an individual from the Facility without formal transition planning occurring, or an individual transferring to another SSLC would be considered alternate discharges. These would be situations in which the Facility would be expected to follow the Centers for Medicare and Medicaid (CMS) discharge | Not Rated |

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| | individuals:<br>(a) individuals who move out of state;<br>(b) individuals discharged at the expiration of an emergency admission;<br>(c) individuals discharged at the expiration of an order for protective custody when no commitment hearing was held during the required 20-day timeframe;<br>(d) individuals receiving respite services at the Facility for a maximum period of 60 days;<br>(e) individuals discharged based on a determination subsequent to admission that the individual is not to be eligible for admission;<br>(f) individuals discharged pursuant to a court order vacating the commitment order. | procedures.<br><br>However, since the previous review, there had been no alternate discharges of individuals served by the Facility. As a result of no alternate discharges having occurred, this provision of the Settlement Agreement was not rated. | |

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

1. The professional teams supporting individuals at ABSSLC should independently make recommendations regarding individuals' appropriateness for transition to the most integrated setting, appropriate to meet their needs. Such recommendations should be presented to the entire team, including the individual and LAR, for consideration, and clearly documented in the PSP. 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. (Section T.1.a and T.1.b.3)
2. 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. (Section T.1.b)
3. 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) might be an issue, etc. Such detail is essential to ensuring that the State has the information necessary to make changes. (Section T.1.b.1)

4. 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 Facility and the State. (Section T.1.b.1)
5. As teams begin to better define obstacles to movement, and begin to talk in greater depth about the options available in community settings to meet individuals' specific needs in comparison with services and supports available at the Facility, this discussion should be memorialized in the PSP to document that individuals and their families are making informed decisions with regard to an individual's living options. (Section T.1.b.1)
6. Teams should be provided with training on the development of action plans/strategies to overcome identified barriers. Such training should be competency-based. (Section T.1.b.1)
7. ABSSLC should expand the creative and individualized educational activities to meet the needs of various individuals and families/guardians. The action plan developed should be revised, as needed, to provide an adequate scope of educational activities. (Section T.1.b.2)
8. Particular focus should be placed on improving the action plans in individuals' PSPs to ensure that they are individualized to meet individuals' and guardians' specific needs for education related to community options. The Admissions Placement Coordinator, as well as the Post-Move Monitor, who have knowledge about community programs and successful transitions, should play a key role in working with teams to individualize these action plans. (Section T.1.b.2)
9. 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. (Section T.1.c)
    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. (Section T.1.c.3)
10. Essential and non-essential supports should be better defined in Community Living Discharge Plans. More specifically:
    a. The role of the Facility and community provider staff in the transition and discharge process should be defined better. This should include, but not be limited to defining:
        i. Which community provider staff need to complete which training (e.g., direct support professionals, management staff, clinicians, day and vocational staff, etc.), and/or what level of mastery of the information was required (e.g., demonstration of competence);
        ii. The method of training, for example, if it would be necessary for community provider staff to shadow ABSSLC staff, and/or show competency in actually implementing a plan, such as a PBSP, PNMP, etc. For some individuals, specific components of their PSPs should be targeted for more intensive training of community provider staff prior to the individual's transition (i.e., an essential support), or, at a minimum, evidence that the community provider staff have the competencies necessary to safely support the individual;
        iii. Collaboration between the Facility clinicians currently working with the individual and the community clinicians who will assume responsibility for supporting the individual (e.g., medical staff, nurses, therapists, psychologists, etc.);
        iv. Coordination between current and future residential or day/vocational staff;
        v. ABSSLC's staff's involvement in evaluating potential sites at which individuals would be served (e.g., Habilitation Therapies staff to ensure adequate accessibility and/or equipment, Behavioral Services Department staff to determine if safety issues could be addressed in specific settings, and/or if modifications needed to be made to existing plans to address changes in environment); and

vi. The role ABSSLC staff or community provider staff might play in assisting the individual to make the transition;

