United States v. State of Texas

Monitoring Team Report

Abilene State Supported Living Center

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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, 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. Substantial Compliance Ratings and Progress

Across the State's 13 Facilities, there is variability in the progress being made by each Facility towards substantial compliance in the 20 sections of the Settlement Agreement. The reader should understand that the intent, and expectation of the parties who crafted the Settlement Agreement was for the State to make systemic changes and improvements at the SSLCs that would result in long-term, lasting change.

The parties foresaw that this would take a number of years to complete. For example, in the Settlement Agreement the parties set forth a goal for compliance, when they stated: "The Parties anticipate that the State will have implemented all provisions of the Agreement at each Facility within four years of the Agreement's Effective Date and sustained compliance with each such provision for at least one year." Even then, the parties recognized that in some areas, compliance might take longer than four years, and provided for this possibility in the Settlement Agreement.

To this end, large-scale change processes are required. These take time to develop, implement, and modify. The goal is for these processes to be sustainable in providing long-term improvements at the Facility that will last when independent monitoring is no longer required. This requires a response that is much different than when addressing ICF/DD regulatory deficiencies. For these deficiencies, facilities typically develop a short-term plan of correction to immediately solve the identified problem.

It is important to note that the Settlement Agreement requires that the Monitor rate each provision item as being in substantial compliance or in noncompliance. It does not allow for intermediate ratings, such as partial compliance, progressing, or improving. Thus, a Facility will receive a rating of noncompliance even though progress and improvements might have occurred. Therefore, it is important to read the Monitor's entire report to identify the Facility's progress or lack of progress.

Furthermore, merely counting the number of substantial compliance ratings to determine if the Facility is making progress is problematic for a number of reasons. First, the number of substantial compliance ratings generally is not a good indicator of progress. Second, not all provision items are equal in weight or complexity. Some require significant systemic change to a number of processes, whereas others require only implementation of a single action. For example, Section L.1 addresses the total system of the provision of medical care at the Facility. This is in contrast with Section T.1c.3., which requires that a document, the Community Living Discharge Plan, be reviewed with the individual and Legally Authorized Representative (LAR).

Third, it is incorrect to assume that each Facility will obtain substantial compliance ratings in a mathematically straight-line manner. For example, it is incorrect to assume that the Facility will obtain substantial compliance with 25% of the provision items in each of the four years. More likely, most substantial compliance ratings will be obtained in the fourth year of the Settlement Agreement. This is due to the amount of change required, the need for systemic processes to be implemented and modified, and because so many of the provision items require a great deal of collaboration and integration of clinical and operational services at the Facility (as was the intent of the parties).

V. Executive Summary

As with the last review, this report reflects a number of areas in which ABSSLC made progress. During this review, it was evident that many staff had developed a stronger understanding to the efforts needed to comply with the Settlement Agreement. A number of plans were underway to build or strengthen the basic foundations for achieving compliance, and in some areas, work had progressed beyond this initial phase to the stage of refining the procedures in place and implementing practices to ensure their effect across the Facility. However, in some areas, little, if any improvement was noted. Overall, much additional work was needed to comply with the Settlement Agreement. At this

stage of the Settlement Agreement, it is particularly important that the Facility focus on the areas where little movement has been seen. At the same time, it is important to bring projects that are underway to fruition, and to maintain progress where it has been made.

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

- With regard to restraints, areas of progress included:
  - The available data indicated that use of restraints was continuing to decline.
  - A curriculum had been developed for Restraint Monitor training. During January and February 2012, over 20 staff had been trained.
  - There had been changes in residences designed to provide more space for people with problem behaviors, and to offer activity centers closer to residences increasing the opportunities for engagement in productive activities.
  - Use of desensitization plans was noted for a growing number of individuals, particularly with regard to dental visits. The desensitization processes included use of a mock dental unit, where individuals could learn to adjust to dental office procedures.
  - Behavioral Services had instituted a tracking system for restraints used more than three times in 30 days for any individual.
  - The Restraint Reduction Committee was meeting monthly, and thoroughly examining the use of restraints and the follow-up by the Interdisciplinary Teams.
- Some of the areas that need improvement to assure continued progress toward substantial compliance included:
  - A number of issues continued to be found with regard to the monitoring of restraints, including, for example, the lack of adequate assessment of the circumstances of restraints, the lack of timely initiation of monitoring, the lack of prompt and adequate assessments of individuals in restraint by nurses, the lack of adequate documentation to show appropriate training of all restraint monitors and of nurses for the period reviewed, inconsistencies between the training curricula provided for nurses and the State and Facility policies, as well as a lack of direction from physicians for the monitoring of medical restraints.

- The roles of the Unit Teams and the Incident Management Team need to be clarified to describe the expectations of their reviews of restraints. Their minutes need to identify the episodes of restraint they chose to track, and then include the tracking to conclusion of the identified issue.
- There had been a change in the statewide data system that resulted in some issues with the reliability of restraint data and the issuance of monthly trend reports. Behavior Services compensated for the issues by using data collected through the review of restraints to create a monthly trend report. Processes will be needed to assure the accuracy of data in the new system and to allow production of monthly trend reports.

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

- With regard to Section D, progress was noted in a number of areas. Highlights of progress included:
  - Actions to protect individuals who were involved in unusual incidents or allegations of abuse or neglect were taken quickly. Staff alleged to have been abusive or neglectful were routinely placed on temporary work reassignment to remove them from direct contact with individuals served, or monitoring was put in place in the residence.
  - Investigators were trained in investigation techniques and in interviewing people with developmental disabilities.
  - Monitoring tools were in use and producing data, though work on inter-rater reliability was still needed.
  - Training for staff on abuse and incident reporting was in place, and 99% of staff were current on that training.
  - There was evidence of cooperation with law enforcement, the Office of the Inspector General (OIG), and with DFPS in the conduct of investigations.
  - When staff were found to have failed to act to stop abuse or to report it, disciplinary action was taken and retraining was conducted.
- Some of the areas in which improvements were necessary included the need to:
  - Address the issues related to the timeliness of reporting and completing investigations.
  - Provide clear notes on the supervisory reviews of investigations that the Facility and Department of Family and Protective Services (DFPS) complete.
  - Monitor the inclusion of discussions about abuse reporting in annual Individual Support Plan (ISP) meetings, and the distribution of abuse resource materials to individuals and Legally Authorized Representatives (LARs) to ensure that the established procedures are being followed.
  - Include adequate recommendations in investigation reports, and document follow-through on those recommendations, including observations in some cases to ensure that the actions taken produced the desired outcome.
  - Develop the semi-annual audit of injuries to include how determinations will be made about what types of injuries or patterns of injuries will be investigated.

- Improve the data system to resume production of monthly trend reports for Abuse/Neglect/Exploitation (A/N/E) and Unusual Incidents.
- Improve the Incident Management Team (IMT) process for reviewing allegations, investigations and injuries so that minutes reflect discussion, decisions on steps to address identified issues, and resolutions of those issues.

Quality Assurance

- DADS had issued a revised policy for Quality Assurance, SSLC Statewide Policy #003.1, effective 1/26/12. The policy called for SSLCs to adopt procedures to implement the policy, but due to the proximity of the effective date of the policy to the Monitoring Team's visit, no local procedures were in place, and the Facility was operating under the previous policy and related procedures. The Monitors will comment on the revised policy, when all of the Monitoring Teams have had an opportunity to review it.
- Use of monitoring tools to self-assess the Facility's performance was underway for all sections of the Settlement Agreement, and some summary data reports were available. 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. Program Compliance Monitors were working closely with their assigned disciplines to establish inter-rater reliability on the application of the tools.
- A data manager (analyst) had been hired to assist in the management of the data system. However, the AVATAR data system will need to be brought up to full functioning, allowing the resumption of monthly trend reporting for abuse/neglect/exploitation, unusual incidents, injuries, and restraints. The process for cleaning data in the AVATAR system, which was underway, will need to be completed and procedures set in place to prevent errors in the future. If Facilities will be responsible for producing trend reports, the necessary training for producing them will need to be provided.
- While QA Monitoring Tools were in use for all sections of the Settlement Agreement, improved instruction sheets or guidelines were still needed for many.
- 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 proactively identify the 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.
- Once issues with the data system have been resolved, trends are being identified, and the QA monitoring data and other discipline-specific data are being used to identify trends with regard to key indicators of progress, the Facility will need to proceed with 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 the actions taken effectively address the issues.

Integrated Protections, Services, Treatments and Supports

- The State's Individual Support Plan (ISP) Consultants continued to work on revising the ISP process, and, as a result, the State Office policy was under review. Once the process is finalized, the Facility should develop policies and procedures to ensure full implementation of the State Office policy.
- The Qualified Developmental Disability Professional (QDDP) Coordinator, four QDDPs, and the Program Compliance Monitor (PCM) had undergone additional training on the competency-based check-off tool for meeting facilitation. Based on the findings of the completed tools, QDDPs requiring more training or technical assistance were being identified. Some had undergone additional classroom training, and others were provided on-the-job mentoring. One of the State consultants had provided some additional training to QDDPs, as well as some technical assistance to QDDPs and teams during annual planning meetings. Beginning in January 2012, teams began to use a revised ISP template. Based on the meetings observed while the Monitoring Team was onsite, these efforts had begun to show some positive changes with regard to facilitation skills, more productive meetings, and a more person-centered focus. However, significant work remained in a number of areas. In addition, due to the timing of a number of changes, the ISPs reviewed during this review were not substantially different from the previous review.
- Some areas that required attention included:
    - As noted in many sections of this report, comprehensive, thorough, and adequate assessments were missing in many areas, including but not limited to nursing, speech and communication, psychiatry, skill acquisition, and physical and nutritional supports. Although vocational assessments had improved, they often were not present for individuals who required them. 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. Shortly before the Monitoring Team's onsite visit, the Facility had developed a workgroup to address issues related to integrated protections, services, treatments, and supports. The first task of the group was to address the issue of scheduling of ISP meetings to ensure maximum attendance;
    - Action plans largely addressed skill acquisition plans and regular medical appointments. Although some had begun to reference other supports (e.g., PNMPs and BSPs), these supports were not well defined, generally did not have measurable objectives or outcomes associated with them, and provided little to no description of the methodologies that would be employed to realize the objectives. Many other supports, services, treatments, or strategies were not mentioned in the ISPs. For example, risk action plans had not been incorporated or integrated into the ISPs. Focused effort was needed to improve the scope of action plans, as well as to ensure measurable outcomes and clear methodologies were included; and

- 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.

Integrated Clinical Services

- The morning medical meeting provided an important contribution to integrated clinical services. The concerns the group addressed focused on acute changes in health care status. However, the scope of the morning meeting had expanded to include individuals in the residences that required a call to the on-call physician, those admitted to the Infirmary, and those hospitalized. The attendance had expanded and become interdisciplinary. The Medical Department continued to attempt to recruit other disciplines to the meeting.
- Despite the significant number of issues and individual changes in health status discussed at the morning meeting, few concerns were raised to the level of needing closure. Critical thinking about ways to improve individuals' health and/or prevent negative outcomes, such as hospitalizations, often was not occurring to the extent necessary. Evidence also was not provided that the recommendations or decisions/concerns identified during the morning meeting were then communicated to the QDDP, and followed by the IDT convening an ISPA meeting, with information being returned to the morning meeting for follow up and eventual closure. From the information submitted, few ISPAs resulted from a morning medical meeting recommendation or concern. The morning meeting had great potential to be influential in health care through the IDT process, but this was not demonstrated.
- Similarly, the PCPs had improved their documentation of review of consultation reports. However, there was little information concerning whether these reports were communicated to the IDT, and whether they were discussed and reflected in ISPAs.
- There was a clear need for the Quality Assurance Department to develop measurement tools for these processes and to monitor for improvement over time.

Minimum Common Elements of Clinical Care

- Although the building blocks for measurement related to compliance with Section H were being created, there was limited evidence of measurement of minimum common elements of clinical care. Additionally, to date, the information the Facility submitted focused on the Medical Department, but other departments were not reflected in the data. The Facility should ensure that all clinical departments measure the services they provide to ensure each individual needing care has benefitted from the expertise of that department.
- The Medical Department had high rates of overdue annual medical assessments, and had only begun to attempt to complete quarterly medical reviews. The Pharmacy Department did not appear to closely track the QDRRs for timeliness.
- The clinical indicators to measure quality of care and improvement in health had not been determined at ABSSLC. The Facility did not appear to have reviewed or implemented State Office clinical guidelines. These

guidelines also could be used to identify measures of the quality of the risk action plans and outcomes for individuals. However, despite their great potential for assisting the Facility to identify measurable objectives and clinical indicators, they had not been incorporated into the process.

- The Facility needed to develop an organizational structure of committees as well as a policy structure. These were necessary to ensure integration between the various departments, that the various committees were not overlapping in responsibility and covered all aspects of health care, and that policies guided each step of this process.

At-Risk Individuals

- The Facility continued to make progress in this area, and continued to focus on training staff to help staff understand the risk process. Additionally, the Facility identified change of health status as an important area requiring additional structure and training.
- The quality of the data submitted on the Integrated Risk Rating Form, and the quality of the decision-making process was highly variable from team to team, and continued training and mentoring was needed to ensure a quality process was developed.
- There was little data to support the requirement that assessments began within five working days of a risk determination.
- The risk action plans generally had little focus on prevention, or minimizing risk through additional assessments (e.g., labs, radiographic testing, consultations).
- No data was submitted to verify that implementation of action plans occurred in a timely manner.
- Functional and measurable objectives were not part of the Risk Action Plans, nor were clinical indicators identified to monitor progress. The Facility had no data to begin to track risk reduction.

Psychiatric Care and Services

- ABSSLC now had three full-time Psychiatrists, who continued to be supported by one Psychiatric Nurse and two Psychiatric Assistants. The Chief Psychiatrist completed an analysis of the workload distribution among the Psychiatrists, which took into account the requirements of the Settlement Agreement. Based on this analysis, it appeared that this number of Psychiatrists should be adequate.
- The progress with regard to the completion of the Comprehensive Psychiatric Evaluations (CPEs) had continued. The data available indicated that CPEs, which the Facility believed complied with the criteria set forth in the Settlement Agreement, had been completed for 116 of the 199 individuals (58%) who received psychotropic medication. However, as discussed in further detail below, the Monitoring Team identified concerns with a number of the CPEs in the sample it reviewed. The current plan was to complete these in conjunction with the annual ISP, and then also perform the annual updates to coincide with the annual ISP, which would make the process self-sustaining. The Psychiatrists also had begun to attend the ISPs on a selected basis.
- The documentation that accompanied the Quarterly Psychiatric Reviews had been expanded. Examples of information that had been added to the Quarterly Psychiatric Reviews included differentiation of the behaviors

that were symptoms of the psychiatric disorder, as opposed to being present on a behavioral basis or represented an overlap of both of these factors, and a much more detailed description of the symptoms that justified the psychiatric diagnosis. Although these were positive additions, they had not yet been implemented for many of the individuals prescribed psychotropic medication.

- There was also an expanded risk-benefit section. The teams were experiencing some difficulties in implementing these tools, because they were attempting to view the risk-benefit assessment as a static assessment when, in practice, it is a dynamic process that evolves over time.
- The Psychiatry Department, working in conjunction with the Psychology Department and Human Rights Committee (HRC), also had initiated a process to allow for a separate review of the psychotropic medications, apart from the Behavioral Support Plan. In order to facilitate that process, the Chief Psychiatrist had developed a Physician Psychotropic Medication Treatment Plan.
- During the onsite review, members of the Monitoring Team attended a HRC Meeting, and it was clear that the Committee had a number of questions about the new process. To some degree, this confusion related back to the aforementioned issue of viewing the risk-assessment process as a static, one-time assessment, rather than a dynamic process. The Psychiatry Department had agreed to work more closely with the HRC in implementing the new system.
- Progress continued in decreasing the rates of polypharmacy at ABSSLC, which had been reduced to approximately 25% of those who prescribed psychoactive medications. In addition, a number of individuals had active tapering schedules. The Psychiatry Department made a distinction between those individuals whose medications were being actively tapered, and those for whom the continued use of the medication was thought to be essential for their continued stability. However, the Facility will need to assemble the necessary documentation to justify the efficacy of psychotropic medications that they maintain are essential for the individuals' continued stability.
- The Chief Psychiatrist also had begun to attend the Neurology Clinics in an attempt to develop a system that would address the issues related to Section J.15.

<u>Psychological Care and Services</u>

- 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, one Associate Psychologist had taken the certification exam, and fourteen others continued to complete coursework in pursuit of certification. The Director of Behavioral Services met the requirements outlined in the Settlement Agreement, and continued to provide the required supervision to his staff.
- Both internal and external peer review continued. Thoughtful feedback and recommendations were provided regarding the content of behavioral assessments and resulting behavior support plans. The Behavior Support Committee continued to provide internal peer review for plans developed or revised annually. However, there remained no mechanism for regular and timely internal peer review of particularly challenging cases.

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. As the Director of Behavioral Services reported, the role of these consultants was increasingly focused on staff training. Accommodations will be necessary to ensure regularly scheduled external peer review occurs.

- 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.
- Annual psychological assessments and functional behavior assessments had been combined to streamline the work of the psychology staff. While these assessments followed a similar format, the content of the assessment varied across individuals. Outdated measures of cognitive abilities and adaptive behavior were often reported, descriptive assessment of problem behavior was often limited, and recommended changes to the behavior support plan did not always reflect the information gained from the assessment.
- Behavior support plans were inconsistent in quality of services offered. Greater emphasis was needed on the teaching of functionally equivalent replacement behaviors; varied preventative strategies, including expanded opportunities for active treatment; enriched schedules of reinforcement for appropriate behavior; and individualized consequences that correspond to the hypothesized function.
- On-the-job competency-based training remained a challenge. As staff training improves, there should be a corresponding improvement in treatment integrity.

<u>Medical Care</u>

- The Medical Department had continued to make progress toward compliance. The morning medical meeting now encompassed health status changes of the individuals for which the Medical Department was involved, including individuals in the Infirmary, those hospitalized, as well as those for whom the on-call physician was contacted during after hours. Detailed minutes were taken of the meetings.
- External peer review results indicated progress in the nonessential components of their review, and indicated the primary care providers (PCPs) maintained compliance in essential areas.
- A total of 34 Do Not Resuscitate Orders (DNRs) were rescinded. This was positive given that during previous reviews, for many individuals with DNR Orders at ABSSLC, qualifying conditions had not been established and/or documented.
- However, a number of weaknesses and challenges remained in the Medical Department. Annual medical assessments were generally not completed in a timely manner. Quarterly medical reviews could not be found in the sample of records reviewed.

- At the morning medical meetings, there remained a lack of critical thinking for acute care issues. Although cases of aspiration pneumonia were intensively followed and critically reviewed for opportunities of improvement, that same critical review was not occurring with other types of diagnoses.
- The Facility did not appear to have a follow-up communication pathway for recommendations made at the morning medical meeting to the QDDP and IDT, and then back to the morning medical meeting.
- In November 2011, the internal medical review process appeared to have halted, and was expected to resume in February 2012. Routine communication with the QA Department was needed to ensure corrective action plans were completed in a timely manner.
- The Medical Department's databases appeared to be maintained for the Monitoring Team's visit, rather than as working tools that the Medical Department used to improve care at ABSSLC.
- Lastly, the number of decubiti appeared to troublingly high, and the Facility needed to create and sustain a close monitoring system to review all cases.

<u>Nursing Care</u>

- Although the Nursing Department had experienced a high degree of nursing turnover, and a change in some of the leadership and management positions related to retirements, the new Chief Nurse Executive reported that the Facility had continued to not use the services of any agencies to cover nursing positions.
- Some of the Facility's positive steps forward included:
    - In October 2011, the QA Nurse and the Program Compliance Monitor for nursing had begun meeting monthly to discuss auditing findings, and discrepancies regarding compliance scores in an attempt to assess inter-rater reliability;
    - The QA/QI Data, Section M: Nursing Services Quarterly summary for September through November 2011 contained a very promising summary of the selection process for the samples for a number of the nursing monitoring tools, and a summary of the data;
    - The QA Department focused on the data for the areas of most concern, including acute injury/illness, hospitalization/Emergency Room visits, and Annual/Quarterly Nursing Assessments. This was a positive step for the Facility, since these particular areas have significant clinical ramifications regarding the individuals' health issues;
    - The Infection Control (IC) monitoring audit results had been integrated into the minutes of the IC Committee;
    - A number of appropriate and timely in-service training sessions were provided to staff in response to acute infectious illnesses;
    - Additional emergency scenarios had been added to the emergency drills, and were documented on the Emergency Drill Checklists;

- The Pharmacist reviewed the medications for buildings 6730 and 6740, and made recommendations for changes in the medication administration times, amounts, and routes to decrease the potential for medication errors; and
- The Pharmacy had begun to track medication variances regarding pharmacy technician variances and prescriber variances, and these variances were being reported in the Medication Variance Committee meetings.

- Although the Facility had made some positive steps in the areas noted above, of most concern was the lack of overall progress made in the critical areas addressing nursing Health Management Plans, nursing assessment and documentation in response to changes in status, and the quality and timeliness of the quarterly and annual nursing assessments. These troubling findings were consistent with the findings from the past four reviews, and no concrete plan appeared to be in place to address these findings.

Pharmacy Services and Safe Medication Practices

- The Pharmacy Department continued to make considerable progress toward compliance, and had a number of strengths. The WORx system was able to generate warnings on drug-drug interactions, potential allergies, and the addition of the Misys system allowed the pharmacists to review a panel of lab test reports to assist them in determining whether acceptable lab monitoring was taking place. Patient intervention notes indicated frequent and timely communication with the PCPs related to significant warnings generated by the pharmacy's software.
- A major weakness of the WORx system at ABSSLC was the inability of the software to warn the pharmacist of a nontherapeutic dose of medication. It was unclear if this function was available, but it had been disabled, or if it was not an option offered by the software. The Facility is encouraged to resolve this concern promptly. Additionally, the Settlement Agreement also requires the Facility to screen new orders for side effects. There was little demonstration that new order monitoring included this component, or that the Pharmacy Department was providing significant side effect information to the PCPs.
- The chemical restraint checklist form was now being forwarded to the Pharmacy Department. The Pharmacy was completing the essential components of its review in a timely manner, including review of the justification for the chemical restraint, drug-drug interaction(s), and consideration of other options or recommendations. However, the Psychiatry Department was not yet conducting an adequate review.
- The calendar of drug utilization evaluations and follow-up studies represented a well-established system. It was having a practical impact on the clinical practices of the PCPs.
- Pharmacy had expanded tracking of medication variances to include pharmacy variances and prescriber variances.
- Problems were noted with two of the many components of the QDRR. There was lack of information concerning justification for use of anticholinergics, as well as justification for polypharmacy. Other areas monitored by the QDRR appeared to be complete.

- Although the adverse drug reaction (ADR) reporting process was identifying some ADRs, the system was not sustainable unless more staff throughout the Facility participated in its implementation. This will require extensive teaching of direct support professionals, nursing staff, and PCPs in order for them to recognize potential adverse drug reactions and report them.
- Medication errors remained a challenge. The Pharmacy Department will need to partner with the Nursing Department to initiate root cause analyses, medication room inventory checks, shortened time periods for medication refills to assist in determination of cause of medication errors, etc.