b. Due to the current inadequacies of the PSPs, teams should start at the beginning, and describe the full array of supports the individual needs and prefers. Once these are listed, the CLDPs should identify how the necessary supports will be provided in the community, by whom, when, with what frequency, and for how long. This can be accomplished by reviewing current assessments, which, as noted above, were inadequate, and then asking each team member what they do for the individual hourly, daily, weekly, monthly, quarterly, and annually. Based on this knowledge, the foundation for the CLDP could be built;
c. With regard to clinical services, the CLDPs should define the intensity of the supports, as well as the qualifications, and the roles of clinicians;
d. Clinical supports that ABSSLC is providing should be included in the CLDPs, or adequate justification for not identifying a functionally equivalent support should be documented in the CLDP;
e. In removing any support that the individual utilized at the Facility from the array of supports that will be provided in the community, teams should justify why the support is not needed in the community;
f. Teams should factor in modifications that needed to be made to current programs or plans, and writing such modifications into the essential or nonessential supports;
g. As appropriate, teams should identify as an essential or nonessential support the implementation of current plans (e.g., nursing care plans, health management plans, PNMPs, diets, exercise programs, etc.). As necessary, modifications might need to be made to the methodology for providing these supports, with the end result being the individual's need for the support being met;
h. For individuals who have specific health care indicators that require monitoring (e.g., seizures, weight, aspiration triggers, etc.), team should include supports in the CLDPs to ensure that specific staff are responsible for monitoring such indicators, and when specific criteria were met, reporting these to health care staff;
i. As appropriate, crisis intervention plans should be developed, and/or essential and non-essential supports should define how the current methods for dealing with crises at the Facility should be modified in a community setting;
j. Direct support staffing ratios and requirements should be specified. In specifying staffing supports, teams should identify specifically the individual's staffing needs in relation to others supported in the home or day/vocational program (e.g., if an individual requires line-of-sight supervision, and other individuals live in the home, the team should consider this in describing an appropriate ratio), as well as in different situations (e.g., in the home, in the community, at a day or work site, at night, etc.), as well as the qualifications of staff (e.g., specific training requirements for staff, competencies or certifications needed, etc.);
k. Recommendations in assessments should be addressed specifically in CLDPs (e.g., SPL, and OT/PT therapy recommendations, adherence to weight reduction programs, etc.), and justification provided for any recommendation not included as an essential or non-essential support;
l. As recommended previously, 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;
m. 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. Supports that need to be provided across day and vocational programs, as well as residential programs (e.g., nursing, psychology, therapy, etc.) should included as part of the day/vocational component; and
n. Focused effort should be placed on ensuring each of the supports identified is measurable. (Sections T.1.c.1 and T.1.e)

11. In addition to addressing recommendations related to assessments in other sections of this report to improve the overall quality of assessments used in developing CLDPs, modifications should be made to assessments to:
    a. Provide a summary of relevant facts related to individuals' stays at the Facility. Although it is understandable that an individual's

full history cannot be included in a discharge summary, it is important that the Facility provide community providers with a summary of, for example, treatments or plans that have particularly successful or unsuccessful, and important milestones during the individual's stay at the Facility;

b. Assist teams in developing a comprehensive list of protections, supports, and services in a community setting. Assessments should describe or recommend the protections, treatments, and supports that an individual requires (e.g., implementation of plans, staffing supports, training for staff, specific staff qualifications, etc.), as well as the specific clinical supports required (i.e., qualifications of clinical staff, the frequency and level of their involvement, etc.); and

c. Identify supports that might need to be provided differently or modified in a community setting, and/or make specific recommendations about how to account for these differences. (Section T.1.d)

12. 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. (Section T.1.d)
13. With regard to monitoring activities related to the Facility's performance with this section of the Settlement Agreement, the Facility should:
    a. Modify, as appropriate, the monitoring tools, particularly to improve the guidance provided to auditors;
    b. Provide staff responsible for conducting audits with competency-based training;
    c. Ensure the reviews accurately evaluate quality as well as the presence or absence of items;
    d. Establish inter-rater reliability; and
    e. 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. (Section T.1.f)
14. The action plans that are part of post-move monitoring checklists should be focused on resolving the issues identified. Whenever appropriate, PSTs should identify actions necessary to resolve issues related to the essential and nonessential supports provided to individuals who have transitioned to the community. The PSTs' decisions and activities should be documented through to completion. (Section T.2.a)
15. Staff responsible for the completion of post-move monitoring activities should complete competency-based training on the completion of monitoring reviews, including the methodology, proper documentation, and the development and implementation of action plans to address issues identified. (Section T.2.a)
16. The Facility should improve the standards used to monitor, including consistently holding community providers accountable for the provision of these supports. When a community team makes the decision to revise the protections, supports, and services the Facility team had determined to be necessary, there should be full review by the Facility PST, and justification if an element of the CLDP is modified. If there is not adequate justification, then the Facility should use its best efforts to ensure such supports are implemented. (Section T.2)
17. As has been recommended in previous reports, 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. (Section T.2.a)
18. As the Facility expands its self-assessment activities, the POI should include the results of data analysis to substantiate the Facility's findings of noncompliance or substantial compliance. The POI also should indicate how the Facility has used this data to identify problematic trends, and develop corresponding corrective actions. (Facility Self-Assessment)

| SECTION U: Consent | |
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| | **Steps Taken to Assess Compliance:** The following activities occurred to assess compliance:<br>▪ **Review of Following Documents**:<br>o Presentation Book for Section U;<br>o Draft DADS Policy #019: Guardianship/Advocate, undated;<br>o Announcement, agenda, and minutes for Self Advocates meetings on 2/8/11, 3/8/11, 4/12/11, 5/10/11, and 7/12/11;<br>o Response to record request for any State or Facilities policies, procedures, and/or other documents regarding consent and/or the identification of legally authorized representatives (LARs): "ABSSLC does not have a current policy regarding consent";<br>o ABSSLC Policy: Guardianship, dated 1/8/10;<br>o Statement in response to TX-AB-1108-XVII.7 stating: "AbSSLC does not currently utilize any instruments or process to determine functional capacity or a process used to prioritize the needs of individuals… Tools are to be developed as well as policy to determine capacity/prioritized needs and submitted to State Office for approval. Meeting in San Angelo to develop tools 7/11/2011-7/14/2011";<br>o Client Assignment and Registration System (CARE) blank form, revised 1/10;<br>o ABSSLC Guardianship Priority Tools for Priority I and Priority II, with instructions, undated;<br>o Priority I and Priority II lists of individuals needing guardians, updated 5/5/11, and 1/7/11, respectively;<br>o List/Name of individual who obtained a guardian and/or advocate since last review, undated;<br>o Guardianship Assistance Committee meeting minutes, dated 3/16/11;<br>o Letters (10) mailed explaining the Guardianship Assistance Program;<br>o Texas Guardianship Statute - Probate Code, Chapter XIII. Guardianship, Sections 601 through 700;<br>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;<br>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; and<br>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.<br>▪ **Interviews with**:<br>o Shae Butts, Human Rights Officer; and<br>o Donnie Wilson, State Office Continuity Services Coordinator. |

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| | **Facility Self-Assessment:** In its POI, the Facility reported that it was not in compliance with either of the subsections of Section U of the Settlement Agreement. This was also reflective of interviews with staff, and was consistent with the Monitoring Team's findings.<br><br>The POI included narrative descriptions of steps being taken to attain compliance. However, based on the POI, it was unclear what formal processes the Facility was using to assess its compliance. In the last report, the Monitoring Team noted that the Facility had used some summary data from reviews or self-audits it had completed, but it was unclear specifically what had been measured. However, in this most recent POI, no audit data was mentioned. The Facility provided some numbers of individuals requiring guardians, as well as numbers of individuals who had been appointed guardians, or for whom advocates had been identified. As the processes for assessing individuals' capacities to make decisions are implemented, it will be important for the Facility to conduct audits to ensure that teams are correctly identifying individuals who might need guardians or other assistance in making decisions, that individuals are appropriately prioritized on the list, and that adequate efforts are being made to identify needed supports. In addition to providing statistics and narrative descriptions of activities, the POI should include analyses of the audit results.<br><br>The Facility also included an action plan in its POI. The action plan revolved around the development and implementation of a Facility policy once the State Office policy was finalized. It was anticipated that this would begin on 9/1/11. In the Monitoring Team's opinion, this action plan would be important to implement. As discussed at the exit conference, it also will be important for the Facility to learn more about the local nonprofit guardianship program to determine if it would be a viable option for some individuals. In addition, focused efforts should continue to be made to identify alternatives to guardianship, as well as specific supports that might assist individuals in making decisions or participating in the decision-making process. |
| | **Summary of Monitor's Assessment:** DADS State Office was still in the process of finalizing policies on guardianship and consent that were expected to provide guidance to the Facilities with regard to the implementation of this Settlement Agreement requirement. The Guardianship/Advocate Policy had been disseminated for final review, and the policy on consent remained in the development phase. As discussed below, this resulted in minimal progress being made at the Facility level.<br><br>At the time of the review, the process for assessing individuals' "functional capacity to render a decision" and provide informed consent was still not being completed using an adequate standardized tool. However, it was anticipated that the State Office policy would set forth a methodical approach for screening individuals to determine a possible need for assistance in decision-making, and, as appropriate, assessing in more detail individuals' functioning in this area.<br><br>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 |

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| | 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. Using the processes currently in place, a total of 91 individuals had been identified as requiring guardians.<br><br>Since the last review, five individuals had obtained guardians. The Guardianship Committee had approved another two individuals for funding to defray the costs of guardianship proceedings. The Guardianship Assistance Program (GAP) had received an additional donation, increasing the amount of funds available to assist family members and other interested in petitioning for guardianship. |