Physical and Nutritional Supports

- A Physical and Nutritional Management Team (PNMT) Coordinator position was established to provide ongoing leadership and direction to the PNMT, and in August 2011, a Speech Language Pathologies (SLP) was hired as the PNMT Coordinator. The two dedicated PNMT members were the PNMT Coordinator (SLP) and Nurse. A Facility physician joined the PNMT in January 2012. The appointment of the physician to the PNMT should assist the PNMT members in achieving positive clinical outcomes for individuals the PNMT supports.
- The Habilitation Therapies (HT) Department had drafted a Facility policy to further define the roles and responsibilities of the PNMT. However, additional information should be included in the policy in reference to PNMT continuing education requirements, PNMT assessment and action plan development and implementation timelines, and further description of the PNMT discharge process, including a description of a PNMT Discharge Plan.
- Although the PNMT continued to revise their processes for the PNMT assessment format and action plan documentation, these processes only recently been had implemented. In addition, the HT Department had not yet implemented an auditing process of PNMT assessments, action plans, and related documents to assess the quality of PNMT work products and to determine if progress was being made.
- The HT Department identified 178 individuals as having "no PNM needs." However, the Monitoring Team's review for some of these individuals found they did have PNM needs, because they were ranked as being at high risk for aspiration, choking, skin integrity, and/or falls.
- State Consultants had recommended the HT Department personnel create standards of practice and core competencies to streamline information provided on Physical and Nutritional Management Plans (PNMPs). Using a pilot residence, therapists and IDT members worked in partnership to develop a user-friendly PNMP format. The draft PNMP template reflected significant positive changes from the previous PNMP template. However, the Monitoring Team continued to observe staff non-compliance with prescribed PNMP and dining plan strategies. Competency-based training and performance check-offs for PNMP core competencies and individual-specific PNMP strategies were not yet being implemented. In addition, a PNMP audit tool had not yet been developed to track compliance with the Facility PNMP procedures. In addition, the Facility did not yet have a system in place to ensure that individuals at higher risk were monitored more frequently.

- New employees completed eight physical management performance check-offs. The HT Department was still in the process of developing and implementing additional PNM core competencies performance check-offs for New Employee Performance Training (NEPT). In addition, the Facility had not yet fully implemented core competency check-offs for existing staff.
- The State Physical and Nutritional Management (PNM) consultants recommended the HT Department "utilize one monitoring tool for effectiveness and compliance to eliminate the HT, PNMP, meal and PNMP monitoring separately." At the time of the review, only therapists recently had begun implementing the new Compliance Monitoring tool. The monitoring results had not been tracked and/or trended to provide an analysis of the monitoring data. Consequently, the HT Department did not have monitoring data available.
- The Monitoring Team's review of individuals' APEN assessments continued to show that these assessments were inadequate and did not meet the intent of the Settlement Agreement.

Physical and Occupational Therapy

- The Director of Habilitation Services was to be commended for her success in recruiting and hiring two Occupational Therapists (OTs) and three Physical Therapists (PTs) since the Monitoring Team's last review. The HT Director continued to recruit to fill three OT vacancies.
- The HT Department had not adopted the State-established OT/PT assessment format. At the time of the on-site review, therapists were reviewing the format.
- The HT Department personnel had adopted the "rolling assessment" process to provide an update to an OT/PT assessment when an individual experienced a change in status. This required a therapist to go back to the original assessment and update relevant sections, as appropriate. Although this process had just been initiated, the "rolling assessment" concept appeared to be a logical approach to providing adequate assessment information when an individual experienced a change in status.
- Based on documentation submitted, none of the 428 individuals living at ABSSLC received direct OT service programs. Forty-six individuals (11%) received direct PT service programs. Upon review of their risk indicators, it was not clear why some additional individuals had not been considered for or provided direct therapy supports, and others were not.
- The PNMP Clinic process did not document a number of important elements. These included: medium and high-risk indicators that might impact therapeutic interventions; a comprehensive list of individual-specific prescribed PNMP adaptive, mealtime and communication/hearing equipment; an appropriate therapist evaluation/review of prescribed equipment for fit, availability, function, condition, and effectiveness; recommendations, identifying the responsible therapist; date of work order and delivery of equipment; and frequency of equipment monitoring.
- In addition, the PNMP Clinic did not include an interdisciplinary assessment of the function, condition and effectiveness of individuals' bedrails. The assessment should review the relative risk of using the bed rails compared with not using the bed rails, and thoroughly consider if other options would provide the same benefit

while reducing the risk. The use of bed rails should be based on an individual's needs and should be documented clearly and approved by the IDT team.

- Based on interview and observation, multiple individuals' seating systems were not adequate, because they did not provide optimal alignment and support. In addition, individuals' seating systems had not been re-assessed in a timely manner.

Dental Services

- The Dental Department appeared to be improving campus-wide. Restraint use and oral sedation use was low and continued to decrease, and use of mechanical restraints also was decreasing. Oral hygiene ratings were determined to be highly favorable, with most individuals in the good to fair category. This might reflect the diligence of frequent prophylactic care. The system of desensitization prioritization and referral to the IDT appeared to be working. Refused and missed appointments were tracked to ensure a follow-up appointment was completed. The Dental Department appeared to work closely with the residences and the IDTs in resolving missed and refused appointments.
- In addition, a scheduling system was used to ensure timely completion of annual dental exams. An emergency dental log was maintained. The Facility offered a full spectrum of dental services.
- Areas of concern/weakness included the large number of edentulous individuals. The Dental Department is challenged to create a database for these individuals, with tracking of whether dentures or other dental options have been offered, and if such options were successful or not.
- Several individuals had desensitization plans that had been implemented, but data collection and analysis remained in the early stage of development.
- The annual dental summary included some areas that were confusing to those outside of the Dental Department and required further clarification.
- The Dental Department had developed reliable and complete databases. The Dental Department is encouraged to develop formal quarterly reports with analyses of this data, with cumulative trend data over serial quarters. Analysis should lead to formal improvement plans based on the data. Lastly, these quarterly reports should be shared at Dental Department meetings, as well as morning medical meetings and with Facility Administration through the QA/QI Council.

Communication

- At the time of the review, the Facility had a total of three full-time Speech Language Pathologists (SLPs) and two SLP vacancies, one of which would be filled in the coming weeks. In addition, there was one full-time SLP Assistant. On a positive note, in February 2012, a full-time Audiologist began employment and was currently in orientation.
- In November 2011, the Habilitation Therapies (HT) Director and the SLPs worked with a State SLP consultant. The State SLP consultant provided consultation to the SLPs on competency-based training, use of the State speech language assessment template, rolling assessments, Alternative and Augmentative Communication (AAC)

resources, auditing of completed assessments, and equipment monitoring. These topics were relevant and addressed areas of non-compliance.

- The SLPs initiated the process of reassessing 276 individuals living at ABSSLC using the State-established SLP assessment template. At the time of the review, the SLPs had reassessed 11 of the 276 individuals (4%). Based on interview, a total of 176 ABSSLC individuals had been assessed since the beginning of the Settlement Agreement and would not be reassessed. However, the Facility should not to assume the SLP assessments for these individuals were adequate. Based on the Monitoring Team's previous reviews, the SLP assessments reviewed were not adequate, and often did not include assessment of an individual's AAC needs.
- Individuals receiving direct speech therapy did not have adequate plans. In addition, the plans were not integrated into their ISPs.
- In January 2012, the SLPs had developed communication core competencies. The competency check sheet needed revision to further expand and list the individual steps that should be demonstrated to successfully master the skill.
- On a positive note, the HT Department decided to eliminate multiple monitoring tools, and had initiated the process of transitioning to the use of a universal monitoring tool. Therapists only recently had implemented the Compliance Monitoring form.

<u>Habilitation, Training, Education, and Skill Acquisition Programs</u>

- A review of habilitation services offered to the individuals residing at ABSSLC revealed skill acquisition programs that were limited in scope, and often not reflective of needs identified in current assessments. Although a new format for guiding skill acquisition programs had been introduced, many of the concerns raised in the past remained relevant. Learning objectives lacked specificity, teaching strategies were not outlined clearly, consequences applied to effect behavior change were often uniform and not specific to the individual's identified preferences, and there were no plans to ensure the maintenance and generalization of newly learned skills.
- Opportunities for learning remained infrequent. Engagement levels across the individual residences and activity centers were very low, and the observed activities were limited in scope, were often inappropriate for the age of the individuals served, and were clearly not individualized. Training in integrated, community-based settings was severely limited.
- Although more comprehensive assessments of functional, and specifically vocational skills had been introduced, the use of these completed assessments to guide individual support planning was not evident. While the State had developed a policy recognizing the importance of understanding the individual's preferences, these assessments were often incomplete.
- Even when individuals clearly had displayed lack of progress, refusal to participate, or disinterest in an activity, no evidence was present to show that teams were working collaboratively to identify and develop alternative learning opportunities.

Most Integrated Setting

- At the time of the review, although assessments prepared for annual ISP meetings had begun to include the assessor's recommendation regarding transition to the community, individuals' ISPs 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 presented to the entire team, including the individual and LAR, for consideration. Based on team discussion, including any opposition from the individual or his/her LAR, the entire team then should make a decision regarding any potential referral for community transition.
- The Facility continued to be at the initial stages of identifying obstacles to movement to the most integrated setting appropriate to the individual's needs and preferences, as well as strategies to overcome such obstacles. However, in a limited manner, the Facility had begun to analyze the aggregated data. Although more work was needed with regard to completing a full analysis, including integration of information the Facility had in relation to the community provider network(s) in the local area, the Facility had begun to use some information from the analysis to improve data integrity. Based on the initial analysis, the Facility had developed and implemented a corrective action plan. This involved some creative training for QDDPs, as well as work with specific teams to reconsider obstacles that did not appear to be appropriate, or were not adequately justified.
- The Community Living Discharge Plans (CLDPs) reviewed generally included a number of action steps related to the transition of the individuals to the community. However, many of them did not clearly identify the specific steps that the Facility would take to ensure a smooth and safe transition, and were not sufficiently detailed or measurable. The CLDPs reviewed included essential and non-essential supports. However, it appeared that the Facility continued to be 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.
- Post-move monitoring had been completed in a timely manner for 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.

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, and, as appropriate, assessing in more detail individuals' functioning in this area.
- In the meantime, ABSSLC had continued to use tools it had created to attempt to prioritize a list of individuals in need of guardians. Through the individual planning process, for individuals who did not have guardians, teams had reviewed the level of involvement of individuals' families/correspondents, if any existed. In addition, a "Guardianship Priority" tool had been used to review factors related to the need for decision-making (e.g., medical decisions, financial decisions), as well as the use of restrictive procedures, and lists had been developed of individuals with Priority I and Priority II levels of need for guardianship. Using the processes currently in place, a total of 90 individuals had been identified as requiring guardians. However, Facility staff recognized that this likely underestimated the numbers of individuals requiring guardians.
- Since the last review, four individuals had obtained guardians, and petitions for an additional four individuals were in various stages of the process. In addition to the Guardianship Assistance Program funding, the Human Rights Officer had worked with the finance office, and another alternative for funding had been identified using individuals' social security funds.

<u>Recordkeeping and General Plan Implementation</u>

- At the time of the Monitoring Team's last review, the Facility did not have Individual Notebooks. Since then, an interdisciplinary group had met, and made decisions regarding the Individual Notebooks. It appeared that a reasonable table of contents had been devised. It included a combination of information that direct support professionals would need to do their jobs, and data collection forms. The Facility had set forth a plan for implementation, and it was expected that by 3/5/12, use of the Individual Notebooks would begin.
- The Facility was continuing to develop and revise policies to address the requirements of the Settlement Agreement. Further work was needed to clearly identify the staff who required training on policies, as well as the type of training (e.g., classroom training, competency demonstration of skills, etc.), and the timeframes within which training needed to occur.
- With regard to auditing records, the Unified Records Coordinators, a Program Compliance Monitor from the QA Department, and the Records Coordinator continued to consistently conduct record reviews. Extensive follow-up was completed regarding any issues these audits revealed in individual records. Aggregate data was available, but an area in which further work was needed was in the analysis of this data. Such analysis should result in the identification of systemic issues, and the development and implementation of action plans to address the causes.
- Since the last review, the Facility had continued to implement the policy designed to improve the timeliness of filing items in the records. The policy clearly identified roles and responsibilities, and set timelines for

completion of specific activities. Although the timelines in the policy had not yet been met, 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.

- 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.

VI. Status of Compliance with the Settlement Agreement

SECTION C: Protection from Harm-Restraints	
Each Facility shall provide individuals with a safe and humane environment and ensure that they are protected from harm, consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** The following activities occurred to assess compliance: o **Review of Following Documents**: o ABSSLC Policy: Use of Restraints, dated 6/10; o ABSSLC Self-Assessment, dated 2/1/12; o Restraint Checklist POR-MR-7, revised 12/10; o Abilene State Supported Living Center Policies and Procedures Index, current as of 1/6/12; o Abilene State Support Living Center: Restraint by Facility, from 7/1/11 through 12/31/11; o ABSSLC Restraints Trend Analysis Report FY12 for the month of December 2011; o Restraint Reduction Plan Minutes, dated 10/27/11, 11/29/11, 12/22/11, 1/27/12 and 2/16/12; o Do Not Restrain/Modification of Restraint List, undated, provided in response to document request #1202-II.18; o List of Restraint Monitors, dated 2/16/12; o Curriculum for Restraint Monitors, undated; o Presentation Book for Section C; o Settlement Agreement Cross Referenced with ICF/MR Standards: Protection From Harm – Restraints, revised 12/10; o ABSSLC Restraint Summary, from 7/1/11 to 12/31/11; o Curriculum for Restraint Monitors; o Procedure for Desensitization Training, dated 11/8/10; o List of Dental Desensitization Plans Implemented or Revised Since 8/11; o Dental Desensitization Plans for: Individual #440, Individual #151, Individual #105, Individual #276, Individual #505, Individual #127, Individual #168, Individual #507, Individual #450, Individual #169, Individual #144, and Individual #177; o Behavior Assessments for: Individual #95, Individual #48, Individual #507, and Individual #323; o Behavior Support Plans for: Individual #23, Individual #164, Individual #199, Individual #123, Individual #319, Individual #151, Individual #534, Individual #95, Individual #216, Individual #390, Individual #518, Individual #105, Individual #6, Individual #371, Individual #13, Individual #303, Individual #188, Individual #196 (Draft), Individual #505, Individual #48, Individual #104, Individual #466, Individual #318, Individual #507, Individual #313 (Draft), Individual #332, Individual #17, Individual #278, Individual #8, Individual #444, Individual #363, Individual #323, Individual #215, Individual #67, Individual #98, Individual #508, Individual #395, Individual #396, Individual #324, Individual #510, Individual #504, Individual #414, and Individual #11;

- Individual Support Team Addendums for: Individual #95 (9/16/11, 9/27/11, and 12/12/11) and Individual #323 (8/26/11 and 9/7/11);
- PST Review of Repeated Restraints for: Individual #95 (10/6/11);
- List of individuals with Safety Plans for Crisis Intervention (SPCI), updated 1/12;
- Safety Plan for Crisis Intervention for: Individual #95 and Individual #323;
- Restraint Reduction Committee Meeting minutes, dated 10/27/11, 11/29/11, 12/22/11, and 1/27/12;
- Sample C.1 Crisis Restraints: The Restraint Checklist, Face-to-Face Assessment/Debriefing Form, Safety Plan, any reviews of the restraint and any ISP addenda for each of the following 25 instances of crisis restraint involving 21 individuals:

Individual	Date of Restraint	Time of Restraint
Individual #95	9/19/11	3:34 p.m.
Individual #505	10/22/11	8:20 a.m.
Individual #48	9/7/11	3:35 p.m.
Individual #48	11/14/11	1:11 p.m.
Individual #303	8/5/11	5:35 p.m.
Individual #303	12/23/11	7:22 a.m.
Individual #313	9/19/11	1:34 p.m.
Individual #323	8/12/11	8:40 p.m.
Individual #323	8/15/11	6:45 p.m.
Individual #387	7/20/11	3:53 p.m.
Individual #160	7/18/11	10:23 a.m.
Individual #160	12/3/11	7:20 a.m.
Individual #199	8/25/11	11:00 a.m.
Individual #74	10/17/11	3:20 a.m.
Individual #188	9/8/11	6:57 p.m.
Individual #231	9/23/11	3:00 p.m.
Individual #137	12/15/11	6:09 p.m.
Individual #107	11/4/11	1:36 p.m.
Individual #507	12/13/11	10:07 p.m.
Individual #486	11/11/11	7:50 a.m.
Individual #81	9/23/11	10:25 a.m.
Individual #127	12/13/11	10:30 a.m.
Individual #374	10/15/11	5:00 p.m.
Individual #469	10/6/11	1:25 p.m.
Individual #319	7/4/11	3:16 p.m.

- Sample #C.2: Training transcripts for 25 staff drawn at random from the Employee Listing provided by the Facility;
- Sample #C.3: The restraint checklist, documentation of the monitoring of the restraint, and any reviews of the use of restraint, including any desensitization plan that applied, the physician's order for the restraint, and the monitoring schedule used in 25 episodes of medical restraint for:

Individuals	Date of Restraint	Time of Restraint
Individual #451	9/15/11	1215
Individual #213	10/5/11	1630
Individual #429	9/27/11	1200
Individual #543	9/22/11	0845
Individual #305	10/12/11	1440
Individual #65	8/10/11	1435
Individual #137	12/5/11	0815
Individual #480	8/16/11	0630
Individual #242	10/18/11	0750
Individual #459	9/26/11	1007
Individual #120	8/24/11	1015
Individual #455	12/1/11	0800
Individual #196	8/23/11	0745
Individual #42	11/9/11	2345
Individual #523	12/20/11	0745
Individual #533	7/8/11	0440
Individual #33	8/23/11	0730
Individual #458	10/2/11	2200
Individual #203	8/12/11	0800
Individual #344	10/10/11	0815
Individual #370	10/26/11	0745
Individual #131	9/28/11	1355
Individual #388	8/17/11	0630
Individual #312	10/11/11	1035
Individual #527	11/10/11	0800

- Sample C.4 Chemical Restraint for Behavioral Crisis: Documents reviewed included the restraint checklist, face-to-face and debriefing reports, any reviews of the use of restraint, documentation of contact between the psychologist and physician prior to the use of the restraint, any changes to the ISP or Safety Plan as a result of the restraint for five of the 23 (20%) individuals listed in section II.7a of the document request.

Individual	Date of Restraint	Time of Restraint
Individual #313	7/12/11	1150
Individual #39	9/17/11	1145
Individual #284	10/31/11	1650
Individual #95	11/12/11	1559
Individual #59	12/12/11	1830

- Sample C.5 Off-Grounds Restraint: Documents reviewed included: the Restraint Checklist, the face-to-face/debriefing report, the safety plan, any/all reviews of this use of restraint, and any addendums or changes to the individual's ISP or safety plan that resulted. The sample was chosen from the list provided in response to Document Request II.14 with six names. One was chosen for the sample:

Individual	Date of Restraint	Time of Restraint
Individual #539	12/27/11	1640

- Sample #C.6: The sample of individuals with more than three restraints in 30 days was chosen from the list provided in Section II.7 of the document request. Documents reviewed included: Behavior Assessment or Structural and Functional Assessment Report, Behavior Support Plan, Safety Plan, ISP addenda that specifically addressed multiple restraints, and PST Review of Repeated Restraints (Individual #95 only):

Individual	Dates of Restraint
Individual #95	9/2/11, 9/11/11, 9/18/11, 9/19/11, 9/21/11, 9/24/11, 11/12/11, 11/12/11, 12/3/11, and 12/10/11
Individual #323	8/12/11, 8/15/11, 8/24/11, 9/1/11, 9/3/11, 9/15/11, and 9/20/11

- **Interviews with**:
  - Ron Manns, BCBA, Director of Behavioral Services;
  - Pat Smith, Quality Assurance Director;
  - Renay Kellum, Program Compliance Monitor;
  - Various staff in residential units, including 18 Direct Support Professionals;
  - Terri Massengill, RN, Nurse Manager;
  - Debra Schroeder, RN, Nurse Manager;
  - Tracey Cunningham, RN, Nurse Manager;
  - Teresa Lowry, RN, Nurse Manager;
  - Kathy Brannon, RN, Nurse Manager;
  - Amy Jo Bramlett, LVN, At-Risk Coordinator;
  - Mary Willingham, RN, Program Compliance Nurse;
  - Carole Ivy, RN, Nurse Operations Officer (NOO);
  - Judy Henry, RN, Quality Assurance;
  - Mary White, RN, MSN, Quality Assurance;
  - Cathy Northrup, RN, MSN, Chief Nurse Executive (CNE); and
  - Jerry Griffin, DDS, and Pam Acevedo, Dental Hygienist.
- **Observations of**:
  - Residences including: #5962, #5961, #5971, #5972, #6710, #6720, #6330, #6350, #6360, #6360, #6370, #6390, #6400, #6450, #6480, #6500, #6510, #6521, #6690, #6710, #6720, #6730, #6740, #6750, and #6760;
  - ISP annual meeting for Individual #148, on 2/16/12;
  - The IMT meeting, on 2/16/12;
  - The Unit IV Daily Incident Monitoring meeting, on 2/14/12;
  - The operation room of the video surveillance system, on 2/15/12;
  - The QA/QI Council Meeting on 2/16/12; and
  - Activity Center 5921, Activity Center 5922, Activity Center 5923, Activity Center 6340, and Activity Center 6700;
  - Senior Center;

	o Workshop 1, Workshop 2, and Workshop 3; o 5th Street Diner; o 7th Street Dental Clinic; o Center Incident Management Review Team (IMRT) Meeting, on 2/14/12 and 2/15/12; o Human Rights Committee (HRC) Meeting, on 2/14/12; o Behavior Support Committee (BSC) Meeting, on 2/15/12; and o Restraint Reduction Committee Meeting, on 2/16/12.
	Facility Self-Assessment: Based on a review of the Facility's Self-Assessment 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. A new format called the Self-Assessment had replaced the Plan of Improvement. The Facility used the results of the application of the Quality Assurance Monitoring Tool for Section C to determine compliance status with regard to each of the eight provisions of the section. The information included in the Self-Assessment indicated percentages of compliance, based on the use of the monitoring tools. 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. The Quality Assurance Monitoring Tool for Section C had not been upgraded to include adequate guidelines, as evidenced by the reported reliability scoring percentages that ranged from 38% for section C.8 to 90% for sections C.2 and C.3. The sample size was 12 per month for four months, and was drawn by the Quality Assurance staff. Designated Behavioral Services staff applied the monitoring tool to the sample of 48 restraint records. The Director of Behavioral Services and the QA Program Compliance Monitor applied the tool to a subset of 14 of the 48 records. The results of the monitoring were compared to determine reliability. Staff of Behavioral Services and Quality Assurance were meeting to review their results and to work on standardizing interpretations of the tool to improve reliability. In addition to the Self-Assessment the Facility presented four Action Plans for Section C to address training of Restraint Monitors, desensitization plans for individuals who needed repeated restraint for medical or dental procedures, review of Restraint Checklists by Behavior Services, and development of a restraint tracking procedure for repeated restraints. The Action Plans had separate steps with time frames, and each step specified the expected evidence of success and an indication of whether the step had been completed.
	Summary of Monitor's Assessment: The Monitoring Team found the Facility was not in substantial compliance with the provisions in Section C. Areas of progress included: ▪ The available data indicated that use of restraints was continuing to decline. ▪ A curriculum had been developed for Restraint Monitor training. During January and February

	2012, over 20 staff had been trained. ▪ There had been changes in residences designed to provide more space for people with problem behaviors, and to offer activity centers closer to residences increasing the opportunities for engagement in productive activities. ▪ Use of desensitization plans was noted for a growing number of individuals, particularly with regard to dental visits. The desensitization processes included use of a mock dental unit, where individuals could learn to adjust to dental office procedures. ▪ Behavioral Services had instituted a tracking system for restraints used more than three times in 30 days for any individual. ▪ The Restraint Reduction Committee was meeting monthly, and thoroughly examining the use of restraints and the follow-up by the Interdisciplinary Teams. Some of the areas that need improvement to assure continued progress toward substantial compliance included: ▪ The QA Monitoring tools should be improved. This should include adding guidelines or making modifications to promote consistency in ratings, so that inter-rater reliability improves. ▪ Data derived from the tools should be reported according to the discrete elements of each provision, rather than as composite scores. ▪ The roles of the Unit Teams and the Incident Management Team need to be clarified to describe the expectations of their reviews of restraints. Their minutes need to identify the episodes of restraint they chose to track, and then include the tracking to conclusion of the identified issue. ▪ There had been a change in the statewide data system that resulted in some issues with the reliability of restraint data and the issuance of monthly trend reports. Behavior Services compensated for the issues by using data collected through the review of restraints to create a monthly trend report. Processes will be needed to assure the accuracy of data in the new system and to allow production of monthly trend reports.