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| U1 | Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall maintain, and update semiannually, a list of individuals lacking both functional capacity to render a decision regarding the individual's health or welfare and an LAR to render such a decision ("individuals lacking LARs") and prioritize such individuals by factors including: those determined to be least able to express their own wishes or make determinations regarding their health or welfare; those with comparatively frequent need for decisions requiring consent; those with the comparatively most restrictive programming, such as those receiving psychotropic medications; and those with potential guardianship resources. | At the time of the review, DADS State Office was in the final stages of finalizing Draft Policy #019: Guardianship/Advocate. The Facilities had been asked to review the draft policy and offer final comments. A second policy on consent reportedly was in development. Since the last review, because ABSSLC was awaiting further guidance through State Office policy, little had changed with regard to consent and guardianship. The State is encouraged to finalize these policies, as they should assist the Facilities to move forward with regard to the implementation of the Section U Settlement Agreement requirements.<br><br>As Facility staff noted during the on-site review, implementation of the policies 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. At the time of the review, this process was still not being completed using an adequate standardized process, but it was anticipated that the State Office policy on consent would set forth a methodical approach for screening individuals to determine a possible need for assistance in decision-making, and, as appropriate, assessing in more detail individuals' functioning in this area. This likely will require ABSSLC to modify its policies and procedures to ensure thorough implementation of the State policy.<br><br>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. | Noncompliance |

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| | | 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. Of note, the Facility had begun to look at other options to assist individuals with decision-making, mainly the identification and appointment of advocates. As discussed during the onsite review, in addition to continuing these efforts, efforts also should be made to identify other supports that might assist individuals to make decisions. These include, but are not limited to developing information in formats that are more easily understood, including utilizing simpler language, or formats with pictures (e.g., similar to what the State Office was beginning to develop with regard to psychotropic medication); expanding individuals' knowledge about options available (e.g., making informed decisions about jobs or places to live might require individuals to see and experience the different options, or making a decision about inclusion of personal information in an article in the newsletter might require someone to see the newsletter and/or some of the places to which it is distributed); and identifying specific staffing supports to assist an individual to interpret information (e.g., sign interpreters, someone to read and explain information in a user-friendly manner, etc.).<br><br>In the absence of direction with regard to the prioritization of individuals in need of guardians, as reported previously, ABSSLC had developed a document entitled "Guardianship Priority." QMRPs used it 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/correspondent, but who did not advocate for the individual on a regular basis. Based on interview with the Human Rights Officer, a third category was being developed that would include individuals who had family involvement, but needed a guardian.<br><br>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.<br><br>At the time of the most recent review, approximately 41 individuals had been identified as Priority I, and approximately 50 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, | |

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| | | modifications to this list might occur, based on the more formalized screening and assessment processes contemplated by the draft State policy. However, based on these initial projections, approximately 91 out of the 443 individuals residing at ABSSLC (21%) were in need of guardians.<br><br>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 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. | Since the last review, five individuals identified as requiring a guardian had been appointed a guardian. In addition, 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 10 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. Four individuals who had obtained guardians had benefitted from this program, and two additional individuals had been approved for funding.<br><br>ABSSLC recently had identified a nonprofit guardianship program in the area, and had referred one individual to the program. Limited information had been obtained about the program or its potential applicability to other individuals in need of guardians. As the State Office Coordinator recommended to Facility staff during the onsite review, Facility staff should investigate the resources potentially available through the local nonprofit guardianship agency to determine if referrals to this agency might be appropriate for some individuals who require guardianship assistance.<br><br>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). 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. | Noncompliance |

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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. As has been recommended in previous reports, the State should finalize the State Office policies on guardianship/advocacy and consent, and implement them as soon as possible. In doing so, it should consider including in the policies 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. (Section U.1)
2. Once the State policies are finalized, the State should provide key Facility staff with training on their implementation. (Section U.1)
3. Once the State policies are finalized, ABSSLC should modify its policies on guardianship and consent to reflect the State policy. (Section U.1)
4. Based on any additional information provided in the State policies 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. (Section U.1)
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. (Section U.1)
6. Efforts should be made to identify other supports that might assist individuals to make decisions. These include, but are not limited to developing information in formats that are more easily understood, including utilizing simpler language, or formats with pictures (e.g., similar to what the State Office was beginning to develop with regard to psychotropic medication); expanding individuals' knowledge about options available (e.g., making informed decisions about jobs or places to live might require individuals to see and experience the different options, or making a decision about inclusion of personal information in an article in the newsletter might require someone to see the newsletter and/or some of the places to which it is distributed); and identifying specific staffing supports to assist an individual to interpret information (e.g., sign interpreters, someone to read and explain information in a user-friendly manner, etc.). (Section U.1)
7. ABSSLC staff should collaborate with staff from other SSLCs to identify and implement potential initiatives and resources for identifying guardians. (Section U.2)
8. Facility staff should investigate the resources potentially available through the local nonprofit guardianship agency to determine if referrals to this agency might be appropriate for some individuals who require guardianship assistance. (Section U.2)
9. Based on the availability or lack thereof of viable options for guardianship, 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 U.2)

10. As the processes for assessing individuals' capacities to make decisions are implemented, it will be important for the Facility to conduct audits to ensure that teams are correctly identifying individuals who might need guardians or other assistance in making decisions, that individuals are appropriately prioritized on the list, and that adequate efforts are being made to identify needed supports. In addition to providing statistics and narrative descriptions of activities, the POI should include analyses of the audit results. (Facility Self-Assessment)

| SECTION V: Recordkeeping and General Plan Implementation | |
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| | **Steps Taken to Assess Compliance:** The following activities occurred to assess compliance:<br>▪ **Review of Following Documents**:<br>o ABSSLC Recordkeeping Policy and Procedures, dated 7/9/10;<br>o Policy for Routing Reports/Documents, dated 6/15/11;<br>o List of persons responsible for management of records and for auditing records, including names and titles, dated 7/8/11;<br>o ABSSLC Active Record Order and Maintenance Guidelines, revised 6/23/11;<br>o Master Folder Table of Contents, undated;<br>o Statement that ABSSLC did not have Individual Notebooks, and was awaiting further guidance from State Office;<br>o Procedure for Random Monitoring Samples, undated;<br>o Completed review tools for last 10 records reviewed;<br>o Training documentation for record keeping procedures, policy for routing/documentation for records, new breaking point in the Active Record, placement of allergy stickers in records, 24-hour clock, and legibility, various dates;<br>o Documentation of follow-up on individual record reviews, various dates;<br>o Description of electronic records used as part of the active record, dated 6/11;<br>o List of ABSSLC policies and procedures implemented or revised since the last Monitoring Team's visit in February 2011, dated 7/21/11;<br>o List of new or revised policies and procedures completed since the last compliance visit, including copies of policies;<br>o QA/QI Data Sections C, D, F, K, S, V, Completed by Tracyl Gandee, Settlement Agreement Coordinator, FY11 Q3; and<br>o Presentation Book for Section V.<br>▪ **Interviews with**:<br>o Kalana Allen, Records Coordinator;<br>o Vickie Allmand, Unified Records Coordinator;<br>o Gloria Sprecher, Unified Records Coordinator;<br>o Pat Smith, Quality Assurance Director;<br>o Tracyl Gandee, Settlement Agreement Coordinator; and<br>o Renay Kellum, Program Compliance Monitor.<br>▪ **Observations of**:<br>o Record storage systems and individual records in homes and day programs. |
| | **Facility Self-Assessment:** Based on a review of the Facility's POI with regard to Section V of the Settlement Agreement, the Facility found that it remained out of compliance with all of the sub-provisions. This was consistent with the Monitoring Team's findings.<br><br>As is described in further detail below with regard to Section V.3 of the Settlement Agreement, the Unified |

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| | Records Coordinators and the QA Department continued to conduct regular record reviews utilizing tools that the State Office had modified based on the Monitoring Teams' review tools. The Facility recognized the need to establish inter-rater reliability, and the Records and Quality Assurance Departments had begun to meet monthly to review monitoring results and discuss discrepancies. As is noted elsewhere in this report, revisions to the processes the Facility was using to establish inter-rater reliability were necessary. Development of adequate instructions for the audit tools also would facilitate validity and reliability of the data collected.<br><br>In its POI, the Facility had continued to use some data to substantiate its findings related to compliance. However, the data provided often appeared to be an overall score, and did not allow distinctions to be made between the Facility's compliance with the numerous requirements of the Settlement Agreement. In a couple of instances, information was provided about specific problem areas that had been targeted for corrective action. For example, for Section V.3, the Facility identified two indicators, related to inaccurate record-keeping practices and gaps in records, as areas requiring improvement. This was a positive addition to the POI. As is discussed in further detail with regard to Section V.3, during interviews with staff, it was clear that Facility staff had completed additional analyses of the data. As the Facility's self-assessment processes continue to evolve, the POI should include more information related to the analyses of data collected through the internal audit processes.<br><br>The POI included two action plans. The one for Section V.2 related to the development and implementation of a policy on the dissemination and implementation of new policies. The action plan for Section V.4 related to the development, implementation, and follow-up on a policy related to the routing and filing of reports in the active records. These were both appropriate priorities for action plans, and a number of each of the plans' action steps had been completed. As noted during the review, focus should continue to be placed on identifying any weaknesses in the records through regular audits, analyzing the resulting data, and developing corrective action plans to address problematic trends. |
| | **Summary of Monitor's Assessment:** According to staff, all of the individuals at ABSSLC had Active Records and Master Records. 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.<br><br>The Facility did not yet have Individual Notebooks. A workgroup had made a recommendation, which the Facility Director had relayed to State Office. The Facility was awaiting further guidance from State Office.<br><br>The Facility was continuing to develop and revise policies to address the requirements of the Settlement Agreement. A new policy recently had been implemented on the dissemination of policies, and training of staff on new or revised policy requirements. Its implementation was in the early stages of development.<br><br>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 had made some significant progress in formally analyzing aggregated results of monitoring data, and developing and implementing actions necessary to |