#	Provision	Assessment of Status	Compliance
C1	Effective immediately, no Facility shall place any individual in prone restraint. Commencing immediately and with full implementation within one year, each Facility shall ensure that restraints may only be used: if the individual poses an immediate and serious risk of harm to him/herself or others; after a graduated range of less restrictive measures has been exhausted or considered in a clinically justifiable manner; for reasons other than as	A review of the Trend Analysis Report FY12 for December 2011 showed: **Type of Restraint** / **1/1/10 to 12/31/10** / **1/1/11 to 12/31/11** Programmatic personal restraints* / 251 / 153 Crisis personal restraints / 97 / 132 Chemical restraints during a behavioral crisis / 119 / 65 Total of the above: restraints used during behavioral crisis / 467 / 350 * 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.	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	A comparison of the total number of episodes of restraint reported in 2010 and the total number reported in 2011 suggested the number of restraints had dropped substantially. The total number of restraints by year, which the Monitoring Team derived from tallying the numbers for the three separate restraint categories, did not equal the totals derived from the "Total Restraint" sheet in the Facility's report. The Facility should check the numbers to be sure the data is accurate, or add an explanation to the report of the reason for the differences. Sample #C.1 was selected from list of Individuals Restrained Between 7/1/11 to 12/31/11 per Section II.7 of the Monitoring Team's pre-review document request. The list included 142 incidents of restraint purportedly for behavioral crises. A sample of 25 (18%) was drawn. The details regarding the sample can be found in the section listing the documents reviewed. <u>Prone Restraint</u> Based on Facility policy review, prone restraint was prohibited. Based on a review of the restraint records for individuals in Sample #C.1, none showed evidence of the use of prone restraint. The Facility reported in its Self-Assessment that the Behavioral Services staff had reviewed a sample of 48 restraint reports between 9/1/11 and 12/31/11, and found no instances of prone restraint use. In interviews with staff, no one had seen prone restraint used or had used it themselves. In addition, staff appeared to understand that if an individual rolled into a prone position, they were to release the restraint immediately and restart in the proper position. This understanding was supported by comments on Restraint Checklists, indicating that individuals were released when in horizontal side-lying restraint when staff could not hold the restraint. This occurred five times in the cases in the sample. Although it was not clear, these premature restraint releases might have resulted from staff taking the correct action to avoid a prone restraint when the individual rolled. <u>Other Restraint Requirements</u> Based on document review, the Facility policies stated that restraints could only be used: if the individual posed an immediate and serious risk of harm to him/herself or others; after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner; for reasons other than as punishment, for convenience of staff, or in the absence of or as an alternative to treatment. Policy specified, in the definitions section, that restraints could not be used as part of the Behavior Support Plan, but, if needed, restraints could be specified in a Safety Plan. Facility policies identified a list of approved restraints. Specifically, ABSSLC Policy: Use of	

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		Restraints, dated June 2010, at Section II.E.2 identified four mechanical restraints that could be used: helmet, mittens, boxing gloves, and wrist-to-waist restraints, and then only as part of an approved Safety Plan or Behavior Support Plan. Section II.C.4 of the policy indicated that certain mechanical restraints were to be used only in a Safety Plan, or with prior approvals of the psychologist and the Administrator-on-Duty. The list of restraints included helmet, mittens, mittens with ties, and wristlets. The two lists should be reconciled to avoid confusion. The reference at II.E.2 to use of mechanical restraints in Behavior Support Plans needs to be clarified. 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 Monitoring Team's last report that the policy should be amended accordingly. However, there were no policy revisions included in the documentation submitted. This issue required correction. Based on a review of the records for the 25 episodes of restraint in Sample #C.1: ▪ In 22 of the 25 records (88%), there was documentation that the individual posed an immediate and serious threat to self or others. Exceptions included: o Individual #127 was placed in restraint when he reached out and grabbed a peer during snack time. The IDT determined that the restraint was not needed after the psychologist viewed tapes of the episode. Retraining was ordered. o On 9/7/11, Individual #48 was outdoors and began throwing chairs, attempting to run away and kicking staff. Staff applied a basket hold restraint, but they were unable to sustain it. Neither the Restraint Checklist nor the Face-to-Face/Debriefing form indicated how his behavior was brought under control, but the Face-to-Face/Debriefing did indicate that the staff would be in-serviced on the Safety Plan by the psychologist. The absence of an explanation of how the behavior was controlled when the restraint failed, as well as the indication that staff needed training on the safety plan suggested that the staff might not have taken sufficient interventions prior to the attempted restraint and that the restraint might not have been needed. o According to the Restraint Checklist, Individual #188 was outside of the workshop when he began to try to hurt himself and staff. It was not clear from the documentation what he was doing to hurt himself or staff. Staff applied an incorrect restraint, according to the debriefing form, and released immediately. When his home staff arrived, he calmed immediately. A clear description of his behavior (i.e., banging his head on a wall, kicking staff, throwing baseball size rocks at staff) was required to determine if the restraint was needed. ▪ In the 25 restraint records, a review of the descriptions of the events leading to behavior that resulted in restraint found that 25 (100%) contained no evidence	

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		that restraints were being used for the convenience of staff or as punishment. As discussed in the previous bullets, three records contained evidence that the restraint was not needed, but the circumstances suggested a misinterpretation by the staff rather than convenience or punishment. ▪ In 16 of the records (64%), there was sufficient evidence that restraint was used only after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner. However, in the remaining records, the level of evidence was minimal as illustrated by the following examples: o For Individual #374 (10/15/11) the two phrases entered repeated what had been checked off in the boxes, and provided inadequate information to allow a determination that appropriate less restrictive measures had been exhausted. o For Individual #231 there was no description of interventions beyond the checked boxes on the Restraint Checklist. There was no indication of what verbal prompts were given, what sort of redirection was used or how the environment was changed in an effort to avoid restraint. ▪ Based on the review of 25 restraints in Sample #C1, 23 (92%) were approved restraints. o The wristlets were used for Individual #199 without attempting an arm hold restraint, as specified in the Safety Plan. The wristlets did not appear to be on the list of approved mechanical restraints in the Facility policy on use of restraints (page 17 of the policy at E.2). Wristlets did appear on page 14 of the policy at C.4 indicating that wristlets could be used in a crisis, if not specified within a Safety Plan with prior approval by the individual's psychologist, Administrator-on-Duty, and/or Director of Behavioral Services. Since the use of wristlets was not specified in the individual's Safety Plan, and it was not approved as required, this was an improper use of mechanical restraint. One section of the checklist provided a list of possible interventions that staff employed prior to restraint. Documentation included in 29 restraint checklists reviewed indicated that staff had implemented the following interventions prior to restraint: o Interventions outlined in the individual's Behavior Support Plan (11 checklists, or 38%); o Interventions outlined in the individual's Safety Plan for Crisis Intervention (nine checklists, or 31%); o Prompts to demonstrate identified replacement behavior (14, or 48%); o Verbal prompts to cease the behavior (25, or 86%); or o Prompts to change environments (10, or 34%). Based on the narrative description provided in the checklists, it was difficult to	

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		determine the degree to which the BSP had been followed, given that these plans include preventative and antecedent strategies, and adequate narrative was not included in the restraint checklists to determine specifically what actions staff had taken. 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 five recent administrations of chemical restraint used for behavioral crises was requested. (This was a different sample than the Sample C.1 discussed above, which consisted of physical restraints.) Concerns were noted with the completeness of the documentation contained on the forms. The information contained in the section of the form following the prompt to: "Describe events leading to behavior that resulted in restraint" was reviewed. This section of the documentation was present for all five of these individuals. However, the documentation for these individuals only described the overt behavior that necessitated the restraint, and not the "events" that precipitated this behavior for four of these individuals: Individual #137, Individual #59, Individual #95, and Individual #284. The corresponding documentation for Individual #313 adequately described the antecedent events. Thus, the documentation was completed correctly for only one of the five individuals (20%). A clear description of the antecedents to the aggressive behavior is necessary to accurately determine if the administration of the oral or intramuscular (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 oral or intramuscular injection of psychotropic medication against an individual's will was necessary to fully support this observation. A review was completed of 43 Behavior Support Plans (BSPs). 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 the replacement behavior(s) across all environments. Although formal preference assessments had been introduced, their completion had not yet become standard practice as evidenced by the documents provided. Schedules of reinforcement remained inadequate. Treatment programs should include individual specific strategies that are based upon information gained through functional behavior assessment with an emphasis on direct observation. 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 and implemented, did not provide adequate or effective treatment. Because adequate behavioral treatment was not currently available	

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		at ABSSLC, the Monitoring Team could not conclude that restraint was not used in the absence of adequate treatment. Examples of BSPs that were inadequate, and teams failed to modify are provided with regard to Section C.7. The Self-Assessment indicated that 84% of the items on the tool reflecting expectation for this provision were met, without specifying how each of the various requirements or indicators was rated. It specifically cited concerns with documentation of the individuals' condition, and the alternatives attempted that were not specific or complete. While the Monitoring Team found that progress had been made in the reduction of the use of restraints, the Facility was not yet in substantial compliance with this provision, based on the combination of the lack of clarity and consistency in reporting the interventions attempted before restraint was used, the lack of a clear reason to use restraint in some cases, concerns about the need for clarification of the policy related to Safety Plans, and concerns related to BSPs. As a result, the Monitoring Team found the Facility to be out of compliance on this provision.	
C2	Effective immediately, restraints shall be terminated as soon as the individual is no longer a danger to him/herself or others.	The Restraint Records involving the 25 episodes of restraint in Sample #C.1 were reviewed. ▪ In four of the 25 records, restraint ended when the staff member was unable to sustain the restraint hold, and there was no explanation provided. It was not clear from the documentation how the dangerous behavior was controlled, or whether staff attempted the restraint and when they could not sustain it, or determined the behavior was no longer dangerous. The records included: Individual #95, Individual #48 (9/7/11), Individual #303 (12/23/11), and Individual #188. This was a significant concern, because the documentation did not show that the behavior had lessened, but means other than reinitiating the restraint were successful in addressing the situation. The Facility should carefully review these restraints, and staff's actions before, during, and after the restraint. ▪ In 18 episodes the restraint ended when the person was no longer a danger as recorded on the Restraint Checklist ▪ In three episodes of mechanical restraint, it was not clear that efforts were made to end the restraint before the 30-minute limit was reached. o For Individual #505, the restraint was applied and released 30 minutes later, which was the maximum time allowed both by policy and in his Safety Plan. Although the individual's Safety Plan indicates he is to be released when he is no longer struggling against restraints, trying to cause injury, or fighting restraints, no indication was provided regarding the individual's behavior in this regard. While there was a circulation check recorded at 15 minutes, there were no attempts to release.	Noncompliance

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		o For Individual #486 a helmet was used to stop him from hitting his head. He removed the helmet once, and it was replaced. The total time in restraint was at the policy limit of 30 minutes, and it was not clear whether there was an effort to end the restraint sooner. o For individual #199, wristlets were used to stop him from picking at a scab on his head. Staff attempted release after 30 minutes, but resumed five minutes later, and the restraint lasted another 30 minutes. Again, it was not clear if there were interim efforts to release or to consider releasing the restraint. ▪ In summary, 18 out of 21 incidents of restraint for which staff made the decision to release the individual (86%) occurred when the individual was no longer a danger to self or others. In its Self-Assessment, the Facility found it was out of compliance with this provision. This was due to the finding with regard to Section C.1 that some restraints may not have been the least restrictive alternative and therefore, release could not have been as quick as possible. The Monitoring Team concurred with this assessment. With regard to mechanical restraints, the Monitoring Team found release was attempted only after 30 minutes had passed, which was the policy limit, rather than when the person was no longer a danger to himself or others based on individualized criteria in Safety Plans. As a result, the Facility remained out of 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 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:	The Facility's 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. The list of permitted mechanical restraints for crisis intervention included: helmets, mittens, boxing gloves, and wrist-to-waist restraints, but as noted above, there appeared to be two conflicting lists within the policy. A review of 25 staff's records (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. Based on interviews with 18 direct support professionals: ▪ Eighteen (100%) were able to describe the basic policy governing the use of restraint. ▪ Eighteen could describe some approved verbal and redirection techniques (100%). ▪ Eighteen (100%) were able to describe approved restraint techniques.	Noncompliance

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	approved verbal intervention and redirection techniques; approved restraint techniques; and adequate supervision of any individual in restraint.	▪ Eighteen (100%) could describe adequate supervision of any individual in restraint. As noted above with regard to Section C.1, 64% of the restraint records reviewed showed that restraint was only used after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner. In its Self-Assessment, the Facility found that it was not in compliance, based on the findings related to Sections C.1 and C.2. They reasoned that if Sections C.1 and C.2 were noncompliant, that was evidence that restraint policies were not being implemented. The Monitoring Team found that 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 64% of the records reviewed was documentation sufficient to show that the intervention was the least restrictive. As a result the Monitoring Team did not find 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 eliminate the need for restraint.	Based on a review of 25 restraint records (Sample #C.1), in 22 (88%), there was evidence documented that restraint was used as a crisis intervention. In three cases described above with regard to Section C.1, there was insufficient evidence that an immediate and serious injury was imminent. A review was completed of 43 Behavior Support Plans (BSPs). There was no evidence of restraint in 42 of these plans (98%). The plan for Individual #199 referenced restraint for self-injury in the intervention section. Staff should re-write this plan to ensure that restraint is only described in the Safety Plan for Crisis Intervention. At the time of the last review, the Facility had a "Do Not Restrain/Modification of Restraint List." It listed individuals by residence who had some limitation on the use of restraint, but the notations echoed policy wording rather than providing specific information about each individual. This time the list included some more specific information. For example, for Individual #207 the note read: "Only when engaging in life threatening behavior and no horizontal holds or going down to the floor." However most comments continued to be "least restrictive method possible," which was a restatement of the policy that applies to everyone. It was not clear how the list was distributed, posted, or used to assure that no one was restrained in contravention of medical orders. The list should be clarified to include cautions for those individuals who have conditions that could jeopardize their safety if particular restraints are employed. The list should be made available to staff in the residences and to psychologists who are writing safety plans, to help assure that restraints are never used when medically contraindicated.	Noncompliance

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		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. However, the Do Not Restrain list included only 12 individuals. Since many individuals had diagnoses of osteopenia or osteoporosis, have stomas in place for nutrition, and other medical conditions that compromise their physical health, it was difficult to understand how only 12 individuals appeared on this list. The Facility provided a list of 22 individuals who had a dental desensitization plan implemented or revised since 8/11. Twelve of these plans were reviewed. Each 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. ▪ With a goal of increasing the individual's compliance or cooperation with dental exams, 11 of 12 objectives indicated the individual was to participate with verbal prompts for one trial across a designated number of sessions. The objective for Individual #177 indicated he would allow tooth brushing with reduced anxiety for one out of two brushings. Operational definitions of participation or reduced anxiety were not provided. ▪ Baseline was reported as the current need for sedation with possible restraint (four plans), sedation and restraint (two plans), sedation (two plans), restraint (one plan), refusal to participate (two plans), or signs of anxiety (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. ▪ For seven of 12 individuals (58%), training was to occur twice per week. Other schedules ranged from once to three times weekly. It is suggested that so few training opportunities will result in very slow and limited progress. ▪ 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 12 plans (50%), praise alone was identified as the reinforcer. The remaining plans (50%) indicated the individual was to receive praise and an edible reinforcer, or some other tangible for his/her cooperation. Completion of formal preference assessments is recommended to ensure that individual-specific reinforcers are incorporated into these plans. ▪ The task analysis outlined in these plans frequently provided a more in-depth description of staff behavior than the individual's behavior. Eleven of 12 plans (92%) included task analyses in which the majority of the steps (50% to 100%)	

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		described staff behavior. When the individual's behavior was described, the statement indicated the individual would "allow" dental staff to perform some procedure. It will be essential to describe the individual's observable and measurable response to enable objective assessment of his/her progress. It is important to note that a visit to the mock dental office, "Seventh Street Dental," revealed a good effort to create an environment in which an individual could learn to tolerate dental procedures. The Dental Director and one of his dental hygienists spent time describing several strategies they had employed to shape greater tolerance. Special toothbrushes were used, different flavored toothpaste was tried, plastic instruments replaced metal ones, and individual-specific materials were used to motivate those visiting the clinic. Staff are commended for their efforts and are encouraged to continue to expand programs to ensure that measures of individual behavior are collected with sufficient opportunities for training to occur. The Facility did not find itself to be in substantial compliance with this provision based on its application of the QA Monitoring tool. The scoring for this provision was reported as a composite score of 84%. As previously noted, composite scores do not accurately reflect performance on the individual requirements within the provision. Modifications to that methodology are needed to assure the Facility has an accurate picture of its compliance with the various elements, and is able to take action when concerns are identified. Due largely to issues related to desensitization, as well as a lack of a clear method for staff to determine quickly which individuals were on the "Do Not Restrain" list, or had restraint restrictions, the Facility remained out of compliance with this provision.	
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	The Facility provided a list of 31 staff members who had been trained as Restraint Monitors, and training records from January and February 2012 for 24 of those listed (77%). A copy of the "Curriculum for Restraint Monitors" was provided. The curriculum specified responsibilities and discussed the step-by-step procedures from arrival to filing of reports. To be complete, the curriculum needed the following: ▪ The date it was initiated; ▪ The method for ascertaining the competency to monitor restraints (such as a demonstration of how to review and document a restraint); ▪ Coaching techniques for assuring staff enter the correct information onto the Restraint Checklist; ▪ Directions to secure readable signatures by asking staff to print their names; and ▪ A list of common problems to avoid that have been identified in Restraint	Noncompliance

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	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 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.	Checklists and remain persistent, such as incomplete descriptions of behavior (e.g., hitting staff, throwing stones do not explain whether the hitting was forceful and targeted or whether the stones were boulders or pebbles). In the last report, the Monitoring Team noted several issues with the curriculum for RES0300, "Restraint: Ordering, Assessing, and Evaluating." According to the training transcript for one staff member in Sample #C.2, the course was still being used. It was not clear that the issues raised at the last monitoring visit had been addressed. The issues included: ▪ It contained information on programmed restraint. This was in conflict with current policy that permitted restraint only to be used as crisis intervention. ▪ 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. ▪ It addressed the use of restraints that were not on the approved restraint lists (i.e., restraint boards.) ▪ There were numerous other references that had not been updated to reflect current policy and Settlement Agreement requirements. To demonstrate compliance with the training requirements of this provision, the Facility should: ▪ Maintain the list of the staff who serve as Restraint Monitors, and assure that all staff on the list have received the training. ▪ Revise the training for Restraint Monitors to address outstanding issues described above. ▪ 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. ▪ If training used to train nurses on their responsibilities regarding restraint is the course RES0300, then the course should be revised to comply with State and Facility policy and with the requirements of the Settlement Agreement. Based on a review of 25 restraint records (Sample #C.1), a face-to-face assessment was conducted: ▪ In none out of 25 incidents of restraint (0%) by a trained staff member. This was determined based on the supplied list of Restraint Monitors and the dates of their training, which was completed in January and February 2012. Since the restraints in Sample #C.1 occurred before that training and no additional evidence was submitted, such as a list and training dates before January 2012, it was not possible to determine if the staff who monitored restraints prior to January 2012 had been trained or not.	

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		▪ In 20 out of 25 instances (80%), 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 #303 (12/23/11) and Individual #486 (no Face-to-Face/Debriefing Forms), Individual #231 (Restraint Monitor was "on the home", but it was not clear whether he/she was present where the restraint was taking place), Individual #81 on 9/23/11 and Individual #469 (not within 15 minutes). ▪ In 23 instances (92%), the documentation showed that an adequate assessment was completed of the application of the restraint. An example of an adequate assessment was for Individual #127, where the Restraint Monitor identified an incorrectly applied restraint, which led to retraining of the staff member involved. Records that did not contain such documentation included: Individual #303 (12/23/11) and Individual #486 (no Face-to-Face/Debriefing form). ▪ In 17 instances (68%), the documentation showed that an adequate assessment was completed of the circumstances of the restraint. Sections 3 through 6 of the Face-to-Face, Debriefing and Reviews for Crisis Intervention Restraint form required information regarding the entire episode of restraint: whether procedures were followed, what outcomes resulted, what worked, what did not work, and what might be used to prevent restraint. The descriptions were determined to be adequate when all the boxes were checked, any errors or omissions in the Restraint Checklist had been noted, all the questions were answered, and where the answers were not simply "the restraint worked and nothing else did." An example of an adequate description was Individual #107, where the report indicated that the restraint stopped the aggression; approaching his proximity made him more mad; and suggested backing away instead of blocking access to peers. An example of an inadequate assessment was Individual #137: "Nothing worked. Verbal and physical redirection did not work." This was inadequate because it did not provide any information or analysis of what was happening at the time of the restraint, or any ideas about why the efforts to prevent the restraint did not work. ▪ The sample did not contain any episodes where the physician had authorized an alternative monitoring schedule. Based on a review of 25 restraint records for 21 individuals for restraints that occurred at the Facility (Sample #C.1), there was documentation that a licensed health care professional: ▪ Conducted monitoring at least every 30 minutes from the initiation of the restraint in eight (32%) of the instances of restraint. Records that did not contain documentation of this included: Individual #95, 9/19/11; Individual #505, 10/22/11; Individual #48, 9/17/11, and 11/14/11; Individual #303, 8/5/11, and 12/23/11; Individual #313, 9/19/11; Individual #387, 7/20/11;	

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		Individual #160, 12/3/11; Individual #74, 10/17/11; Individual #188, 9/8/11; Individual #486, 11/1/11; Individual #81, 9/23/11; Individual #127, 12/13/11; Individual #374, 10/15/11; Individual #469, 10/6/11; and Individual #319, 7/4/11. ▪ Monitored and documented vital signs in 12 (48%) episodes. Records that did not contain documentation of this included: Individual #95, 9/19/11; Individual #505, 10/22/11; Individual #48, 11/11/11; Individual #303, 8/5/11, and 12/13/11; Individual #323, 8/15/11; Individual #387, 7/20/11; Individual #160, 7/18/11; Individual #199, 8/25/11; Individual #188, 9/8/11; Individual #107, 11/4/11; Individual #507; 12/13/11; and Individual #486, 11/11/11. Problematic issues noted that resulted in noncompliance included the vital signs not recorded or marked as refused. As noted in previous reports, to obtain respirations, the individual's cooperation is not required. In addition, noncompliance with this indicator was found for individuals whose Restraint Checklists indicated that individuals had significantly high or low values for their vital signs, but did not include documentation that the vital signs were retaken to ensure the individuals were medically stable. ▪ The indicator regarding "monitored and documented vital signs for two hours from the initiation of the restraint" was not assessed, because the State Restraint policy that included this requirement was still in draft form and thus, had not been implemented at the time of the review. ▪ Monitored and documented mental status in four (16%) episodes. Records that did not contain documentation of this included: Individual #95, 9/19/11; Individual #505, 10/22/11; Individual #48, 11/14/11; Individual #303, 8/5/11, and 12/23/11; Individual #313, 9/19/11; Individual #323, 8/12/11, and 8/15/11; Individual #387, 7/20/11; Individual #160, 7/18/11; Individual #199, 8/25/11; Individual #74, 10/17/11; Individual #188, 9/8/11; Individual #137, 12/15/11; Individual #107, 11/4/11; Individual #507, 12/13/11; Individual #486, 11/11/11; Individual #81, 9/23/11; Individual #127, 12/13/11; Individual #374, 10/15/11; and Individual #469, 10/6/11. Problematic issues noted that resulted in noncompliance included either the mental status was not recorded, was generic (e.g., "alert, oriented, and aggressive") without a specific description included, or was marked as refused. As noted in the previous reports, to obtain a mental status, the individual's cooperation is not required. The nurse should describe the status of the individual. For example, "Individual yelling, face red, spitting when talking with fists clenched." A description such as this clearly describes the individual's mental status without warranting any type of cooperation. From discussions with the Director of Behavioral Services, the QA Nurse, and the QA Program Compliance Monitor for this area, the Nursing Department had not been	

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		conducting the audits addressing the nursing documentation regarding restraints. Although a QA PCM, who was not a nurse, had been conducting audits on the nursing documentation for restraints, the Facility's data only addressed the completion of the nurse documentation and not the quality of the nursing documentation. Thus, the Facility's data did not accurately reflect the significant problematic issues that were found above, or with regard to Section C.6 that addresses a licensed health care professional's documentation of assessment for any restraint-related injuries or other negative health effects. However, from discussions with the QA Nurse, a nurse would audit this area by the time of the Monitoring Team' s next review. Based on documentation provided by the Facility, six restraints had occurred off the grounds of the Facility in the last six months. One was selected for review related to Individual #539 (Sample #C5). The following was found: ▪ Monitoring was not conducted within 30 minutes of the individual's return to the Facility. Individual #539 left for a walk around the circle (at the Cottages) and extended the walk to off-campus. He was followed, encouraged to return and when he continued away from campus, he was restrained using a Bear Hug and redirected back to campus and presumably back to his residence. The restraint was not reported until two hours later, and the nurse was not called for another hour and a half. ▪ When the nurse was notified, he was seen and his vital signs were monitored. Sample #C.3 included 25 episodes of medical restraint (i.e., chosen from the list provided in response to document request II.7, but noted as II.7.b). This list provided identified 126 restraint reports. The sample of 20% was 25 reports. Fifteen of these restraints were chemical, three were "personal" (hand-hold or arm-hold), one was a combination of chemical and "personal," and six were mechanical (wristlets). For these individuals, the physicians' orders from the Physician's Orders log and as referenced on the Restraint Checklist were reviewed, as well as documentation of monitoring on the Restraint Checklist. The following represents the results of this review: ▪ In none of 25 episodes of medical restraint (0%) did the physician or dentist specify a schedule of monitoring. The Settlement Agreement indicated that: "In each instance of a medical restraint, the physician shall specify the schedule and type of monitoring required." ▪ In each of the 25 episodes, (100%) the Restraint Checklist included monitoring by a nurse. Each case varied depending on the procedure, and the chemical restraint. Monitoring every 10 to 15 minutes for the first two hours was standard, and some continued monitoring every 30 minutes to an hour for as long as 24 hours.	

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		The Facility found itself to be in noncompliance with this provision based on the QA Monitoring assessments that had been done. As with other provisions noted above in Sections C.1, C.2, C.3, and C.4, the use of a composite score does not provide an accurate or adequate assessment of the elements of the provision. The Facility showed improvement in the training of Restraint Monitors with the use of a new curriculum for training. However, a number of problems were noted in relation to the Facility's compliance with the requirements of this provision. These included the lack of adequate assessment of the circumstances of restraints, the untimeliness of the start of monitoring, the lack of prompt and adequate assessments of individuals in restraint by nurses, the lack of adequate documentation to show appropriate training of all restraint monitors and of nurses for the period reviewed, the inconsistency between the training curricula provided for nurses and the State and Facility policies, as well as a lack of direction from physicians for the monitoring of medical restraints. Due to these various issues, 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 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.	Based on review of Sample #C.1, consisting of 25 Restraint Checklists for individuals in crisis restraint according to the Facility, the following compliance rates were identified for each of the required elements: ▪ In 23 (92%), continuous one-to-one supervision was provided. In two cases, the Level of Supervision was not completed on the Restraint Checklist, although it was on the Face-to-Face form without comment (i.e., Individual #231 and Individual #48 on 11/14/11). ▪ In 25 (100%), the date and time restraint began was documented; ▪ In 24 (96%), the location of the restraint was documented (Individual #95 was the exception); ▪ In none of the five cases reviewed, where the time in restraint exceeded 15 minutes, was it evident that there was a need to release the restraint for exercise, meals, fluids or toileting. For example: Individual #199 was in wristlets to prevent picking at a scab for 65 minutes with an attempt to release at 30 minutes and he was released from restraint before lunch. For the other 20 cases, the time in restraint was less than 15 minutes and in such short time periods, opportunities for exercise, meals, fluids and toileting were not noted and were unlikely to have been needed. ▪ In 10 (40%), information was documented about what happened before, including the change in the behavior that led to the use of restraint. ▪ In 16 (64%), 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 (This is discussed with regard to Section C.1.)	Noncompliance

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		▪ In 22 (88%), the reason for the use of the restraint was identified (details for those that did not are provided with regard to Section C.1.) Most checklists had "SIB" or "aggression to staff or peers" checked in the appropriate box, and further descriptions, usually in the space for describing antecedents to the restraint, to describe the type of aggression (hitting, kicking, or throwing stones.) Even better descriptions would have included additional descriptors such as "punching at staff, but not connecting," or "throwing hands-full of pebbles at car windows," or "throwing baseball size rocks at staff." ▪ In 25 (100%), the method and type (e.g., medical, dental, crisis intervention) of restraint was documented; ▪ In 25 (100%), the names of staff involved in the restraint episode were listed, though some entries were difficult to read; ▪ Observations of the individual and actions taken by staff while the individual was in restraint were noted, including: o In 22 (88%), the observations were documented at least every 15 minutes and at release. In the three restraints, where monitoring was not documented every 15 minutes: • For Individual #303 (on 8/5/11), the horizontal restraint lasted 25 minutes with no documentation between the initiation and release. • For Individual #323 (on 8/12/11), the basket hold/horizontal restraint lasted 18 minutes with no documentation between the initiation and release. • For Individual #199 (on 8/25/11), the mechanical wristlet restraints were in place for 30 minutes, released for five, and reapplied for another 30 with no documentation at 15-minute intervals. ▪ In 23 of 25 restraints (92%), the documentation identified the level of supervision provided during the restraint episode as one-to-one. ▪ In 25 of 25 restraints (100%), the date and time the individual was released from restraint was on the Restraint Checklist. ▪ In three (12%), the results were documented of an adequate assessment by a licensed health care professional as to whether there were any restraint-related injuries or other negative health effects. Records that did not contain documentation of this included: Individual #95, 9/19/11; Individual #505, 10/22/11; Individual #48, 11/14/11; Individual #303, 12/23/11; Individual #313, 9/19/11; Individual #323, 8/12/11, and 8/15/11; Individual #160, 7/18/11, and 12/3/11; Individual #199, 8/25/11; Individual #74, 10/17/11; Individual #188, 9/8/11; Individual #231, 9/23/11; Individual #137, 12/15/11; Individual #107, 11/4/11; Individual #507, 12/13/11; Individual #486,	

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		11/11/11; Individual #81, 9/23/11; Individual #127, 12/13/11; Individual #374, 10/15/11; Individual #469, 10/6/11; and Individual #319, 7/4/11. Problematic issues noted that resulted in noncompliance included either the Post Restraint Assessment section being left blank, or the section lacked an appropriate nursing assessment of the individual's overall physical and mental status after being restrained, or there was a lack of appropriate nursing documentation regarding injuries that included the specific descriptions of the injuries. A sample of 25 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. Sample #C.4 was selected from those who had chemical restraint as a crisis restraint. This sample is defined in the documents reviewed section. In three of the five reports (60%), there was documentation that prior to the administration of the chemical restraint, the licensed health care professional contacted the psychologist, who assessed whether less intrusive interventions were available and whether or not conditions for administration of a chemical restraint had been met. In those three cases the record included" an "Administration of Emergency Medication Protocol" with the name of the psychologist and the signature of the licensed health care professional. The record for Individual #95 did not contain the protocol, and for Individual #284, the protocol was unsigned. As illustrated throughout this section, a number of documentation issues continued to exist related to the use of both crisis "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. The Self-Assessment findings were similar, though, as stated in other places in Section C of this report, the separate elements of the provision need to be evaluated and reported on separately.	
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	According to the restraint review provided by the Facility, during the six-month period	Noncompliance

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	skills and biological, medical, psychosocial factors;	(July through December) prior to the on-site visit, a total of five individuals were placed in restraint more than three times in any rolling 30-day period. A sample of two (40%) of these individuals was selected for review to determine if the requirements of the Settlement Agreement were met. The two individuals reviewed were Individual #95 and Individual #323. The following documents were reviewed: Behavior Assessment or Structural and Functional Assessment Report, Behavior Support Plan, Safety Plan, ISP addenda that specifically addressed multiple restraints, and PST Review of Repeated Restraints (Individual #95 only). The results are discussed below with regard to Section C.7.a through C.7.g of the Settlement Agreement. For both of the individuals (100%) reviewed, the individual's team met to discuss the restraints. For neither of the individuals (0%), did the team adequately review the individual's adaptive skills. The following provides an example where the team failed to adequately review and address the individual's adaptive skills: ▪ A review of more than three restraints was held on 9/16/11 for Individual #95. The information recorded did not address observable behavior as repeated reference was made to "junk" behavior prior to other behaviors that led to restraint. As his behavior towards female staff was not described, it was not possible to identify appropriate adaptive behavior that could be taught or reinforced. For both of the individuals (100%), the individual's team adequately reviewed biological, medical, and psychosocial factors. The following are examples of where this was done appropriately: ▪ The team for Individual #95 was instructed to limit interaction with female staff once inappropriate behavior was displayed. However, it would be advisable to define this inappropriate behavior in observable terms. ▪ Medication was increased following a reported increase in paranoid and delusional behavior exhibited by Individual #95. ▪ Medication was to continue to be administered when Individual #95 reported pain following recent dental surgery. ▪ At a meeting of the IDT for Individual #323, nursing staff reported to the psychiatrist a worsening in impulse control displayed by this individual. As this had reportedly led to an increased intensity of aggression that resulted in restraint, a change in medication had been prescribed.	
	(b) review possibly contributing environmental conditions;	For one of the individuals (50%), the individual's team adequately reviewed the possibly contributing environmental conditions. The following is an example of the individual for whom this was done appropriately:	Noncompliance

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		▪ Behavior Services Team staff were scheduled to work with staff in the new home environment for Individual #323.	
	(c) review or perform structural assessments of the behavior provoking restraints;	For both of the individuals (100%), a functional behavior assessment was referenced in the behavior support plan. Behavior assessments for both of these individuals (100%) reflected completion dates within the previous year. However, functional behavior assessment should be an ongoing process, particularly when the individual continues to display problem behavior that results in restraint. The quality of the assessments varied across individuals. The assessment for Individual #95 provided evidence that the psychologist had tested some functional hypotheses during an observation. This proved to be quite informative. An in-depth review of functional behavior assessments is provided with regard to Section K.5 of the Settlement Agreement. One concern raised in the review of ISP addenda related to more than three restraints in 30 days was noted for Individual #95. On 9/27/11, van rides were identified as a reinforcer. However, it also was noted that serious behavior problems had occurred during these rides. Alternative reinforcers were being explored. On 10/6/11, this same comment was included in the PST Review of Repeated Restraints. In this same document, it was noted that the individual's work attendance had been poor. The recommendation was to "…consider adding positive reinforcement for work attendance." As reinforcement for appropriate behavior is an essential component of any behavior support plan, staff should conduct a preference assessment in a timely manner to ensure that this issue is addressed. Similarly, there was a suggestion to assess the individual's response to a brief removal of an activity versus termination of the activity when behavior problems occurred. While a good suggestion, there was no evidence that this assessment had been completed. As a result of concerns related to the quality of assessments and the failure of the teams to address this at meetings held to address more than three restraints in 30 days, 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	Both of the individuals reviewed (100%) had a Behavior Support Plan (BSP). The following was found: ▪ An implementation date was provided for Individual #95 only (50%). The plan for Individual #323 was not dated. ▪ Operational definitions of targeted problem behaviors were provided in both	Noncompliance

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	be treated that leads to the use of the restraint; alternative, positive adaptive behaviors to be taught to the individual to replace the behavior that initiates the use of the restraint, as well as other programs, where possible, to reduce or eliminate the use of such restraint. The type of restraint authorized, the restraint's maximum duration, the designated approved restraint situation, and the criteria for terminating the use of the restraint shall be set out in the individual's ISP;	plans (100%). ▪ Neither of the two plans (0%) included specific, functionally equivalent replacement behaviors to be taught to the individual. ▪ Both plans (100%) provided a brief review of a completed functional behavior assessment. One plan (50%) included the date the assessment was completed. ▪ Both plans (100%) listed the individual's preferences or potential reinforcers, but none (0%) reflected the completion of a formal preference assessment. ▪ Both plans (100%) included specific treatment strategies to utilize when the target behaviors occurred. The behavior support plans for both of these individuals were inadequate in some ways. In meeting to review the instances in which more than three restraints in 30 days occurred, only one team (50%) identified a problem with the plan, and/or made the necessary modifications. This resulted in the addition of self-injury as a target behavior for Individual #323. A Safety Plan for Crisis Intervention had been developed for the two individuals reviewed. This review revealed the following: ▪ The date of implementation was provided in neither plan (0%). ▪ In both of the plans (100%) 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. This general description of criteria for release was not helpful in providing staff with behavioral criteria that was individualized and observable. ▪ Neither of the plans (0%) was signed. Steps should be taken to ensure that safety plans are developed, approved, and implemented in a timely manner for those individuals who experience three or more restraint episodes in any rolling 30-day period. Further, documentation provided to staff should be dated and signed by the plan author.	
	(f) ensure that the individual's treatment plan is implemented with a high level of treatment integrity, i.e., that the relevant treatments and supports are provided consistently across settings and fully as written upon each occurrence of a targeted behavior; and	Treatment integrity for this sample of individuals had not been completed at the time of the restraints, or, for that matter, at the time of the Monitoring Team's visit. The Facility had begun collecting data on treatment plan implementation through interview and role-play. Strategies to ensure high levels of treatment integrity will require ongoing support and training provided by the lead psychologist to the direct support professionals as they carry out their job responsibilities. Competency-based training that is provided on-the-job will be necessary to meet this component of the Settlement Agreement. Further details regarding treatment integrity are provided with regard to Section K.12 of this report.	Noncompliance

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	(g) as necessary, assess and revise the PBSP.	New or revised behavior support plans were identified in either the PSP addenda or the PST Review of Repeated Restraint for both individuals (100%). Upon admission, a behavior protocol was developed for Individual #95. A new BSP was introduced approximately four months later. The PSP addendum, dated 9/16/11, included a note that Behavior Services Team staff were to provide support and training to home staff on this new BSP. The most recent BSP for Individual #323 included self-injury as one of the targeted problem behaviors. However, as noted above with regard to Section C.7.e, concerns that teams should have identified with regard to behavior support plans were not identified, and changes were not made to ensure that individuals were not subjected to unnecessary restraint. In meeting to review the instances in which more than three restraints in 30 days occurred, only one team (50%) identified a problem with the plan, and/or made the necessary modifications. This resulted in the addition of self-injury as a target behavior for Individual #323.	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 documenting restraints started with the restraint monitor who was to arrive at the site of the restraint within 15 minutes of the start of the restraint. The restraint monitor determined if the restraint was necessary and applied correctly, reviewed the Restraint Checklist and completed a Face-to-Face and Debriefing form (one document). The restraint monitor interviewed staff and the individual restrained in order to complete the document. The Restraint Checklist, Face-to-Face/Debriefing sheet then went to the next Unit Team Meeting (within three days) to be checked for completion, and for assignment of responsibility to make corrections, if necessary. According to practice, the Unit Team reviewed the restraint and entered remarks, decisions, and instructions in the Unit Meeting notes. The forms proceeded to Behavioral Services for review by a psychologist to determine whether the documentation was adequate, and if more than three restraints had occurred within a rolling 30-day period. The notes from the Unit Meeting were sent, usually the same day, to the Incident Management Team, where they were presented, discussed, and any additional information was added. If there were additional requests for information or actions to be taken, the minutes of the IMT were set up to note what was needed and to track to completion. The Unit Director noted the dates of the Unit and Incident Management Team reviews on the Debriefing form, and any additional actions to be taken, and returned the form to a clerk for data entry. Depending on the circumstances of the restraint and the determinations of the Unit and Incident Management Review Teams, an Interdisciplinary Team (IDT) meeting might be	Noncompliance

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		called, and an addendum added to the Individual Support Plan. A sample of documentation related to 25 incidents of restraint was reviewed (Sample #C.1), including the Face-to-Face/Debriefing forms and, when available, Unit Team meeting notes, Incident Management Review Team Minutes, Restraint Reduction Committee minutes, and ISP addenda. Not all records contained copies of reviews by the Unit Team or IMT. The documentation that was available showed that: ▪ In 25 (100%), the review occurred within three days of the restraint episode, according to the entries on the Face-to-Face/Debriefing form, and/or the date on the provided notes from the Unit Team or Incident Management Team. ▪ In 16 (64%), the circumstances under which restraint was used were determined. As indicated in Section C.5 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 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. ▪ In 0 (0%), an adequate review was conducted. To have constituted an adequate review, the Unit Team and the Incident Management Team needed to have identified any outstanding issues with the Face-to-Face/Debriefing form; raised possible systemic issues (e.g., overcrowding, inexperienced staff, inadequate opportunities for productive activities); confirmed actions already taken or directed addition action where needed to address individual issues or issues related to the restraint itself; and required reports to close any open issues (loop-closing). o Seven of 25 records included the UT and/or IMT notes. What notes were included were brief. None contained an adequate assessment. o Ten records did not contain any information from reviews by the UT, the IMT, or the Interdisciplinary Team. In addition, as noted above with regard to Section C.7.e, concerns that teams should have identified with regard to behavior support plans were not identified, and changes were not made to ensure that individuals were not subjected to unnecessary restraint. In meeting to review the instances in which more than three restraints in 30 days occurred, only one team (33%) identified a problem with the plan, and/or made the necessary modifications. This resulted in the addition of self-injury as a target behavior for Individual #323.	