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| | correct systemic deficiencies. For example, the Facility had provided initial training across campus to address issues such as legibility and accuracy of records.<br><br>To address issues related to the timely filing of information needed to make decisions a new policy and procedure had been implemented. This policy clearly identified roles and responsibilities, and set timelines for completion of specific activities. Although its implementation was in the early stages, both internal monitoring audits, as well as the Monitoring Team's experience with the records during the onsite review indicated that improvements had been made with regard to the availability of needed documents.<br><br>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 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. | Progress had been made and/or sustained with regard to the establishment and maintenance of a unified record consistent with the guidelines in Appendix D of the Settlement Agreement. Positive developments included:<br>▪ According to staff, all of the individuals at ABSSLC had Active Records and Master Records. The Active Records recently had been updated to reflect changes to the record guidelines issued by State Office.<br>▪ The Facility continued making changes, as appropriate to the content of the records. Since the last review, a Records Committee had been developed. This appeared to be a well-constituted group that included representatives for different departments, and allowed decisions to be made quickly about changes to the records. Review of the minutes available for three meetings showed discussion of relevant issues, and the development of practical solutions.<br><br>Areas in which improvements should be made in order to achieve compliance, included:<br>▪ As Facility staff recognized, challenges remained with regard to ensuring that the records met all of the requirements of Appendix D. This is discussed in further detail with regard to Section V.3. However, some of the issues that internal audits had identified included legibility, accurate recording of time, gaps in records, accuracy of data maintained in records, and signatures being included on initial legends. The Facility continued to take action to correct these issues.<br>▪ Individuals at the Facility did not yet have Individual Notebooks. The Facility had developed a workgroup to address this issue. According to the minutes, the workgroup appropriately focused on the core issues of: 1) staff knowledge of programs; 2) implementation of programs; and 3) documentation. In response | Noncompliance |

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| | | to a request from State Office, with the help of this workgroup, the Facility recommended to that: 1) Individual Notebooks contain information only; 2) data collection pieces be maintained at the program site; and 3) the SSLC determine when the Individual Notebooks should accompany individuals. The Facility was awaiting further guidance from State Office.<br><br>While the Facility had continued to make progress with regard to the quality of the active records, it was not yet in compliance with this provision of the Settlement Agreement. In addition to finalizing a process to address the intent of the requirement for Individual Notebooks, ABSSLC should continue to address issues related to the quality of the records. | |
| V2 | Except as otherwise specified in this Agreement, commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop, review and/or revise, as appropriate, and implement, all policies, protocols, and procedures as necessary to implement Part II of this Agreement. | As is discussed throughout this report, policies and procedures necessary to implement the 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.<br><br>Progress had been made and/or sustained with regard to the development, review and/or revision, as appropriate, and implementation, of all policies, protocols, and procedures as necessary to implement Part II of this Agreement. Positive developments included:<br>▪ The leadership group continued to review draft or revised policies. The group reviewed them 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. A list was provided of 24 policies that had been developed/revised and approved since the last review.<br>▪ In response to comments in the Monitoring Team's previous report, the Facility had developed a draft policy on "Dissemination, Training, and Implementation of New/Revised Policies and Procedures." The policy set forth a methodology for new and revised policies to be officially added to the policy and procedure manual, disseminated to appropriate staff, and for staff involved in their implementation to be trained. The Records Department would be responsible for maintaining documentation of training that was completed.<br><br>Areas in which efforts are needed in order to achieve compliance, included:<br>▪ 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.<br>▪ At the time of the review, the dissemination and training policy was new. Of the 24 policies that were developed or revised since the last review, documentation | Noncompliance |