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		The Restraint Reduction Committee had changed back to monthly meetings and revised their format. On 12/22/11 the meeting had an agenda that included review of the restraint trends for the last month, review of persons with repeated restraints, a discussion of goals for further restraint reduction, and review of a list of concerns and actions to be taken as discussed at the previous meeting. The analyses of repeated restraints that IDTs completed were presented and documented in a prescribed format, including planned actions. In the meeting observed during the February visit, the presentations were well done, the discussion thoughtful, and the resulting actions useful. The Trend Analyses Report in its previous form was no longer available, since the initiation of the new, statewide, AVATAR data system. However, Behavior Services had substituted an abbreviated version that allowed a graph of progress in reducing restraints over a one-year period. Improvements were still needed 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 adequate information about the antecedent behaviors and the graduated efforts to control the behavior short of restraint. When such information is missing or insufficient, they should ask questions to clarify, and document that process in the minutes. In its Self-Assessment, the Facility found itself out of compliance based on two ISPs in their sample that were not promptly reviewed and revised, based on information about restraints. The Monitoring Team found that although the Facility process for reviewing restraints was in place, and substantial improvement had been made in the operation of the Restraint Reduction Committee, the review process was not being completely implemented. 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, and to clarify whether wristlets may be used. (Section C.1)
2. As recommended with regard to Section J.3, the documentation contained in the Chemical Restraint forms that involve the oral or 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 the reason, and whether the restraint could have been released sooner, or whether additional or alternative training of staff is needed. (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 and regularly monitors, and appropriately documents the vital signs, and the mental status of an individual in restraints at least every 30 minutes from the start of the restraint, and for two hours except for a medical restraint pursuant to a physician's order. (Section C.5)
11. The Facility should ensure that nursing assesses and appropriately documents any restraint-related injury. (Section C.6)
12. 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)
13. 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)
14. Since the Restraint Checklist, Face-to-Face sheet and Debriefing all require handwritten information, it is important that the information be legible. Staff should be required to write legibly. (Section C.5)
15. To avoid confusion, the "programmatic" terminology should be removed from the data reports and training curricula. (Section C.5)
16. 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)
17. Restraint Monitors and nurses should be trained to complete the review of the use of restraints and to document the results accurately on the appropriate forms. (Section C.5)
18. 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)
19. 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)
20. 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)

21. Staff should consistently review teaching of adaptive skills to individuals who experience more than three restraints in 30 days. (Section C.7.a).
22. Staff should consistently review the biological, medical, and psychosocial factors related to individuals who experience more than three restraints in 30 days, 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 more than three restraints in 30 days. (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. This should include clear definition of the individualized criteria for release of restraint. (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. 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)
30. 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)
31. With regard to the Facility's self-assessment processes:
    a. Monitoring instruments should include improved guidelines to ensure inter-rater reliability and validity of monitoring results.
    b. The Facility should review and report on data related to the individual indicators within each sub-section of the Settlement Agreement.
    c. The Facility should ensure that the quality of efforts as well as the quality of the documentation is evaluated thoroughly.
    d. 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. (Facility Self-Assessment)

SECTION D: Protection From Harm - Abuse, Neglect, and Incident Management	
Each Facility shall protect individuals from harm consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o ABSSLC Policy #021.1: Protection from Harm-Abuse, Neglect and Incident Management, revised 11/15/11; o ABSSLC Policy #002.3: Incident Management, dated 6/18/10, revised 1/31/11; o ABSSLC Self-Assessment, dated 2/1/12; o Presentation Book for Section D; o ABSSLC Action Plan, dated 2/2/12; o ABSSLC Provision Action Information, dated 1/30/12; o Mental Health (MH) and Mental Retardation (MR) Investigations Streamline Policy, dated December 2010; o List of DFPS-Investigated Cases, from 8/31/11 through 1/3/12; o List of unusual incidents, from 8/5/11 to 1/2/12; o Staff Reassignments list provided in response to Document Request #1202.III.26, undated; o DADTX Course delinquency list for Abuse/Neglect/Exploitation (A/N/E) Training, dated 1/2/12; o ABSSLC Annual Employee Registry Check and Fingerprint Criminal History Submission, dated 9/10/11; o Criminal Background Check for Foster Grandparent Program – Abilene, undated; o Annual Volunteer Registry Check and Fingerprint Criminal History Submission for Volunteers; o Individual Training Records for 25 employees in Sample #C.2; o Sample #D.1 included a sample of 20 DFPS investigations of abuse, neglect, and/or exploitation with the Facility investigation reports that were related. This sample included the following DFPS investigation numbers: #40268679, #40270170, #40287231, #40298840, #40301547, #40311656, #40341456, #40393453, #40423376, #40486998, #40532736, #40628469, #40757236, #40766976, #40779676, #40790336, #40851577, #40867202, #40931326, and #40990656; o Sample #D.2 included a sample of 11 investigation reports completed by the Facility only or by the Facility in conjunction with DFPS. Sample D.2 included cases: #2889, #2919, #2920, #2923, #84, #127, #145, #148, #192, #228, and #237. o Sample #D.4 included 22 Individual Support Plans (ISPs) for: Individual #284, Individual #202, Individual #463, Individual #414, Individual #498, Individual #46, Individual #126, Individual #139, Individual #181, Individual #527, Individual #162, Individual #272, Individual #238, Individual #342, Individual #81, Individual #98, Individual #117, Individual #346, Individual #176, Individual #541, Individual #313, and Individual #210; o Sample #D.5 of reports of abuse or neglect by individuals or by Legally Authorized Representatives (LARs) was not drawn, because it was not possible to determine who

	made any of the allegations due to the right to anonymity of the reporters; and o Sample #D.6 included five of the DFPS investigations from Sample #D.1where abuse or neglect was confirmed and two of the Facility investigation from Sample #D.2, including the following investigations: Facility investigations #84 and #228, and DFPS cases #40268679, #40311656, #40790336, #40298840, and #40990656. ▪ **Interviews with**: o Linda Hinshaw, Facility Director; o Jolene Willis, Assistant Director of Programs; o Luee McCreary, Incident Management Coordinator (IMC); o Patricia Smith, Quality Assurance Director; o Ron Manns, Director of Behavioral Services; o Tracyl Gandee, Settlement Agreement Coordinator; o Ted Wagner and Tommy Johnston, Incident Management Investigators; o Mary White and Judy Henry, Quality Assurance Nurses, regarding death of Individual #131; o Larry Jones, Director of Residential Services; o Richard Martinez, Risk Manager; and o Eighteen staff members responsible for the provision of supports to individuals. ▪ **Observations of**: o Eleven residences including: #5962, #5961, #6710, #6720, #6330, #6360, #6370, #6390, #6450, #6740, and #6400, and one Activity Center #6700; o ISP annual meeting for Individual #148, on 2/16/12; o Incident Management Team (IMT) meeting, on 2/16/12; o Unit IV Daily Incident Management meeting, on 2/14/12; o The operation room of the video surveillance system, on 2/15/12; and o QA/QI Council Meeting, on 2/16/12.
	Facility Self-Assessment: The ABSSLC Self-Assessment indicated the Facility was in substantial compliance with 12 of the 22 provisions in Section D of the Settlement Agreement. The Monitoring Team found the Facility to be in compliance with 13 of the 22. As of the Monitoring Team's last report, a monitoring tool and guidelines to assess compliance with Section D had been developed. At the time of the last review, those tools were being applied, data was being generated, and some of that data was being incorporated into the Plan of Improvement. Since the last review that Plan of Improvement was no longer being used. Instead, a Facility Self-Assessment and Action Plans were compiled for each provision of this section of the Settlement Agreement The Facility's findings were based on a combination of the results of the use of the QA monitoring tool by the Incident Management Coordinator and the QA Program Compliance Monitors (PCMs) with the addition of information from such other sources as the Campus Center Training Compliance Report, Trend Reports, or direct observation, such as checks by investigators of the presence of Rights posters in buildings throughout the campus. Progress on Action Plans developed after the Monitoring Team's last visit was

	considered as well. Although the monitoring tool was in use, and the PCM and the IMC were meeting to discuss differences in interpretation of tool, it was not clear that the results of those discussions were being incorporated into the guidelines in order to establish the correct way to interpret the various indicators. In order to attain valid results, the criteria for monitoring should be clearly established. The Facility used data collected through the Program Compliance Monitor's application of the Section D monitoring tool to 29 records with a look behind audit of nine of those reports by the Incident Management Coordinator. The results were reported for provisions of the Settlement Agreement and broken down by sub-provisions, where necessary. The time period covered by the 29 reports was the first quarter of Fiscal Year 2012 (September to November 2011). In addition to the Self-Assessment, the Action Plans were reviewed. While the Action Plans described action steps related to provisions of the Settlement Agreement, and they addressed some important issues such as policy revisions, they did not always reach the more difficult issues of implementation. For example, for Section D.2.i, which required semi-annual audits of injuries, the actions steps included policy development, training on the policy, compiling monitoring data, and developing corrective action plans. What was needed was a description of how the policy would be modified, how often and by whom the trend reports would be compiled analyzed and reported, when investigations would be triggered by findings, and who would be responsible for following up with corrective action plans. In addition to collecting data on indicators, the Facility addressed some of the Monitoring Team's recommendations from the last visit. For example, as discussed above, although it was inadequate, an Action Plan was included with the Self-Assessment to ensure that semi-annual audits of injuries were conducted, as well as an action plan to promote improvement in timely completion of investigations.
	Summary of Monitor's Assessment: During this review, the Monitoring Team found the Facility to be in compliance with 13 out of 22 provisions of Section D, as opposed to 10 provisions that were in compliance during the last review. Progress was noted in a number of areas. Highlights of progress included: ▪ Actions to protect individuals who were involved in unusual incidents or allegations of abuse or neglect were taken quickly. Staff alleged to have been abusive or neglectful were routinely placed on temporary work reassignment to remove them from direct contact with individuals served, or monitoring was put in place in the residence. ▪ Investigators were trained in investigation techniques and in interviewing people with developmental disabilities. ▪ Monitoring tools were in use and producing data, though work on inter-rater reliability was still needed. ▪ Training for staff on abuse and incident reporting was in place, and 99% of staff were current on that training. ▪ There was evidence of cooperation with law enforcement, the Office of the Inspector General (OIG), and with DFPS in the conduct of investigations.

	▪ When staff were found to have failed to act to stop abuse or to report it, disciplinary action was taken and retraining was conducted. Some of the areas in which improvements were necessary for the Facility to progress toward substantial compliance with the Settlement Agreement included the need to: ▪ Address the issues related to the timeliness of reporting and completing investigations. ▪ Provide clear notes on the supervisory reviews of investigations that the Facility and DFPS complete. ▪ Monitor the inclusion of discussions about abuse reporting in annual ISP meetings, and the distribution of abuse resource materials to individuals and LARs to ensure that the established procedures are being followed. ▪ Include adequate recommendations in investigation reports, and document follow-through on those recommendations, including observations in some cases to ensure that the actions taken produced the desired outcome. ▪ Develop the semi-annual audit of injuries to include how determinations will be made about what types of injuries or patterns of injuries will be investigated. ▪ Improve the data system to resume production of monthly trend reports for Abuse/Neglect/Exploitation and Unusual Incidents. ▪ Improve the IMT process for reviewing allegations, investigations and injuries so that minutes reflect discussion, decisions on steps to address identified issues, and resolutions of those issues.

#	Provision	Assessment of Status	Compliance
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: ▪ Included a commitment that abuse and neglect of individuals would not be tolerated; and ▪ Required that staff report abuse and/or neglect of individuals. In practice, the Facility's commitment to ensure that abuse and neglect of individuals was not tolerated, and to encourage staff to report abuse and/or neglect was illustrated by the following examples: ▪ Posters aimed at reminding individuals of their rights to report abuse were found in all residences and activity centers visited, and could be found in offices and other generally used locations as well. ▪ When a staff member did not act to stop abuse as required by policy and emphasized in training, that lapse was noted and addressed. For example, in case #40393453, both the staff against whom abuse was confirmed, and the staff who stood by and did nothing were terminated. The following are examples of concerns related to the Facility's commitment to ensure that abuse and neglect are not tolerated and/or to encourage staff to report abuse and/or	Noncompliance

#	Provision	Assessment of Status	Compliance
		neglect: ▪ Training for staff on Abuse/Neglect/Exploitation included a PowerPoint presentation designed to promote understanding of the signs of abuse, the necessity to act to stop it, and the requirements for reporting it. That training specifically stated that staff must report abuse to the DFPS hotline and then to the Director or Designee. However, in only ten out of 18 interviews with staff (56%), was it clear that staff knew to report to the Director rather than their supervisor, or that the supervisor receiving that information from staff would automatically report it to the Director. Although ABSSLC's commitment to not tolerate abuse/neglect/exploitation was evident in its policies, it was not clear that these policies had been implemented to the extent that staff clearly understood and were able to describe their reporting requirements. Given that this provision requires the policy to be implemented, the Monitoring Team finds the Facility to be in noncompliance. In its Self-Assessment, the Facility found itself out of compliance with this provision due to issues related to a lack of education of individuals and their guardians.	
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	According to Policy #021.1, 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. With regard to serious incidents, the Facility policy #002.3 required staff to report serious incidents within one hour 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. However, as noted above and discussed in further detail below, it was not clear in interviews that all staff understood that reporting to a supervisor was not the same as reporting to the Director. This should be clarified. 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	Noncompliance

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>Superintendent (or that official's designee). Staff shall report these and all other unusual incidents, using standardized reporting.</td><td>Facility would need to conduct analyses to determine causes, and to review carefully whether incidents 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 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.

According to data the Facility provided in response to Document Request TX-AB-12-02-III.16, the numbers of abuse/neglect/exploitation allegations for the past two years were:

<table>
<tr><th></th><th>1/1/10 to 12/31/10 (12 months)</th><th>1/1/11 to 12/31/11 (12 months)</th></tr>
<tr><td>Total abuse allegations</td><td>390</td><td>439</td></tr>
<tr><td>Abuse substantiated</td><td>50</td><td>53</td></tr>
<tr><td>Total neglect allegations</td><td>167</td><td>199</td></tr>
<tr><td>Neglect substantiated</td><td>99</td><td>78</td></tr>
<tr><td>Total exploitation allegations</td><td>0</td><td>0</td></tr>
<tr><td>Exploitation substantiated</td><td>0</td><td>0</td></tr>
</table>

According to Facility data provided in response to Document Request TX-AB-12-02-III.16, the numbers of Unusual Incidents investigated over the past two years included:

<table>
<tr><th></th><th>1/1/10 to 12/31/10 (12 months)</th><th>1/1/11 to 12/31/11 (12 months)</th></tr>
<tr><td>Deaths</td><td>18</td><td>12</td></tr>
<tr><td>Serious Injuries</td><td>77</td><td>54</td></tr>
<tr><td>Sexual Incidents</td><td>8</td><td>20</td></tr>
<tr><td>Suicide Threat (credible)</td><td>9</td><td>22</td></tr>
<tr><td>Unauthorized Departure</td><td>18</td><td>19</td></tr>
<tr><td>Choking</td><td>7</td><td>4</td></tr>
<tr><td>Other</td><td>4</td><td>15</td></tr>
</table>

For the Monitoring Team's current review, Trend Reports for Abuse/Neglect/Exploitation and Unusual Incident were not available, so it was not possible to compare the numbers in the chart with the Trend Report data, thus reducing confidence in these numbers. The Trend Reports should be reintroduced, and the underlying issues with the data system</td><td></td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		should be resolved. Based on interviews of 18 staff responsible for the provision of supports to individuals, 18 (100%) were able to describe the basic reporting procedures for abuse, neglect, and/or exploitation, indicating they would call the abuse hotline at DFPS or the switchboard to connect them to the DFPS line. Several staff referenced their badges to obtain the reporting number, and it was noted that all staff interviewed were wearing their identification badges. However, eight of the 18 indicated they would also report to their supervisor, not to the Director or Designee as required. Based on an interview of 18 staff responsible for the provision of supports to individuals, all appeared to understand that unusual incidents needed to be reported, and ten identified their supervisor as the person to whom they would report. Policy #002.3 Incident Management contained a requirement that reports of unusual incidents be made to the Facility Director or Designee. Two samples of investigations were selected for review. Sample #D.1 included 20 (20% of the 98 reports listed as having been completed between 8/31/11 and 1/2/12), and the associated Facility Unusual Incident Reports. Sample #D.2 included 11 Facility reports of investigations (19% of the 57 Facility Investigations between 8/5/11 and 1/2/12). The Documents Reviewed section above contains a complete listing of each sample. The samples were drawn from the lists the Facility supplied together with the documents requested prior to the Monitoring Team's onsite visit. Based on a review of the 20 investigation reports included in Sample #D.1: ▪ Six (30%) included evidence that allegations of abuse, neglect, and/or exploitation were reported within the timeframes required by Facility policy. In those six cases, the date and time of the alleged abuse was identified and the report was within the one-hour timeframe. In nine cases (45%) the date and time of the alleged incident was not identified, and there was no way to determine if the report was made timely. In five others (25%), the time was identified and the report was later than the one hour allowed. Since the identity of reporters was protected, it was not possible to determine whether the person making the call was a staff member, or an individual who was not bound by the rule to report within one hour. Those five cases were Investigations #40393453, #40423376, #40628469, #40766976, and #40931326. ▪ 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. However, 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	

#	Provision	Assessment of Status	Compliance
		DFPS. The result was that both the Facility and DFPS received the report. Based on a review of 11 incident reports included in Sample D.2: ▪ Nine (82%) showed evidence that serious incidents were reported within the timeframes Facility policy required. In case #145 (suicide threat), the report was late by 1.5 hours, and in case #148 (broken leg), the report was late by over six hours. From the record it appeared that the staff heard a "pop" at approximately 7 a.m. while bathing the individual and called for a nurse to assess. The nurse responded promptly, and notified the physician who ordered an x-ray. The x-ray was completed by 9 a.m., and revealed a fracture of the upper left femur. Although the individual appeared to have received prompt and appropriate treatment, the report of the incident was made seven hours later, after the fractured bone was diagnosed ▪ Eleven (100%) showed evidence that serious incidents were reported to the Director or Designee. However, it was not clear whether the initial call went to the Director or Designee or whether the call went to a supervisor first. The Monitoring Team noted that Campus Administrators were using a quiz of basic reporting rules to help keep staff's reporting skills sharp. This appeared to be a useful exercise, and it should continue to be employed periodically to maintain that skill level. The Facility reported in the Self-Assessment that, based on the sample monitored, in 87% of the records reviewed, incidents were reported within the hour, and 74% were reported to appropriate parties. In interviews with direct support professionals, the Monitoring Team found that some 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. A review of the Abuse/Neglect/Exploitation course indicated that the training emphasizes the correct procedure. The Facility will need to continue its efforts to inform staff about the need to report to the Director/Designee, and to understand that reporting of serious incidents and allegations of abuse are two areas where the usual hierarchical chain of command is not the rule. In interviews it appeared that staff were told to reach DFPS to report abuse by calling the switchboard to connect them to the DFPS hotline, or they could make a call directly to the hotline number on their badges. To report serious incidents, they could call the switchboard operator, who would take the report and forward it to the Director or Designee. If that was the procedure, it was simple to remember and could achieve the desired result of informing the Director/Designee immediately. If not, then additional instructions were needed to assure that staff report promptly and to the right person.	

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		The Facility had a standardized reporting format for all unusual incidents including abuse/neglect and exploitation that met generally accepted standards. When staff called in a report of an unusual incident to the Director or Designee, the information was collected on a Report Intake Sheet and included: date and time, the reporter staff involved, the circumstances and events, location, and other information depending on the type of incident. If the call went to DFPS first, DFPS called the Facility, and the Facility used the same form to collect the information. Based on a review of 31 investigation reports included in Sample #D.1 and Sample #D.2, 31 (100%) contained a copy of the report utilizing the required standardized format. Since the Monitoring Team determined that staff were not always reporting promptly or directly to the Director/Designee, the Monitoring Team concurred with the Facility that it was not in substantial compliance with this provision.	
	(b) Mechanisms to ensure that, when serious incidents such as allegations of abuse, neglect, exploitation or serious injury occur, Facility staff take immediate and appropriate action to protect the individuals involved, including removing alleged perpetrators, if any, from direct contact with individuals pending either the investigation's outcome or at least a well- supported, preliminary assessment that the employee poses no risk to individuals or the integrity of the investigation.	According to ABSSLC Policy #021, 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 reassignment (TWR). Based on a review of 20 investigation reports included in Sample #D.1, the alleged perpetrator was removed in 13. In three of the remaining cases (i.e., #40790336, #40867202, and #40931326), the perpetrator was unknown. In two of the remaining cases, (i.e., #40423376, and #40779676), the individual was identified as someone who made false allegations and the alleged perpetrator was not removed, but monitoring was put in place. In two cases, the identity of the alleged perpetrator was not immediately known (i.e., #40268679, and #40757236), but the alleged perpetrator was removed when identified. In all cases (100%), the actions appeared to be appropriate. When the Facility received a report where there was any suspicion of possible neglect or abuse, the report was referred to DFPS for investigation. As a result, the unusual incidents investigated by the Facility did not result in the need to remove staff from direct contact. The Facility provided a list of four individuals (i.e., Individual #48, Individual #94, Individual # 156, and Individual #319) for whom it had been agreed with DFPS that their allegations would be treated as "streamlined" investigations. Two of these individuals appeared as alleged victims in two cases in Sample #D.1 (i.e., #40423376, and #40779676), and their cases were handled as spurious allegations. With both individuals, the evidence supporting their making false allegations was strong. Individual #48 alleged three staff members had raped him. Upon examination the nurse found no evidence of	Noncompliance

#	Provision	Assessment of Status	Compliance
		rape and the Behavior Support Plan listed allegations of sexual abuse to be one of his target behaviors. Individual #319 alleged sexual abuse by four staff members, but the nurse found no evidence of trauma consistent with the allegation. The nurse reported that the individual told her he made the report because someone took his X-Box. Individual #319 also had target behaviors referenced in his Behavior Support Plan that indicated he made false allegations. In both cases, documents were collected and reviewed, and closing summaries were written, but witness statements were not taken. These cases appeared to be handled according to policy for "streamlined cases." Based on a review of 20 investigation files included in Sample #D.1, a total of eight cases were confirmed as abuse or neglect, and three were confirmed in part. Documented disciplinary action was as follows: ▪ Case #40268679: Confirmed with one employee terminated and two returned to work; ▪ Case #40270170: Confirmed and employee terminated; ▪ Case #40298840: Verbal abuse confirmed and employee returned to work after disciplinary action and retraining; ▪ Case #40311656: Confirmed against an unknown perpetrator who did not provide clear instructions to staff on how to keep an individual awake during the daytime. Unconfirmed against direct support professional. Behavior Services staff were directed to provide written instructions to direct support professionals in the future; ▪ Case #40393453: Confirmed against two alleged perpetrators who were terminated. Abuse was not confirmed against two additional staff, and they were returned to work; ▪ Case #40532736: Confirmed and employee terminated; ▪ Case #40628469: Confirmed and two employees were terminated and one voluntarily resigned; ▪ Case #40757236: Neglect confirmed, one employee terminated and two disciplined and returned to work; ▪ Case #40790336: Confirmed against unknown perpetrator; ▪ Case #39434048: Confirmed neglect against an unknown perpetrator; and ▪ Case #40990656: Neglect was confirmed against the Facility, but not the staff member, who was returned to work. In the Monitoring Team's last report, it was noted that it had been difficult to determine who had been returned to work, based on the handwritten tracking sheet that was provided. At the time of this visit, a Staff Status Tracking sheet was available in a spreadsheet format. It included the name of the reassigned staff member, the DFPS case number, the date returned to work or the date of termination, and some explanatory notes where needed. This was a significant improvement over the handwritten sheet provided	

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		in past visits and made it easier to account for staff that had been placed on temporary work assignment. However, information continued to be missing. Specifically, based on the information, it could not be determined on which date the employee was placed on TWR to confirm that this coincided closely with the date of the allegation, or whether or not retraining was provided, as appropriate to staff returning to work. Based on a review of the 31 investigations in Samples #D.1 and D.2, it was documented that adequate additional action was taken to protect individuals in 29 cases (94%) where other actions were required, such as examining the individual for possible injury, providing treatment for injuries, separating peers who were engaging in inappropriate sexual behavior, or increasing the individual's level of supervision to assure safety. Where this was not found: • In one case (#40298840), several staff members witnessed a supervisor intimidating an individual, but did not act to stop the intimidation or take steps to report. • In Case #40268679, DFPS reported a concern that there were noticeable injuries to the individual, and staff members did not have him assessed by medical staff and did not report the injuries in a timely manner. While the Staff Status Tracking system was an improvement over the past hand-written tracking system, further information was needed, including the date the staff member was placed on TWR, and a notation about whether retraining was provided to ensure adequate protection of individuals upon the employee's return to work. 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 completion of such training.	According to ABSSLC Policy #021.1, all staff were required to attend competency-based training on preventing and reporting abuse and neglect. This was identified in the policy as course ABU0100. This was consistent with the requirements of the Settlement Agreement. The Facility provided a copy of a 2006 version of the training, which appeared from the context to have been updated some time in 2008. However, an undated copy of the training with color formatting also was made available. Both contained essentially the same information. The training curriculum for new employee orientation as presented was reviewed, and it appeared to be the same for annual refresher training. The results of this review were as follows: ▪ In relation to the requirement that training be competency-based, the Settlement Agreement defines "competency-based training" as "the provision of knowledge	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		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, as well as tests for competency. ▪ The training included adequate content regarding recognizing and reporting signs and symptoms of abuse, neglect, and exploitation. Review of a list of staff who were delinquent in training (DADTX Course delinquency list for Abuse/Neglect/Exploitation Training) showed that 1339 of 1353 staff (99%) were up-to-date in training on abuse and neglect. This excellent rating was no doubt due in part to the practice of providing feedback to departments on their performance with regard to staff participating in training on time. The reminder at the conclusion of the delinquency report was noteworthy: "Remember to work ahead—the best way to get off the monthly report is to never be on the monthly report." Review of 25 staff records (Sample #C.2) showed that 25 (100%) of these staff had completed competency-based training on abuse and neglect prior to working directly with individuals. The Facility's monitoring had been showing this provision to be in compliance, which was consistent with the findings of the Monitoring Team. A quiz for staff was being used to keep working knowledge of the reporting system sharp, a monthly reminder was sent to departments to keep training up-to-date, and training for staff was at the 99% level. 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 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	ABSSLC Policy #021.1 required that all staff sign an acknowledgement of their responsibilities to not tolerate and to report suspected abuse, neglect and exploitation during their pre-service training and annually thereafter. A sample of 25 staff (Sample #C.2) was randomly selected to determine if acknowledgements had been signed. Of the 25 staff in the sample, 25 (100%) had signed annual acknowledgments. As to whether the Facility had taken appropriate personnel action in response to any mandatory reporter's failure to report abuse or neglect, in case #40268679, when evidence was uncovered during the course of the investigation of failure to report, appropriate action was taken. In this case, failure to report resulted in disciplinary action and a termination. In case #40628469, staff were disciplined as a result of an investigation that demonstrated staff were watching, but not intervening to protect an individual against abuse. While it was not possible to be sure that everyone who	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	mandatory reporter's failure to report abuse or neglect.	witnessed an abusive act reported it, due to the rule permitting anonymous reporting, sufficient evidence was found that when failures to report were detected, they were being handled appropriately. As a result, the Facility was found to be in substantial compliance with this provision.	
	(e) Mechanisms to educate and support individuals, primary correspondent (i.e., a person, identified by the IDT, who has significant and ongoing involvement with an individual who lacks the ability to provide legally adequate consent and who does not have an LAR), and LAR to identify and report unusual incidents, including allegations of abuse, neglect and exploitation.	According to Facility Policy #021, the Facility maintained a resource guide on recognizing and reporting abuse, and provided it to individuals, Legally Authorized Representatives, and primary correspondents upon admission and annually thereafter. Discussions with staff revealed that this guide was to be provided at the annual Individual Support Team meeting. The QDDPs had received training on it in January 2011, and additional training was provided to all attendees at Unit Meetings during November 2011. A review was conducted of the materials to be used educate individuals, LARs, or others significantly involved in the individual's life. The guide was a brochure with lists of signs of abuse, and information about where to call. While most individuals living at ABSSLC did not have the reading skills necessary to understand the brochure, if used in combination with the posters about rights, it did an adequate job. The Facility should consider supplying the individual with a copy of the poster at the IDT meeting along with the brochure to maximize the chance that individuals will understand it, and to assure that they were informed about their right to report any unusual incident. Based on a review of 22 individuals' ISPs (i.e., Individual #284, Individual #202, Individual #463, Individual #414, Individual #498, Individual #46, Individual #126, Individual #139, Individual #181, Individual #527, Individual #162, Individual #272, Individual #238, Individual #342, Individual #81, Individual #98, Individual #117, Individual #346, Individual #176, Individual #541, Individual #210, and Individual #313), minimal 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. QDDPs recorded a discussion of abuse reporting in 10 of the 22 ISPs (45%), and steps had been taken to track the mailing of the guide to the LARs as evidenced by the tracking sheet that had been prepared. Some individuals were able to, and did know how to report abuse. This 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 #40423376 and #40779676. In these cases, it was clear that staff had facilitated access to the phone and DFPS phone number. While the Facility had a resource guide in place, and progress had been made with regard to tracking distribution of the guide and documenting discussions of abuse reporting in	Noncompliance

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		ISPs, the Facility remained out of compliance with this provision.	
	(f) Posting in each living unit and day program site a brief and easily understood statement of individuals' rights, including information about how to exercise such rights and how to report violations of such rights.	According to ABSSLC Policy #021.I., posting of a statement on individuals' rights and information on how to report was required in each residence and day program site. The Monitoring Team's observations of 11 residences and one activity center on campus showed that all (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 information 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. 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 ABSSLC to be in substantial compliance with this provision.	Substantial Compliance
	(g) Procedures for referring, as appropriate, allegations of abuse and/or neglect to law enforcement.	According to ABSSLC Policy #021.1 the Director or designee had to report all allegations that might involve criminal activity to DFPS within one hour. DFPS had the responsibility to notify the appropriate law enforcement agency. The notification to the Director of an allegation was by phone and her notification to DFPS was by phone as well. DFPS recorded the date and time of the referral in their report, and the Incident Management Coordinator recorded the notification to DFPS, as well as the DFPS notification to law enforcement in the Incident Investigation Report. Based on a review of 20 allegation investigations completed by DFPS (Sample #D.1), in 10 of the cases for which a referral to law enforcement was necessary/appropriate, DFPS had made referrals in 10 (100%). In the remaining 10 cases, eight were allegations of neglect or verbal abuse that did not contain elements of criminal activity. Two cases involved an allegation of physical abuse, which did not include elements of criminal activity. One case #40311056 involved a staff member who was carrying out verbal instructions from the psychologist to keep an individual awake during the day by rocking his chair, which she did repeatedly throughout the day. The DFPS investigator found that the staff member had not knowingly, recklessly, or intentionally acted to cause harm, and the individual sustained no injury. Another case #40341456 involved an improper lift, where the investigator determined there was no injury and no intent to harm. In both cases, the decision not to inform law enforcement appeared to be reasonable. Based on a review of 11 investigations completed by the Facility (Sample #D.2), referral to law enforcement was neither needed nor made in 10 cases. One Facility investigation was completed concurrently with a DFPS investigation, and DFPS made the referral to law	Substantial Compliance

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		enforcement. Since the Facility routinely referred allegations of abuse, neglect or exploitation to DFPS, and 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 substantial compliance with this provision of the Settlement Agreement. This finding concurs with the Facility's own monitoring reviews.	
	(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 #021.1 prohibited retaliation against staff, individuals, family members, or others who reported abuse. Anyone who believed they had been retaliated against was informed to call the Director, the Office of the Attorney General, the Office of the Inspector General, or DFPS, and phone numbers were provided. Based on interviews with 18 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. Based on interviews and observations of individuals in 11 residences and one activity center, it was clear than some individuals were able to report abuse, but that many did not have the communication skills to do so. As noted with regard to Section 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. Based on a review of investigation records (Sample #D.1 and Sample #D.2), there were two concerns noted related to retaliation. In DFPS case #40287231, a staff member expressed a concern that another staff member was reporting her for abuse because of personal differences. This did not meet the definition of retaliation as an act perpetrated as a result of the reporting of abuse. In case #40298840, the investigator learned that several staff members did not report a possibly abusive act by their supervisor for fear of retaliation. That case was resolved with the termination of the supervisor and retraining of staff. This appeared to be an isolated case of a supervisor with an intimidating personality that was used to control both individuals and staff. However, investigations in such cases should include interviews with staff, at least within the residence to determine if the practice of supervising through intimidation is more widespread. The Incident Management Coordinator provided additional evidence of actions taken to prevent retaliation, when investigation reports uncovered signs of disharmony among staff that could result in retaliation. In both cases (Facility #176 and #204), discussions	Substantial Compliance

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		with staff and retraining of staff on retaliation were provided. The Facility was asked for a list of staff that had alleged that they had been retaliated against as a result of their good faith reporting of an allegation of abuse/neglect/exploitation, and six names were submitted. The Director indicated that referrals were made to the Office of the Inspector General, but no findings were made that retaliation for reporting of abuse had occurred. A review of the abuse investigation files including two of the staff who alleged retaliation revealed that in one (DFPS Investigation #40287231), the person named as the alleged perpetrator indicated that she was reported for abuse in retaliation for spreading rumors about fellow staff members. After discussion with her manager, she withdrew the allegation. This case illustrated the confusion that can exist between retaliation that is expressly forbidden, defined as act taken against another as a result of a report of abuse, and retaliation for an act such as spreading rumors, which is a personnel matter. The second case (DFPS Investigation #40851577) involved a staff member who was the alleged perpetrator and who reported that the allegation against her was made in retaliation for a report she had made. Upon further investigation by the Facility, it was clear that two staff members distrusted one another and each was suspicious of the other, but no action meeting the definition of retaliation had occurred. The Facility reported that their self-monitoring scores on this provision showed 100% compliance with this provision. The results coincided with the findings of the Monitoring Team, and the Facility was found to be in substantial compliance this provision.	
	(i) Audits, at least semi-annually, to determine whether significant resident injuries are reported for investigation.	According to ABSSLC Policy #002.3, the Incident Management Coordinator was responsible to make use of audit reports to evaluate whether significant resident injuries were reported for investigation, at least semi-annually. The purpose of a semi-annual audit of injuries is to assure that serious injuries are reported for investigation, and to ensure that injuries that raise suspicions of abuse because of the nature or location of the injury (for example bruises on the inner thigh might suggest sexual abuse), or the frequency of injury also are reported for investigation. The Incident Management Coordinator conducted an audit of non-serious injury reports of injuries that occurred from June to August of 2011. Ten individuals were identified as having the most non-serious injuries during that period, and data was displayed to show where or at what time of day injuries were occurring. While this was a positive step in reviewing injuries, it did not lead to the initiation of any investigation into the possible programming or environmental causes for the injuries. A review of the documentation regarding peer-caused injuries (TX-AB-1202.III.18)	Noncompliance

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		revealed that 181 individuals between January and December of 2011 were involved in usually injuries caused by peers. These reports should be audited to determine which individuals or which patterns of injury raise concerns that would benefit from investigation. The Monitoring Team's review of documents provided in response to request III.1202.15 revealed that during 2011, 4529 non-serious injuries occurred. The range by individual was from one to two injuries to a high of 91. An investigation into the causes of non-serious injury to individuals experiencing the highest frequency could provide important information, potentially leading to reductions in the number of injuries. An Action Plan should be developed to clarify how the Facility intends to review significant 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, and investigate patterns to determine if programmatic or environmental causes exist that need to be addressed. While recognizing the positive direction the Facility had taken in auditing injuries, the Monitoring Team concurred with the Facility that it was not in substantial compliance with this provision. The Monitoring Team recommends continued efforts to analyze injury data and investigate the underlying causes of patterns or individuals with a high frequency of injuries that are uncovered.	
D3	Commencing within six months of the Effective Date hereof and with full implementation within one year, the State shall develop and implement policies and procedures to ensure timely and thorough investigations of all abuse, neglect, exploitation, death, theft, serious injury, and other serious incidents involving Facility residents. Such policies and procedures shall:		
	(a) Provide for the conduct of all such investigations. The investigations shall be conducted by qualified investigators who have training in working with people with developmental	According to ABSSLC Policy #002.3, 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	Substantial Compliance

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	disabilities, including persons with mental retardation, and who are not within the direct line of supervision of the alleged perpetrator.	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: ▪ Described in a comprehensive fashion the conduct of all such investigations in section VI of the policy; ▪ Required that investigators be qualified; ▪ Required that investigators have training in working with people with developmental disabilities, including persons with mental retardation; and ▪ Required that investigators be outside the direct line of supervision of the alleged perpetrator in Section I.H. 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. Labor Relations Associates (LRA) conducted this course, and it 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 for participants to complete a 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. Training curricula was reviewed for the Department of Family and Protective Services and Facility investigators. This review was described in detail in the Monitoring Team's last 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. In its comments on the Monitoring Team's draft reports, DFPS offered to provide all three Monitoring Teams with copies of the training that it believed addressed these issues. At the time of the writing of this report, the training materials had not yet been made available. A review of the training records of Facility Investigators and Campus Administrators revealed that the IMC, both Investigators and two Campus Administrators had completed all four courses required for investigation. In addition, two QA Nurses and two Campus	

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		Administrators had each completed three of the four courses. Since none of these four were full-time investigators, the policy appeared to allow them to complete only one of the two courses in investigation. While this was permitted, it would be best if both nurses completed the remaining investigation course, since they have been called upon to independently conduct death investigations. The two investigators conducted all investigations in Sample #D.2, except for a death investigation that the two QA nurses conducted. The following chart summarizes the	

Investigator	Comprehensive Investigator Training	Conducting Serious Investigations	People with Mental Retardation	Root Cause Analysis
IMC (L.M.)	Yes	Yes	Yes	Yes
Investigator (T. J.)	Yes	Yes	Yes	Yes
Investigator (T.W.)	Yes	Yes	Yes	Yes
Campus Administrator (C.R.)	Yes	Yes	Yes	Yes
Campus Administrator (S.S.)	Yes	No	Yes	Yes
Campus Administrator (K.W.)	Yes	Yes	Yes	Yes
Campus Administrator (T.T.)	No	Yes	Yes	Yes
QA Nurse (M.W.)	Yes	No	Yes	Yes
QA Nurse (J. H.)	No	Yes	Yes	Yes

required and completed training for the staff conducting investigations at ABSSLC:

Six of the seven DFPS investigators assigned to complete ABSSLC investigations had conducted one or more of the investigations in Sample #D.1, which consisted of 20 files. The training records for these investigators were reviewed with the following results:

- All six DFPS investigators (100%) had completed the requirements for

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		investigations training. ▪ All six DFPS investigators (100%) had completed the requirements for training regarding individuals with developmental disabilities. While the policy remained unclear about whether the IMC and Campus Administrators were required to take two of the four investigative courses, the documentation provided indicated that the Investigators and IMC had taken all the courses, required or not, as had two of the Campus Administrators. The remaining staff had each taken three of the required courses. Since the QA nurses serve as investigators in death cases, they should take the remaining two courses to fully qualify them. The DFPS staff had all completed the required investigative courses. As a result, the Facility was in substantial compliance with this provision.	
	(b) Provide for the cooperation of Facility staff with outside entities that are conducting investigations of abuse, neglect, and exploitation.	Based on ABSSLC Policy #002.3, the Director or designee was to abide by all instructions law enforcement agencies gave. ABSSLC Policy #021.1 specified the nature of cooperation between the Facility and DFPS. Facility staff were required to cooperate with outside entities conducting investigations of abuse and neglect. As described above with regard to Section D.2.a of the Settlement Agreement, two samples of investigation files were selected for review. These included Sample #D.1 and Sample #D.2, which consisted of DFPS investigations, and Facility investigations, respectively. In the reports included in these samples, it appeared that there was good cooperation between Facility staff and DFPS investigators. The IMC provided copies of memoranda from the Office of the Inspector General attesting to the cooperation of staff at the conclusion of investigations. This appeared to be a good practice to assure that the OIG had an opportunity to raise any issues that might have had an impact on the investigation. None were raised in the memos presented. In interview, investigators and the IMC were asked about any difficulties that might have arisen in the conduct of investigations in conjunction with law enforcement entities or the DFPS investigators. They indicated generally good working relationships with all outside entities. The Monitoring Team concurred with the Facility's assessment that it had maintained substantial compliance with this provision.	Substantial Compliance
	(c) Ensure that investigations are coordinated with any investigations completed by law enforcement agencies so	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	Substantial Compliance

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	as not to interfere with such investigations.	Services Commission, the Department on Aging and Disability Services, the Department of State Health Services, the Department of Family and Protective Services, the Office of the Independent Ombudsman for State Supported Living Centers, and the Office of the Inspector General. DADS Policy #002.3 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." Based on a review of the investigations completed by DFPS and the Facility, the following was found: ▪ Of the 20 the investigation records from DFPS (Sample #D.1), 10 had been referred to law enforcement agencies. For 10 out of these (100%), there was adequate coordination to ensure that there was no interference with law enforcement's investigations. ▪ Of the 11 investigation records from the Facility (Sample #D.2), the one that was concurrent with DFPS investigations had been referred to law enforcement agencies and the coordination was adequate as well. 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 #002.3 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. 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 residence's office or medication room until it was transported to the Infirmary Medication room for storage, that being a room that was locked. Other forms of evidence, such as documentary and testimonial evidence, were maintained with the case files, which were secured in the Incident Management offices. Based on a review of the investigations completed by DFPS (Sample #D.1) and the Facility (Sample #D.2): ▪ Evidence that needed to be safeguarded was in 20 out of 20 (100%) DFPS	Substantial Compliance

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		investigations; and ▪ Evidence that needed to be safeguarded was in 11 out of 11 (100%) Facility investigations. Video surveillance was in place throughout the ABSSLC campus, and investigators were using it regularly as part of their investigations. Since video footage was often cited in investigation, a visit was made to the "Camera Room," where live footage was monitored and where copies were made of tape segments that might be needed in an investigation. The operation was professional, with training manuals and protocols available. The clarity of tapes was good and staff appeared knowledgeable about their responsibilities. Based on interviews with the IMC and the two Investigators, it was clear that securing evidence other than documents and video footage was rarely needed. Only two or three cases could be recollected where such items as a coke can or an I-Pod had to be stored as evidence. The Facility found itself in substantial compliance with this provision based on its self-assessment process with 100% of the data from 29 records reviewed during the September through November quarter indicating compliance with this provision. 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 #002.3, investigations of serious incidents: ▪ Were to commence within 24 hours or sooner, if necessary; ▪ Were be completed within 10 calendar days of the incident; ▪ Required a written extension request from the Facility Director or Adult Protective Services Supervisor to be completed outside of the 10-day period, and only under extraordinary circumstances; and ▪ Were to result in a written report that included a summary of the investigation findings, and, as appropriate, recommendations for corrective action. To determine compliance with this requirement of the Settlement Agreement, samples of investigations conducted by DFPS (Sample #D.1) and the Facility (Sample #D.2) were reviewed. The results of these reviews are discussed in detail below, and the findings related to the DFPS investigations and the Facility investigations are discussed separately. <u>DFPS Investigations</u> The following summarizes the results of the review of 20 DFPS investigations: ▪ Eighteen out of 20 (90%) 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	Noncompliance

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		as documentation regarding the tasks that were undertaken within 24 hours of DFPS being notified of the allegation, including the initial interviews involved. Of those that did not: o Case #40341456: Interviews were not scheduled for three days. This was too long a period to expect that witnesses would retain essential information, as DFPS documented in the case. o Case #40628469: This was a case alleging physical and emotional/verbal abuse, as well as multiple staff not following programmatic rules or rules about reporting abuse. The first interviews were not until three days after the allegation was made. Given the number of staff that were potential witnesses, the seriousness of the allegation, and the potential for collusion amongst staff, interviews should have occurred sooner. ▪ Nineteen out of 20 (95%) were completed within 10 calendar days of the incident, or the investigator requested and received an extension. For the one remaining case (i.e., #4076697), there was no notation of a request for extension either in the DFPS report or in the concurrent Facility report. However the investigator did note that the report was late due to illness. ▪ Twenty (100%) resulted in a written report that included a summary of the investigation findings. The quality of the summary and the adequacy of the basis for the investigation findings are discussed below with regard to Section D.3.f of the Settlement Agreement. ▪ In 10 of the DFPS investigations reviewed, recommendations for corrective action were included or concerns were expressed, usually as concerns rather than recommendations. In these cases, the companion Facility report expressed similar concerns and/or addressed them through recommendations. For example: o In Case #40268679, DFPS reported a concern that there were noticeable injuries to the individual, and staff members did not have him assessed by medical staff and did not report the injuries in a timely manner. The Facility's Unusual Incident report reiterated that concern, and noted that the IMC review added that since the individual was on a one-to-one level of supervision, it was hard to understand why the injuries were not reported. The recommendations section of the Unusual Incident Report included that disciplinary actions would be taken. (Follow-up materials in file indicated that disciplinary actions were taken.) ▪ In 10 cases where the DFPS report did not contain concerns or recommendations, there was no need for them, based on their report. However, in some cases, the associated Unusual Incident report reflected further investigation or added recommendations. For example: o Case #40287231 involved an allegation of verbal abuse and was inconclusive. DFPS made no recommendations. The Facility	

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		investigators re-investigated twice in an effort to determine exactly what happened with no success. However, in the process of investigating the possibility of retaliation arose, and the Unusual Incident report included a recommendation that the Unit Director investigate further, and the resulting finding was that there was no retaliation. o Case #40270170 was a confirmed allegation of physical abuse that did not include any recommendations in the DFPS report. The Unusual Incident report did not include recommendations, likely because in cases of confirmed physical abuse, staff were generally terminated. In this case the perpetrator was dismissed, and two staff who witnessed the event, but did not act to stop it were retrained. <u>Facility Investigations</u> The following summarizes the review of the 11 files in Sample #D.2: ▪ For the 11 investigations, the only documentation that showed that the investigation had been commenced was the time the incident was reported on the Unusual Incident Report. Based on interviews with the IMC and investigators, it appeared that investigators were routinely assigned and began their work within the first 24 hours. However, the activities taken to commence the investigation should be documented more clearly in the report. ▪ Eleven out of 11 (100%) were completed within 10 calendar days of the incident, including sign-off by the supervisor or an extension of time had been requested. ▪ Eleven (100%) resulted in a written report that included a summary of the investigation findings. The quality of the summary and the adequacy of the basis for the investigation findings are discussed below with regard to Section D.3.f of the Settlement Agreement. ▪ In the eleven investigations reviewed, recommendations for corrective action were included in seven. In the four investigations that did not include recommendations, nothing further was needed. Progress was noted in completion of reports on time or obtaining extensions. However, based on issues related to investigations not being started timely and/or adequate documentation not being provided with regard to the activities undertaken to commence the Facility investigations, the Facility remained out of compliance with this provision.	
	(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	Based on a review of ABSSLC Policy #002.3, the policy required that: ▪ The contents of the investigation report be sufficient to provide a clear basis for its conclusion; and ▪ The report utilize a standardized format that set forth explicitly and separately: o Each serious incident or allegations of wrongdoing; o The name(s) of all witnesses;	Substantial Compliance

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	and separately, in a standardized format: each serious incident or allegation of wrongdoing; the name(s) of all witnesses; the name(s) of all alleged victims and perpetrators; the names of all persons interviewed during the investigation; for each person interviewed, an accurate summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material statements made; all documents reviewed during the investigation; all sources of evidence considered, including previous investigations of serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency; the investigator's findings; and the investigator's reasons for his/her conclusions.	o The name(s) of all alleged victims and perpetrators; o The names of all persons interviewed during the investigation; o For each person interviewed, an accurate summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material statements made; o All documents reviewed during the investigation; o All sources of evidence considered, including previous investigations of serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency; o The investigator's findings; and o The investigator's reasons for his/her conclusions. The Facility investigation files were accessible and arranged to provide easy access to key information. To determine compliance with this requirement of the Settlement Agreement, samples of investigations conducted by DFPS (Sample #D.1) and the Facility (Sample #D.2) were reviewed. The results of these reviews are discussed in detail below, and the findings related to the DFPS investigations and the Facility investigations are discussed separately. <u>DFPS Investigations</u> The following summarizes the results of the review of DFPS investigations: ▪ In 20 out of 20 investigations reviewed (100%), the contents of the investigation report were sufficient to provide a clear basis for its conclusion. ▪ The reports utilized a standardized format that set forth explicitly and separately: o In 20 (100%), each serious incident or allegation of wrongdoing; o In 20 (100%), the name(s) of all witnesses; o In 20 (100%), the name(s) of all alleged victims and perpetrators; o In 20 (100%), the names of all persons interviewed during the investigation; o In 20 (100%), for each person interviewed, a summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material statements made; o In 20 (100%), all documents reviewed during the investigation; o In 20 (100%), all sources of evidence considered, including previous investigations of serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency; o In 20 (100%), the investigator's findings; and o In 20 (100%), the investigator's reasons for his/her conclusions.	