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| | | of staff training was provided for two. Based on the documentation, it could not be determined if all related staff had been trained, and/or if the staff trained had met the required competency level to successfully complete the training. The implementation of the new dissemination and training policy should be a focus, and tracking should occur to ensure that all staff who require training on new or revised policies and/or procedures successfully complete the training.<br><br>Although the Facility continued to make progress in updating and/or developing policies to address the various requirements of the Settlement Agreement, it was not yet in compliance with this provision. | |
| 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 been made and/or sustained with this provision of the Settlement Agreement. Positive developments included:<br>▪ At ABSSLC, the Unified Records Coordinators were conducting reviews of at least five records each month. The QA Department also was conducting reviews of a subsample of records, as was the Records Coordinator.<br>▪ To accomplish this, the Facility was randomly selecting a sample of 10 records. Based on documentation provided for reviews conducted in the months prior to the onsite review, two audit tools were used to complete reviews of all 10 records selected, including the Settlement Agreement Section V – Recordkeeping and General Plan Implementation review tool, and the Active Record Order Review. Based on review of completed audit tools, they appeared to be completed thoroughly. Concerns are discussed below with regard to inter-rater reliability and validity.<br>▪ As during the Monitoring Team's last review, after each record review was completed, the Unified Records Coordinators were reviewing the results with and/or sending emails to staff who needed to take actions to correct identified problems. Based on interview, as well as document review, the Unified Records Coordinators were then completing a follow-up review of the record. The goal was to complete these within 30 days. The Unified Records Coordinators were documenting their findings of this second review. The Monitoring Team's review of documentation submitted continued to show effective and strong follow-up to ensure deficiencies were corrected.<br>▪ In addition, beginning in May 2011, using the interview tool that State Office developed for Section V.4, responses were solicited from team members for one of the individual's records reviewed. This was a positive addition to monitoring efforts, but as discussed below was not adequate to measure compliance with Section V.4.<br>▪ The Facility had made some significant progress in formally analyzing aggregated results of monitoring data, and developing and implementing actions necessary to correct systemic deficiencies. Utilizing data reports, which the | Noncompliance |

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| | | Settlement Agreement Coordinator produced, the Records Department had conducted an analysis to identify specific indicators for which data showed problematic trends. Corrective actions had begun to address some of the issues identified. For example, the Facility had provided initial training across campus to address issues such as legibility and accuracy of records.<br><br>Areas in which improvements should be made in order to achieve compliance, included:<br>▪ The procedure entitled "Procedure for Random Monitoring Samples" indicated that a sample of 10 records would be selected and reviewed "using the compliance Monitoring Tool, Interview Tool and Active Record Review." However, later in the same paragraph, the procedure indicated that: "Two Active Record Reviews will be completed per month as well to determine the accuracy of the Active Records." This did not appear to be consistent with the current practice based on documentation provided. It also did not appear to be consistent with the Settlement Agreement, which required five reviews of active records to be completed monthly. This review should determine the accuracy of the records, as well as the presence or absence of items.<br>▪ As noted above, the Facility had obtained guidance from State Office on methodologies for monitoring Section V.4 of the Settlement Agreement. This consisted of an interview tool, which provided some information about PST members' use of the records. However, as has previously been discussed, monitoring of Section V.4 will require a number of different methodologies, including, for example, 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.<br>▪ The Facility recognized that inter-rater reliability had not yet been established between the various staff responsible for monitoring Section V requirements. In addition, staff identified concerns about the adequacy of the instructions on the forms, particularly with regard to terms such as "complete," and "accurate." The Facility had begun to address these issues through monthly meetings between the QA and Records Departments. These efforts should continue until inter-rater reliability is established, and adequate instructions are in place to ensure the validity of the monitoring results.<br>▪ The Facility was in the beginning stages of using information gained from internal audits to develop and implement corrective actions. These efforts were laudable. However, as discussed onsite, it will be important to assess the results of the corrective actions taken, take any additional steps necessary, and coordinate activities related to the analysis and corrective action processes with | |

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| | | the QA Department, as well as the QA/QI Committee.<br><br>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, as well as the comprehensiveness of the monitoring efforts for Section V.4. In addition, as efforts continue to analyze aggregated results of monitoring data, and to develop, and implement actions necessary to correct systemic deficiencies, efforts also should be made to assess the effectiveness of the actions taken, and modify them, as necessary. | |
| 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. | Progress had been made and/or sustained with regard to the Facility's use of such records in making care, medical treatment, and training decisions. Positive developments included:<br>▪ In order to facilitate sharing of information, electronic folders had been set up, and a standardized set of documents was being maintained in the folders. Based on discussions with staff during the week of the onsite review, this had enhanced team members' use of information. For example, having such information available electronically facilitated the process of preparing for individuals' annual PSP meetings.<br>▪ To address issues related to the timely filing of information needed to make decisions (i.e., medical reports, and non-medical reports), a specific policy entitled: "Policy for Routing Reports/Documents," dated 6/15/11, had been implemented. This policy clearly identified roles and responsibilities, and set timelines for completion of specific activities. Although its implementation was in the early stages, both internal monitoring audits, as well as the Monitoring Team's experience with the records during the onsite review indicated that improvements had been made with regard to the availability of needed documents.<br><br>Areas in which improvements should be made in order to achieve compliance, included:<br>▪ As discussed with regard to Section L.1, there appeared to be need for improvement in filing of the hospital liaison nurse's notes, as well as the dictated physician IPNs. Additionally, requests for the hospital discharge summaries should be followed up to ensure they are received and filed in the record.<br>▪ 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 accurately, consistently and timely documenting data, and processes were not in place to ensure data reliability. | Noncompliance |