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		Facility Investigations The following summarizes the results of the review of 11 Facility investigations: ▪ 11 out of 11 investigations reviewed (100%), the contents of the investigation report were sufficient to provide a clear basis for its conclusion. ▪ The report utilized a standardized format that set forth explicitly and separately: o In 11 (100%), each serious incident or allegations of wrongdoing; o In 11 (100%), the name(s) of all witnesses; o In 11 (100%), the name(s) of all alleged victims and perpetrators; o In 11 (100%), the names of all persons interviewed during the investigation; o In 11 (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 did), but statements were referenced or summarized when needed to explain findings. o In 11(100%), all documents reviewed during the investigation; o In 11 (100%), all sources of evidence considered, including previous investigations of serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency; o In 11 (100%), the investigator's findings; and o In 11 (100%), the investigator's reasons for his/her conclusions. The Facility reported substantial compliance with this provision based on its audits of 29 records including the "look behind" audits of nine of those records to ascertain inter-rater reliability, in the September through November quarter. The Monitoring Team's findings based on Samples #D.1 and #D.2 were similar. The Facility remained in substantial compliance.	
	(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	Based on review of ABSSLC Policy #002.3, it required that staff supervising the investigators review each report and other relevant documentation to ensure that: 1) the investigation was complete; and 2) the report was accurate, complete, and coherent. The policy required that any further inquiries or deficiencies be addressed promptly. To determine compliance with this requirement of the Settlement Agreement, samples of investigations conducted by DFPS (Sample #D.1) and the Facility (Sample #D.2) were reviewed. The results of these reviews are discussed in detail below, and the findings related to the DFPS investigations and the Facility investigations are discussed separately. DFPS Investigations	Noncompliance

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	and/or report shall be addressed promptly.	The following summarizes the results of the review of DFPS investigations: ▪ In 20 of the 20 reports, there was a notation that a supervisor had reviewed the report. However, there was nothing in the record to provide detail on the nature of the review, or how many errors were corrected due to that supervision. However the reports appeared reasonably thorough, complete, and accurate. ▪ In 0 (0%), there was evidence of any changes being recommended by the supervisor as to the quality and completeness of the report. <u>Facility Investigations</u> The ABSSLC companion reports and Facility only investigation reports included supervisory signatures on reports and an "Investigation Review/Approval Form" that the IMC had signed with comments on the investigation. While this was a useful step, the comment sections on the forms needed information on any issues with accuracy or thoroughness rather than a summary of the results. A finding of noncompliance has been made based on the lack of documentation of the content of supervisory review for DFPS investigations, and on the need for more explicit comment on the quality of investigations on the Facility review forms. This was consistent with the Facility's self-assessment.	
	(h) Require that each Facility shall also prepare a written report, subject to the provisions of subparagraph g, for each unusual incident.	The findings from the Monitoring Team's review of the Facility's investigation of Unusual Incident Reports are discussed with regard to Section D.3.f above.	Substantial Compliance
	(i) Require that whenever disciplinary or programmatic action is necessary to correct the situation and/or prevent recurrence, the Facility shall implement such action promptly and thoroughly, and track and document such actions and the corresponding outcomes.	According to ABSSLC Policy #002.3, 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 the section 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. In order to determine compliance with this provision of the Settlement Agreement, a subsample of seven of the investigations included in Sample #D.1 and Sample #D.2 were selected for review, referred to as Sample #D.6. The following summarizes the results of this review: ▪ For two out of the two (100%), investigations in Sample #D.6, where disciplinary action should have been considered, prompt and adequate disciplinary action had	Noncompliance

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		been taken and documented. For example, the following disciplinary actions had been taken: o In Case #40268679, physical abuse was confirmed. The perpetrator was dismissed, and two staff were given letters of reprimand and retrained on reporting. o In Case #40298840, verbal/emotional abuse was confirmed. The perpetrator was dismissed, and staff who failed to report were required to sign new acknowledgement of responsibility to report abuse forms. ▪ For five of the seven investigations reviewed (71%), where programmatic action to prevent recurrence should have been considered, prompt and thorough development of programmatic action was planned and the plan documented. For example: o In Case #40311656, Behavioral Services staff gave verbal instructions to direct support professionals to keep an individual awake during daytime hours without any written instructions. When a staff member repeatedly shook the individual's chair, an abuse complaint was filed. The investigation revealed that the staff member did shake the individual's chair repeatedly, because she believed that was what the psychologist had told her to do. The investigation found the Facility responsible for the abusive acts, because it was not clear that psychology staff needed to provide instructions to direct support professional in writing. The direct support staff member was directed to document any informal instructions in the log, and the Psychologist was instructed on proper documentation of instructions to staff. In the two cases where the plans for programmatic action were not comprehensive: o In Case #40298840, where a supervisor was found to be intimidating, an individual and staff feared retaliation if the supervisor was reported, the supervisor was dismissed and staff signed new acknowledgment of responsibility to report forms. However, follow-up was needed on two additional concerns regarding implementing the individual's Behavior Support Plan, and allowing individuals to use their bedrooms rather than requiring them to remain together in the living room to wait for meals. o In Case # 40990656 neglect was confirmed against the Facility, because it was not clear who was supposed to be supervising the individual while he was in the shower. As a result he fell and was injured. It was not clear how staffing assignments would be made in future to assure against a repetition. ▪ In four of the five cases where plans were in place (80%), there was documentation to support the implementation of the plan. In the remaining one,	

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		it was not clear what the plan was or whether the plan had been implemented. For example: o In Case #40790336, where an individual had gone outdoors without shoes and without staff being aware that he had left, there were comments on a possible move to another residence with door enunciators, but it was not clear whether that option was carried out or another plan substituted. As noted with regard to Section D.2.b, the Staff Status Tracking sheet used to document disciplinary actions was a significant improvement over the handwritten sheet provided in past visits. However, information continued to be missing, such as the date the employee was placed on temporary work reassignment to confirm that this coincided closely with the date of the allegation, or whether or not retraining was provided, as appropriate to staff returning to work. The IMC and the Facility Director had begun to send memos to staff directly responsible for carrying out corrections related to investigations, and requiring responses and evidence of completion in return. This process had the potential for creating the feedback loop needed to assure that corrective plans were implemented. However, at times, direct observation of corrections or outcomes will need to be completed. Facility Investigators and/or QA Department staff should be involved in this process. While there was progress in documenting disciplinary actions and programmatic actions were developed, it was not clear that the programmatic changes were always made and whether they were successful in protecting the individual. The Monitoring Team's finding was similar to the Facility's self-assessment, and the Facility was not in compliance with this provision.	
	(j) Require that records of the results of every investigation shall be maintained in a manner that permits investigators and other appropriate personnel to easily access every investigation involving a particular staff member or individual.	Based on review of the ABSSLC policy, records of every investigation were to be maintained in a manner that permitted investigators and other appropriate personnel to easily access every investigation involving a particular staff member or individual. At the Facility, 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. When personnel other than investigators needed to access the files, they had to request them in writing, explaining their need, and log them out.	Substantial Compliance

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		Files were in the electronic system and available to investigators. There was restricted access to the electronic files, as there was to the paper copies. DFPS files 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's record. However, DFPS was in the process of making their reports available electronically to the Facility. According to the self-assessment, the IMC reviewed files monthly to assure they were properly maintained. The Monitoring Team concurred with the Facility that there was 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 new DADS AVATAR system, which required logging of information on incidents into a database. That database included: ▪ Type of incident; ▪ Staff alleged to have caused the incident; ▪ Individuals directly involved; ▪ Location of incident; ▪ Date and time of incident; ▪ Cause(s) of incident; and ▪ Outcome of investigation. Since the installation of the AVATAR system, trend reports had not been available for abuse, neglect, exploitation, and unusual incidents. The Facility was working with their new data manager to restore use of the trend reporting system locally. As a result of the interruption of production of trend reports, the Monitoring Team concurred with the Facility that this provision was not in substantial compliance.	Noncompliance
D5	Before permitting a staff person (whether full-time or part-time, temporary or permanent) or a person who volunteers on more than five occasions within one 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	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. In concert with the State Office, the Director had implemented a procedure to track the	Substantial Compliance

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	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.	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. 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 2011. 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. 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 one person had been terminated for failure to self-report since the last review. In an interview with the Facility Director, her decisions regarding the employment of a sample of applicants with any criminal history were discussed on a case-by-case basis. In each instance, her decisions were based on the facts and were mindful of her responsibility to safeguard the individuals and staff of the Facility. 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.1 and D.2.a)
2. Trend Reports for Abuse/Neglect/Exploitation and Unusual Incidents should be reinstituted. (Section D.2.a)
3. 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)
4. 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)
5. The Facility should improve its staff reassignment tracking system to include the date an employee is reassigned, 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 and to emphasize reporting to the Director. (Section D.2.a, D.2.b and D.2.d)
7. The Facility should include the Resource Guide in the ISP 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. Review of injuries that peers cause to one another should be part of the semi-annual audit. (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. DFPS should finalize the system for documenting the activities related to the commencement of the investigation. (Section D.3.e)
11. The Facility should develop and implement a system for documenting the activities related to the commencement of the investigation. (Section D.3.e)
12. 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)
13. The Facility should add commentary on any issues with accuracy or thoroughness to its summary of the supervisor's review of investigations. (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. In addition to reviewing documents, as appropriate, the Facility should physically confirm that changes expected as a result of the implementation of recommendations resulting from investigation reports have occurred. It will be important to document evidence of the follow-up, such as what has changed in the individual's life or in Facility practice as a result. (Section D.3.i)
16. 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)
17. 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	
Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall develop, or revise, and implement quality assurance procedures that enable the Facility to comply fully with this Agreement and that timely and adequately detect problems with the provision of adequate protections, services and supports, to ensure that appropriate corrective steps are implemented consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o DADS Policy #003.1: Quality Assurance, dated 1/26/12; o ABSSLC Policy #003: Quality Assurance, dated 11/13/09 (note that this was not adopted until 7/11/11); o Abilene State Supported Living Center Policies and Procedures Index, current as of 1/6/2012; o Presentation Book for Section E; o Abilene QA Process Flowchart, undated; o Incident Management Team Presentation for 2/13/12; o ABSSLC FY 2010: Quality Enhancement Plan FY 2012, undated; o ABSSLC Self-Assessment, dated 2/1/12; o ABSSLC Trend Analysis Report: Allegations of Abuse/Neglect/Exploitation, for 6/1/11 to 8/31/11; o ABSSLC Trend Analysis Report: Injuries, October and November 2011; o ABSSLC Unusual Incidents Trend Report Q4 (abbreviated), undated; o ABSSLC Restraints Trend Analysis Report FY12 for November and December 2011; o ABSSLC Leadership Council/Quality Assurance/Quality Improvement Council meeting notes, dated 11/21/11, and 12/12/11; o ABSSLC Leadership Council/Quality Assurance/Quality Improvement Council meeting agenda and handouts for meeting on 2/16/12; o ABSSLC Settlement Agreement Training, undated; o Monitoring tools associated with the Quality Enhancement Plan; o QA/QI Data Summary, Section I and Section J, FY 2012 Q1, by Brian P. Luster, Program Compliance Monitor (PCM), dated 12/16/11; o QA/QI Data Summary, Section K FY 2011 Q4, by Brian P. Luster, PCM, undated; o QA/QI Data Summary, Section L: Medical Services, FY 2012 Q1, by Mary White, RN, QA Nurse; o QA/QI Data Summary, Section M: Nursing Services, FY 2012 Q1, by Mary White, RN, QA Nurse; o QA/QI Data Summary, Section N: Pharmacy Services, FY 2012 Q1, by Mary White, RN, QA Nurse; o QA/QI Data Section Q, FY 12, by William Whitaker, PCM, dated 12/19/11; o Individual Support Plans for Individual #272, Individual #238, Individual #342, Individual #81, Individual #98, Individual #117, Individual #346, Individual #176, Individual #541, Individual #210, and Individual #313. ▪ **Interviews with**: o Patricia Smith, Director of Quality Assurance; o Tracyl Gandee, Settlement Agreement Coordinator; o Program Compliance Monitors;

	○ Mary Willingham, RN, Program Compliance Nurse; and Mary White, RN, MSN, Quality Assurance; ○ Renay Kellum, Program Compliance Monitor; and ○ Various staff in residential units, including 18 Direct Support Professionals. ▪ **Observations of**: ○ IMT meeting, on 2/16/12; ○ Unit IV Daily Incident Management meeting, on 2/14/12; ○ The operation room of the video surveillance system, on 2/15/12; ○ QA/QI Council Meeting, on 2/16/12; ○ Eleven residences including: #5962, #5961, #6710, #6720, #6330, #6360, #6370, #6390, #6450, #6740, and #6400, and one Activity Center #6700; and ○ ISP annual meeting for Individual #148, on 2/16/12;
	Facility Self-Assessment: Based on a review of the Facility's Self-Assessment, with regard to Section E of the Settlement Agreement, the Facility found that it remained out of compliance with all of the provisions. This was consistent with the Monitoring Team's findings. The Self-Assessment included, for each provision of Section E, a list of activities engaged in to conduct the self-assessment, the results of the self-assessment, and the self-rating. The Facility included lists of specific documents cited as sources of information, tallies of monitoring activities completed, and corrective action plans presented. The Facility should expand its self-assessment activities in this area to include: ▪ Identifying documents reviewed; ▪ An examination of the results of the reviews conducted. For example, instead of merely listing reviews conducted, analysis should be included of the findings of the reviews; ▪ Any information about the reasons for the results (such as the reason for the absence of trend reports); ▪ Comment on the quality of the information reviewed as well as the quantity (i.e., in Section E.3 of the Self-Assessment include a comment on the inter-rater reliability of the reviewed monitoring reports or the trend in inter-rater reliability scores in general). ▪ Include any information resulting from monitoring activities, and, as appropriate, develop, implement, and monitor action plans to address identified concerns. The Self-Assessment for Section E should include an assessment of the adequacy or quality of the action plans, as well as information about their effectiveness in addressing issues identified. In addition to the Self-Assessment, the Facility provided an Action Plan for Section E.1, to address the use of Monitoring Tools and preparation of trending reports for the QA/QI Council. The Action Plan appeared to have two separate components: Steps 1 through 5 addressed the use of the Monitoring Tools and how to improved inter-rater reliability, and Step 6 addressed the completion of Monthly and Quarterly Trending reports, which were not based on the QA Monitoring Tool use. These two distinct and separate data-related issues needed to be divided into two Action Plans. In general the action plans needed to:

	▪ Be specific in describing the steps, including how the step was to be accomplished [i.e., "Compile, trend and report self-monitoring results in QAQI" needed to include how the results would be compiled (data base or spreadsheet or in a narrative report), who would compile them (PCMs or data analyst or someone else) and who would report them to QAQI and on what schedule]. ▪ Give a status update where a projected compliance date had past and the step was still in process. For example: the step to "develop corrective action plans" needed to indicate how many plans were expected to date, how many had been completed, and whether the quality of the plans was satisfactory. While there was progress in the adoption of a new format for self-assessment and development of action plans, there was some regression in the production of trend reporting. The Facility will need to address the issues with the data system and proceed in developing the Quality Assurance System to continue to make progress toward substantial compliance.
	Summary of Monitor's Assessment: There had been some progress since the last monitoring visit, including: ▪ DADS had issued a revised policy for Quality Assurance, SSLC Statewide Policy #003.1, effective 1/26/12. The policy called for SSLCs to adopt procedures to implement the policy, but due to the proximity of the effective date of the policy to the Monitoring Team's visit, no local procedures were in place, and the Facility was operating under the previous policy and related procedures. The Monitors will comment on the revised policy, when all of the Monitoring Teams have had an opportunity to review it. ▪ Use of monitoring tools to self-assess the Facility's performance was underway for all sections of the Settlement Agreement, and some summary data reports were available. ▪ 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. ▪ Program Compliance Monitors were working closely with their assigned disciplines to establish inter-rater reliability on the application of the tools. ▪ The results of monitoring were summarized and reported to the QA/QI Council for the fourth quarter of FY 11 (9/1/11 through 12/30/11) for seven sections (I, J, K, L, M, N, and Q). ▪ A data manager (analyst) had been hired to assist in the management of the data system. Some of the areas that will need to continue to improve for the Facility to progress toward substantial compliance with the Settlement Agreement include: ▪ The AVATAR data system will need to be brought up to full functioning, allowing the resumption of monthly trend reporting for abuse/neglect/exploitation, unusual incidents, injuries, and restraints. ▪ The process for cleaning data in the AVATAR system, which was underway, will need to be completed and procedures set in place to prevent errors in the future. ▪ If Facilities will be responsible for producing trend reports, the necessary training for producing them will need to be provided. ▪ While QA Monitoring Tools were in use for all sections of the Settlement Agreement, improved instruction sheets or guidelines were still needed for many. Guidelines will be important to:

	o Ensure that various Facility staff implementing the tools are using the same methodologies to rate indicators, thereby increasing the likelihood of inter-rater reliability and the validity of the results; and o Provide adequate guidance to reviewers who do not have specific subject-matter expertise to ensure accurate rating of the tools. ▪ If the data from the monitoring tools will 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. Otherwise, the data specific to each element of each provision will need to be reported separately. ▪ Additional indicators will need to be developed to better enable the Facility to identify problems with regard to protections, services, and supports provided to individuals served by ABSSLC. This is important for a few reasons, including providing the Facility with the ability to identify objectively the individuals who require additional attention to ensure they are safe and are receiving the supports and services they require, as well as to identify proactively homes, day programs, and/or departments that require improvement, and to identify a wide array of potential systemic issues. At the time of the review, the Facility did not have a system such as this in place. Throughout this report, there are references made to data that should be incorporated into such a system. ▪ The 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. Once issues with the data system have been resolved, trends are being identified, and the QA monitoring data and other discipline-specific data are being used to identify trends with regard to key indicators of progress, the Facility will need to proceed with 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 the actions taken effectively address the issues.

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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	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. As indicated in the Monitoring Team's last report, although the Facility had begun to	Noncompliance

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	receiving services and supports.	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. At the time of the review, the Facility did not have a complete system such as this in place, but it did have certain critical elements. A review of those systems for this visit revealed: ▪ A Quality Assurance Plan was in place for monitoring the various sections of the Settlement Agreement. It was designed as a monitoring matrix, specifying responsibilities for monitoring of each section, samples sizes, responsible parties, and timeframes for conducting the monitoring activities. ▪ One element in place during the last review was 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. At this review, these Trend Reports were not available for abuse, neglect and exploitation, and unusual incidents, and there was only limited availability (October and November 2011) for injuries. Trend Reports for Restraint were available for November and December 2011. ▪ When production of trend reports resumes, the previously noted issues related to reporting data by building, by staff and by individual need to be addressed. (The Monitoring Team's previous report provides more details.) ▪ The QA/QI Council was meeting twice each month from September through December 2011 to review progress toward compliance with the Settlement Agreement and to address a variety of other management issues. ▪ Monitoring data were emerging from the use of the Settlement Agreement monitoring tools to assess compliance with the Settlement Agreement. The 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.	

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		Upon interview, the Program Compliance Monitors 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 still some issues with double negatives that needed to be worked out 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 reviews, their replies were in the range of one to two hours. From the Monitoring Team's perspective, work still needed to be done to refine these tools for the Facility's use, 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. As indicated in the Facility's Self-Assessment, the Facility was not in substantial compliance with this subsection. There had been some progress with application of the Monitoring Tools, and in work with the disciplines on inter-rater reliability. In addition, the QAQI Council was meeting twice each month. There were issues with the production of trend reports related to the introduction of the AVATAR data system. Much work remained, however, in developing an adequate auditing system, as well as in the identification, 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	The Program Compliance Monitors had analyzed data from some of their sections for the last quarter of FY11, and produced a summary report. They presented the summaries to the QA/QI Council. The summaries described the tool (number of provisions and indicators), and described the data collected, noting when percentages were unweighted, composite scores. Most of the summaries included a list of the individual indicators within the section with scores that fell below 70%. For example, Section L noted that seven provisions of 22 had been identified as essential and given priority for action. Section M noted that three areas had been prioritized for attention. The summaries included recommendations, but most of them related to improving the monitoring process, rather than addressing the concerns raised through the results of the	Noncompliance

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	action step; the person(s) responsible; and the time frame in which each action step must occur.	monitoring process. From interviews, it was clear that the Facility planned to complete summary reports of analyses of data from the use of monitoring tools for all sections of the Settlement Agreement on a quarterly basis. Overall, this was a good start. As indicated with regard to Section E.1 above, the reporting on scores from the monitoring tools should reflect the different importance of various indicators, if the scores are going to be reported in aggregate. At this early stage, it was appropriate and necessary for recommendations to include actions related to the monitoring process. Going forward, in order to address the expectation that quality assurance monitoring will lead to improvements in services to individuals, recommendations should include corrective actions to address the identified concerns with service delivery. In this report a distinction has been made between "Action Plans" that were generated and appended to the Self-Assessment as evidence of the Facility's efforts to comply with the provisions of the Settlement Agreement and "Corrective Action Plans" that were generated in response to data collected about the quality of services. In interviews with the Director of Quality Assurance, "Corrective Action Plans" were described as plans that identified issues and deficiencies with the delivery of services. There had been little progress on the development of Corrective Action Plans. The notes for the QA/QI Council meeting on 11/21/11 captured the presentation of some of the monitoring data summaries. A review of those notes revealed, that although some of the presentations included recommendations (Section J, K, and D), only one resulted in a CAP (Section D). However, there was no notation that an assignment had been made for development of the Section D plan. At a later point in the notes, describing presentations by the Section Leads, there was information about the development of the plan, but again, no information was captured in the columns for "Action to be Taken", "Person Responsible" or "Due Date." Other Section Leads (i.e., Section K) included lists of corrective action plans in their presentations, but these plans were apparently action steps to correct identified issues that did not require full Corrective Action Plans. The Facility reported that only three formal Corrective Action Plans (CAPs) had been developed: ▪ Section D's CAP addressed the lack of education and/or documentation of the education of individuals, primary correspondents and LARs about identifying and reporting unusual incidents, including abuse and neglect. The plan included training of staff, review of personal folders to check documentation in ISPs, and development of a spreadsheet to track mailing of the abuse/neglect resource guide. ▪ Section T's CAP addressed the Monitoring Team's recommendation in the	

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		11/22/11 report that teams be provided with competency-based training on identifying obstacles to movement of individuals to the most integrated setting appropriate to their needs and preferences. The plan included steps to train staff and review obstacles identified. ▪ Section V's CAP addressed the development of guidelines for auditing charts for errors. All of these CAPS were designed to remedy issues that had been identified in processes related to compliance with the Settlement Agreement, rather than as plans to correct issues with delivery of services raised through application of the monitoring processes. The summary reports the Program Compliance Monitors presented sometimes identified issues with service that called for corrective action. For example in the report on Section J, the PCM included a list of the areas that consistently scored less than 70% on the monitoring tools. Among them was, "J.13.4: the treatment plan identifies the objective psychiatric symptoms or behavioral characteristics that will be monitored to assess the treatment's efficacy." This appeared to be just one of many areas with potential for development of a Corrective Action Plan. During the last three monitoring visits, the 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 still not clear how these remedies, some of which were discussed as having been successful, were documented. If the QA/QI Council 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.	