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| | | ▪ As noted with regard to Sections F and I, PSTs were not consistently using information in the records to substantiate decisions they were making regarding individuals' treatment, and planning.<br><br>Although progress was being made, the Facility remained out of compliance with this provision. Teams were not consistently using data to make decisions, and the quality of data and information in the records often was not adequate to allow teams to make well-informed decisions. | |

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

1. The State Office should provide the Facility with additional guidance with regard to Individual Notebooks. Once this guidance is provided, the Facility should move forward to quickly implement the decided upon procedures. (Section V.1)
2. 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. (Section V.2)
3. The implementation of the new dissemination and training policy should be a focus, and tracking should occur to ensure that all staff who require training on new or revised policies and/or procedures successfully complete the training. (Section V.2)
4. The procedure entitled "Procedure for Random Monitoring Samples" should be reviewed and clarified, as necessary, to ensure that the required five monthly reviews of active records are completed. (Section V.3)
5. Monitoring efforts for Section V.4 should be expanded to include a number of different methodologies, including, for example, 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. (Section V.3)
6. As is recommended elsewhere in this report, revisions to the processes the Facility was using to establish inter-rater reliability should be made. Development of adequate instructions for the audit tools also would facilitate validity and reliability of the data collected. (Section V.3 and Facility Self-Assessment)
7. As efforts are made to correct issues identified through internal audits, the Facility should assess the results of the corrective actions taken, take any additional steps necessary, and coordinate activities related to the analysis and corrective action processes with the QA Department, as well as the QA/QI Committee. (Section V.3)
8. 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. (Section V.4)
9. 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. (Section V.4)
10. As the Facility's self-assessment processes continue to evolve, the POI should include more information related to the analyses of data collected through the internal audit processes. (Facility Self-Assessment)

**List of Acronyms**

| Acronym | Meaning |
|---|---|
| AAC | Alternative or Augmentative Communication |
| ABA | Applied Behavior Analysis |
| ABSSLC | Abilene State Supported Living Center |
| ADOP | Assistant Director of Programs |
| ADR | Adverse Drug Reaction |
| AED | Automatic External Defibrillator |
| AED | Antiepileptic Drug |
| A/N/E | Abuse/Neglect/Exploitation |
| 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 |
| CPE | Comprehensive Psychiatric Evaluation |
| CPR | Cardiopulmonary Resuscitation |
| CRIPA | Civil Rights of Institutionalized Persons Act |
| CT | Computed Tomography |
| CV | Curricula Vitae |
| DADS | Texas Department of Aging and Disability Services |

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|---|---|
| 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 |
| GAP | Guardianship Assistance Program |
| 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 |
| HOBE | Head of Bed Evaluation |
| HPT | Home Program Technician |
| HRC | Human Rights Committee |
| HRO | Human Rights Officer |
| HT | Habilitation Therapies |
| 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 |
| I/R | Integrity/Reliability |
| 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 |
| 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 |
| PIC | Performance Improvement Council |
| PICC | Peripherally Inserted Central Catheter |
| PLACHECK | Planned Activity Check |

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|---|---|
| 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 |
| QA | Quality Assurance |
| QA/QI | Quality Assurance/Quality Improvement |
| QDDP | Qualified Developmental Disabilities Professional |
| QDRR | Quarterly Drug Regimen Review |
| QE | Quality Enhancement |
| QMRP | Qualified Mental Retardation Professional |
| RD | Registered Dietician |
| RN | Registered Nurse |
| ROM | Range of Motion |
| RWR | Recommended Weight Range |
| 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 |
| TSH | Thyroid Stimulating Hormone |
| TST | Tuberculin Skin Test |
| UTI | Urinary Tract Infection |
| VNS | Vagus Nerve Stimulator |
| VPA | Valproic Acid |
| VTE | Venous Thromboembolism |