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		In summary, there did not appear to have been much progress in development of Corrective Action Plans resulting from the data generated by the Facility as part of their internal monitoring processes. The Facility was not yet in substantial compliance with this provision due to the need for more extensive analysis of additional information, and the assignment and development of CAPs to address identified issues.	
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. Three corrective action plans were submitted in response to Document Request TX-AB-1202-IV.7, which included a request for "any corrective action plans, including information related to follow-up and modification of corrective actions plans." The three CAPs submitted, listed with regard to Section E.2 above, included assignment of responsibility, actions to be taken, expected outcomes, and dates due. The CAPs were distributed to and approved by the QA/QI Council. The QA Plan outlined the responsibilities for each of the Settlement Agreement sections, This included responsibilities for proposing and implementing CAPs in response to data analysis. ABSSLC was still at an early stage of the CAP development process and had not 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 had the tracking system been in place to sufficiently monitor progress. As a result, the Facility was not in substantial compliance with this provision.	Noncompliance
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. The QA Director had designed a spreadsheet for Corrective Action Plan Tracking that included the date the CAP was developed, the issue, actions, expected outcome, person responsible, due date, monitoring frequency, a re-monitor date, and the score or information from re-monitoring. The three listed CAPs had been entered on the sheet and updates entered. The expected outcomes needed work, however. The header on the outcomes column correctly prompts the outcome to be "measurable: how will you know you have corrected the problem?" Yet the listed outcomes were "…decreased number of obstacles to community placement." instead of a more specific outcome that cited the numbers to be achieved. Likewise, the listed outcome for the Section D CAP was " to improve documentation and education of individuals…" rather than a more specific	Noncompliance

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		description of outcome such as "all ISPs will contain documentation of discussion of abuse reporting with individuals, and all LARs will receive copies of the reporting brochures." For the CAP for audits of records, the outcome could have been that "legibility of charts will improved from __% to __% within one year" rather than simply "improvement in percentages." At the time of the review, the use of the tracking tool and analysis of results were just getting underway. As noted in the Facility's Self-Assessment, there had been no monitoring of corrective action plans, and this indicator was not yet in substantial compliance.	
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. 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 scores or percentages. Depending on the tool, a composite or average of all the tools applied or indicators within a tool 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 Settlement Agreement, 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 is 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. Issues with the AVATAR system should be addressed so that Monthly Trend Reports can resume for Abuse/Neglect/Exploitation and Unusual Incidents, and Monthly Trend Reports for Injuries and Restraints can be completed using the AVATAR system. (Section E.1)
4. 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)
5. The data referenced in Recommendation #4 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)

6. 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)
7. 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)
8. As particularly complex corrective action plans are developed, the Facility should consider focusing on making substantial changes in one residence or unit at a time as they have done with the young men's 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)
9. CAPs should include measurable outcomes (e.g., decreased in injuries from 1000 to 500, or increase in active engagement from ___ to ____), 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	
Each Facility shall implement an integrated ISP for each individual that ensures that individualized protections, services, supports, and treatments are provided, consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o DADS Policy Number 004: Personal Support Plan Process (Integrated Protections, Services, Treatments, and Supports) with attachments, 7/30/10; o State Supported Living Centers Procedure – Personal Focus Assessment, dated 9/7/11; o Procedure for Scheduling Disability Rights Texas (DRTx) Meetings, dated 11/29/11; o Change of Status Flow Chart, undated, and related template letters; o A list of Qualified Developmental Disabilities Professionals (QDDPs) with their current assignments, and the number of individuals on their caseloads, dated 10/28/11; o ABSSLC Self-Assessment, updated 2/1/12; o Training sign-in sheets and training materials for: ▪ Personal Focus Assessment (PFA): Revised Form and Procedure Training Webinar, dated 9/1/11; ▪ Risk Expectations – At Risk Process, dated 9/30/11; ▪ QDDP Meeting, dated 9/30/11; ▪ October QDDP Meeting/PFA/Third Quarterly, dated 10/28/11; ▪ Q Construction: Facilitating for Success, dated 11/8/11; ▪ Identifying Obstacles and Supports and Services, dated 12/16/11; ▪ Skill Acquisition Program Training, Part 2, dated 12/21/11; and ▪ ISP Training, dated 1/3/12; o Settlement Agreement Cross Referenced with ICF/MR Standards – Section F: Integrated Protections, Services, Treatments and Supports, revised August 2010; o Settlement Agreement Cross Referenced with ICF/MR Standards – Section S: Habilitation, Training, Education, and Skill Acquisition Programs; o Q Construction: Facilitating for Success – Qualified Mental Retardation Professional (QMRP) Facilitation Skills Performance Tool, with instructions, dated 6/7/11; o In response to request for any tools to measure competency with the writing of ISP documents, the following statement: "No information for TX-AB-1108-V.7.b.;" o Last 10 Facilitation Skills Performance Tools that the QDDP Coordinator completed, various dates; o List of QDDPs with designation of whether or not they had been deemed competent with regard to the facilitation of ISP meetings, dated 10/28/11; o An alphabetical list of each individual at the Facility, with the most recent ISP meeting date, the date on which the ISP document was completed/filed, and the date of the previous ISP meeting date; o In response to request for the total number of ISP annual meetings that occurred more than 365 days after the previous meeting: "2 Annual PSP meeting occurred after the 365 time line (per guardian's request);" o In response to request for the total number of ISPs filed past the 30-day timeframe: "87

	PSPs were documented to be past the 30 day time-frame to be placed into the charts;" o The Olmstead Decision handout, and training sign-in sheets for ISP training conducted in August 2011; o In response to request for "Email from State Office that provided direction regarding recommendations in assessments regarding appropriateness of transition to the community," the response: This item was not available;" o Annual ISP Meeting Preparation Checklist, undated; o ISP Meeting (Facilitation and Documentation): POR-MR-6, revised 1/12; o Individual Support Plans (ISPs), Sign-in Sheets, Assessments, Individual Support Plan Addenda, (ISPAs), Personal Focus Assessments (PFAs), skill acquisition and teaching programs, last three monthly reviews, last two quarterly reviews, individual's daily schedule, and Special Considerations list for: Individual #284, Individual #202, Individual #463, Individual #414, Individual #498, Individual #46, Individual #126, Individual #139, Individual #181, Individual #527, Individual #162, Individual #272, Individual #238, and Individual #342, Individual #81, Individual #98, Individual #117, Individual #346, Individual #176, Individual #541, Individual #210; and Individual #313. o Individual Support Plan for Individual #34; o Presentation Book for Section F. ▪ **Interviews with**: o Kristin Wyrick, QDDP Coordinator; o Jeff Branch, Active Treatment Coordinator; o Ron Manns, Director of Behavioral Services; o Jolene Willis, Assistant Director of Programs (ADOP); o Pat Smith, Quality Assurance Director; o Tracyl Gandee, Settlement Agreement Coordinator; and o Various staff in residences and attending IDT meetings. ▪ **Observations of**: o ISP Meeting for Individual #101, on 2/13/12; o ISP Meeting for Individual #76, on 2/15/12; o ISP Meeting for Individual #468, on 2/15/11; o ISP Meeting for Individual #148 on 2/16/12; and o Activities in homes and day programs.
	Facility Self-Assessment: Based on a review of the Facility's Self-Assessment with regard to Section F of the Settlement Agreement, the Facility found that it was out of compliance with all of the subsections. This was consistent with the Monitoring Team's findings. Since the Monitoring Team's previous review, the Facility had made improvements in the justification it offered for its findings. Over a short period of time working with a new format from State Office, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating using the information cited in the section on results. Although a number of concerns continued to exist with the Facility's self assessment process, over time, this format should be

	helpful in substantiating the Facility's findings with regard to compliance. On a positive note: ▪ By using the data it had collected through its monitoring activities, the Facility had begun to identify some of the issues that needed correction. ▪ Generally, some of the pieces of the methodology necessary to review this section were intact, such as observations of meeting, review of ISPs, and review of monthly review documentation. The quality of the reviews continued to be a piece on which the Facility was working. The following concerns were noted: ▪ The Facility's Self-Assessment did not define how the samples were selected, or from where the data was drawn (i.e., QDDP Department reviews, QA Department reviews, or both). ▪ The criteria used to evaluate components of the Settlement Agreement were often unclear. For example, for Section F.2.a.1, the Facility's data was vastly different from that of the Monitoring Team (as it was for many subsections) for indicators such as ISPs building upon individuals' strengths and preferences, or encouraging community participation. The Facility honestly recognized issues related to the integrity of the data in a number of the self-rating sections of its Self-Assessment for Section F. ▪ At times it was unclear how the self-assessment activities related to the requirements of the Settlement Agreement. For example, Section F.1.c addresses the quality and timeliness of assessments, but the self-assessment activities did not relate to these requirements. ▪ In addition, not all requirements of the Settlement Agreement had been reviewed. More specifically, within a sub-section, the Settlement Agreement might have numerous requirements, but only some were included in the Facility's Self-Assessment (e.g., F.2.e and F.2.g). If the Facility was choosing, for example, to prioritize assessing certain areas before others, that would be acceptable, but it should be stated specifically. ▪ For the various monitoring/audit tools, inter-rater reliability needed to be established with the QA and programmatic staff (e.g., QDDP Coordinator) responsible for conducting audits. ▪ As discussed during the last review, the need still existed to add or revise the guidelines/instructions for the audit tools. This will be essential to improve the accuracy of the monitoring results (validity), as well as the congruence between various auditors (reliability). ▪ The data presented clearly identified areas of need. However, the Facility Self-Assessment did not yet provide any analysis of the information, identifying, for example, potential causes for the issues, or connecting the findings to portions of the Facility's Action Plans to illustrate what actions the Facility had put in place to address the negative findings. Overall, the Facility had demonstrated some good use of the data it had collected. Efforts to ensure the validity and reliability of the data will be important next steps, as will using the data to identify areas in which focused attention is needed. The Facility's progress in developing a quality assurance process for Section F is discussed in further detail below with regard to Section F.2.g.
	Summary of Monitor's Assessment: The Facility had adopted the State Office ISP policy, but had not yet developed corresponding Facility policies and procedures. The State's ISP Consultants continued to work on revising the ISP process, and, as a result, the State Office policy was under review. Once the process is

	finalized, the Facility should develop policies and procedures to ensure full implementation of the State Office policy. The QDDP Coordinator, four QDDPs, and the Program Compliance Monitor had undergone additional training on the competency-based check-off tool for meeting facilitation. Based on the findings of the completed tools, QDDPs requiring more training or technical assistance were being identified. Some had undergone additional classroom training, and others were provided on-the-job mentoring. One of the State consultants had provided some additional training to QDDPs, as well as some technical assistance to QDDPs and teams during annual planning meetings. Beginning in January 2012, teams began to use a revised ISP template. Based on the meetings observed while the Monitoring Team was onsite, these efforts had begun to show some positive changes with regard to facilitation skills, more productive meetings, and a more person-centered focus. However, significant work remained in a number of areas. In addition, due to the timing of a number of changes, the ISPs reviewed during this review were not substantially different from the previous review. Some areas that required attention included: ▪ As noted in many sections of this report, comprehensive, thorough, and adequate assessments were missing in many areas, including but not limited to nursing, speech and communication, psychiatry, skill acquisition, and physical and nutritional supports. Although vocational assessments had improved, they often were not present for individuals who required them. 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. Shortly before the Monitoring Team's on-site visit, the Facility had developed a workgroup to address issues related to integrated protections, services, treatments, and supports. The first task of the group was to address the issue of scheduling of ISP meetings to ensure maximum attendance; ▪ Action plans largely addressed skill acquisition plans and regular medical appointments. Although some had begun to reference other supports (e.g., PNMPs and BSPs), these supports were not well defined, generally did not have measurable objectives or outcomes associated with them, and provided little to no description of the methodologies that would be employed to realize the objectives. Many other supports, services, treatments, or strategies were not mentioned in the ISPs. For example, risk action plans had not been incorporated or integrated into the ISPs. Focused effort was needed to improve the scope of action plans, as well as to ensure measurable outcomes and clear methodologies were included; and ▪ The State and the Facility will need to ensure that person-centered concepts are incorporated with the need to develop comprehensive, integrated plans. Many individuals require plans with multiple supports. The State, working in conjunction with the Facility, should figure out ways to have adequate, technical team discussions, while focusing on the individual and his/her preferences, strengths, etc.

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F1	**Interdisciplinary Teams -** Commencing within six months of the Effective Date hereof and with full implementation within two years, the IDT for each individual shall:	DADS Policy #004 Personal Support Plan Process was issued on 7/30/10. In response to the Monitoring Team's request for related policies, ABSSLC provided copies of three procedures, including: ▪ State Supported Living Centers Procedure – Personal Focus Assessment, dated 9/7/11; ▪ Procedure for Scheduling Disability Rights Texas (DRTx) Meetings, dated 11/29/11; and ▪ Change of Status Flow Chart, undated, and related template letters. As noted in the Monitoring Team's last report, the DADS Personal Support Plan Process policy and associated procedures outlined the basics of ISP 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 ISP 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. The Monitoring Team recognizes that the State Office was continuing to modify its practices with regard to ISPs, and this likely will result in revisions to its policy. Once changes are finalized, ABSSLC should develop any facility-specific policies and/or procedures necessary to ensure full implementation of the State Office policy. In order to review this section of the Settlement Agreement, a sample of ISPs was requested, along with related assessments, sign-in sheets, ISPAs, Personal Focus Assessments, skill acquisition programs, and monthly and/or quarterly reviews. The 22 ISPs that were reviewed were those that the Facility provided in response to a document request for a sample of the most recent plans from each residence. These are listed above in the documents reviewed section. Therefore, a variety of QDDPs and IDTs had been responsible for the development of the plans. The Facility provided one additional plan for an individual for whom the plan was developed using the most recent format and training from the State Office's ISP consultants (i.e., Individual #34). Although this plan was not included in the sample, because the full array of documents necessary to complete a thorough review was not provided, some general comments are provided below with regard to Section F.1.a.	
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 ISPs 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: ▪ DADS Policy #004 at II.C.1.b continued to indicate that the QDDP would plan and facilitate the ISP meeting. ▪ The QDDP Coordinator confirmed that QDDPs facilitated the teams, including	Noncompliance

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		team meetings. Reviews of ISPs also suggested that the QDDP was the team leader and responsible for ensuring team participation. ▪ 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. Based on the caseload list provided, a total of 20 QDDPs resulted in a QDDP generally being assigned to each residence, with a few QDDPs who supported individuals from more than one residence. This resulted in an average caseload of 22, with a range of 12 to 28 individuals. Based on interview with the QDDP Coordinator, another QDDP had been added, which was expected to reduce the average caseload. In addition, one of the QDDPs that carried a small caseload had been assigned specific responsibilities to assist with compliance with the Settlement Agreement. At the time of the review, the Facility was planning to involve this QDDP more with the at-risk process. ▪ In November 2011, the QDDP Coordinator, four QDDPs, and the Program Compliance Monitor (PCM) attended training that the State Office offered. It included further instruction on the use of the "Q Construction: Facilitating for Success QMRP Facilitation Skills Performance Tool." Since then, this team had been observing ISP meetings in pairs. Based on interview, the QDDP Coordinator and PCM often observed meetings together, and completed the forms independently of one another. Results then were compared. ▪ When areas on which QDDPs did not demonstrate competence were identified, the Facility was taking various actions to assist QDDPs to improve their skills. For example, when new QDDPs participated in training on facilitation, some of the QDDPs that needed improvement also went through the training again. Training also reportedly had been provided to some on the specific areas in which they lacked competence. For others, the QDDP Coordinator was attending meetings and providing coaching. The Facility also planned to have some of the stronger QDDPs co-facilitate with some of the QDDPs that needed to improve their facilitation skills. This would allow QDDPs with skills in facilitation to model good facilitation. ▪ The State Office ISP Consultants continued to provide training and technical assistance to QDDPs and teams on the ISP process. One of the consultants had been at the Facility between January 2nd through 5th, 2012. In addition to working with the QDDP Coordinator and Assistant Director of Programs on the new ISP process, the Consultant provided training to the QDDPs, attended approximately five ISP meetings to provide technical assistance, and facilitated one ISP meeting. A number of QDDPs attended the various meetings during the week to benefit from the technical assistance provided. During the training, the Consultant presented a revised ISP Meeting (Facilitation and Documentation) template, dated 1/2012. Based on interview with the QDDP Coordinator, QDDPs who had used the revised format found it helpful.	

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		▪ An area in which training was being provided and emphasis placed was on the third quarterly meeting. During these meetings, teams were now expected to conduct planning that would be helpful in preparing for the annual ISP meeting. Teams were to review the PFA to determine the individuals' "optimistic, realistic vision of preferred living environment, work/jobs, relationships with others, leisure activities, and participation in organizations/clubs." Team members were to use this information and information related to individuals' preferences as they conducted their assessments, and made recommendations. ▪ During the week of the review, the Monitoring Team observed a number of team meetings. Progress definitely continued to occur with regard to the facilitation of meetings. Based on these limited observations and review of ISPs, some of the areas in which progress had begun included: o At annual ISP meetings, an agenda was clearly set forth, along with ground rules. o Efforts were made to include the individual, and focus the discussion on him/her. o Paper hung on the walls or white boards was used to track key components of the ISP process, such as the agenda, the individuals' preferences, and action plans that needed to be developed. 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. o Preparation by the QDDP for the ISP meeting for Individual #148 was evident in his use of pre-written wall charts describing potential areas for team discussion based on the assessments. The QDDP used the ISP Meeting (Facilitation and Documentation) outline to integrate information the team reviewed, commented on, and modified. A person had been designated to capture the team discussion and to fill in the outline as the discussion progressed. The QDDP followed the outline to keep discussion focused and moving forward, and to assure that key points in the plan development were covered. This outline had only been approved in January 2012, so it was too early to tell how the ISP will be improved as a result, but this early effort looked promising. o During the onsite observations, discussions about individuals' optimal living vision showed improvement, with discussion being linked back to individuals' preferences. In reviewing ISPs, although most teams had not fully documented their recommendations independent of the individual and/or guardian, it appeared that more discussion was occurring. ▪ As noted above, the Facility provided one plan for an individual for whom the plan was developed using the most recent format and training from the State	

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		Office's ISP consultants (i.e., Individual #34). In general, this plan showed a number of improvements, and promising aspects. Some of the strengths included documentation of more robust deliberations by the team; clear connection between these discussions and the action plans the team developed; review of incidents and allegations over the last year, and discussion about whether or not further action was needed; clear documentation of the team's review of recommendations from assessments that had not been otherwise discussed, and either action plans to implement such recommendations, or justification for not implementing them; and the action plan format was easier to interpret, and contained elements to show who would implement the plan and who would monitor the plan's implementation. This plan still had a number of issues of concern. For example, based on what was written, it was unclear if the team had made data driven decisions. The plan reviewed, for example, the BSP and skill acquisition programs, but did not include specific data. General statements were made, such as "made progress" or "no progress shown" without specific data being cited. It remained unclear how some assessment information was used, such as the Functional Skills Assessment, and/or how priority areas for training were selected. Risk action plans remained inadequate, and did not address many of the issues discussed with regard to Section I. In general, clinical plans were not adequately incorporated or integrated into the ISP through, for example, inclusion of measurable outcomes or objectives, and/or integration with other disciplines. Measurable objectives to assist the team in determining whether the person was doing better or worse were lacking in a number of important areas. Community integration and integration of the individual's preferences were lacking in the action plans. Although these issues remained, overall, this plan showed a number of important improvements from previous plans, and Facility staff are encouraged to continue working with State Office staff and consultants to improve the individual planning process. Based on review of ISPs 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 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: ▪ As noted above, the team that had undergone training on the competency-based assessment portion of the Q Construction: Facilitating for Success was conducting assessments of QDDPs skills during annual ISP meetings. This process had assisted in identifying areas in which all of the QDDPs reviewed	

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		needed to improve their meeting facilitation skills. Recommendations had been made individually at the conclusion of the competency checks, which were in the process of being implemented. As noted above, the Facility was taking a number of steps to address any issues found. The QDDP Coordinator recognized that this would be an ongoing process until the QDDPs had reached the necessary level of competence. ▪ Based on review of ISPs 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: 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. o As is discussed below, ISPs did not consistently show adequate incorporation of preferences into action plans. o During onsite observations, as well as in ISPs 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 programing, choice-making, etc.); 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 ISPs 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	

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		community placements, etc.). This is essential information to inform planning for future training, treatment, supports, and services. 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.). 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 ISPs 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. o Likewise, teams generally did not discuss measurable, functional objectives during team meetings, and, as a result, they often were not included in ISPs. 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," "shopping trips," or "activities with animals"), 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, or individual will meet at least five new people who are not staff or peers, or individuals will increase her potential vocational activities with regard to animal care by volunteering at an animal shelter). o Methodologies often were absent. In other words, teams did not discuss how outcomes would be accomplished. For example, for a number of individuals, "attend community outings" was an objective. These objectives were not supported with methodologies regarding how the team was going to assist the individual in attending community outings and/or incorporating individuals' preferences into outings. For example, it was unclear if individuals with this objective could learn to use public transportation, how they would be assisted to learn about different opportunities for types of community outings related to their specific preferences, and/or if they would choose such outings or just go on outings designed for them and their peers. Based on discussions with staff, a number of barriers continued to exist with regard to the frequency of such outings, particularly for certain residences. However, none of the ISPs reviewed identified any barriers to providing supports to individuals overall, or specifically with regard to community outings.	

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		Progress had been made. However, based on observations as well as review of ISPs, while some meetings were much improved, the meetings were not consistently resulting in the adequate assessment of individuals, and the development, monitoring and revision of adequate treatments, supports, and services. As a result, the Facility remained out of compliance with this provision of the Settlement Agreement.	
F1b	Consist of the individual, the LAR, the Qualified Mental Retardation Professional, other professionals dictated by the individual's strengths, preferences, and needs, and staff who regularly and directly provide services and supports to the individual. Other persons who participate in IDT meetings shall be dictated by the individual's preferences and needs.	DADS Policy #004 described the Personal Support Team as including the individual, the Legally Authorized Representative (LAR), if any, the 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. Although based on staff interview, attendance had begun to improve, specifically with regard to physicians and psychiatrists, the Facility recognized that this was an areas that continued to require attention. As a result, shortly before the Monitoring Team's visit, the Facility had established a workgroup. Based on email correspondence, the group was designed to be interdisciplinary, and included many Department Heads, or their representatives. The goal of the group was to determine what changes could be made to the ISP meeting schedule to assist in improving attendance. This was no easy challenge. This was illustrated at the first meeting, on 1/31/12, during which the group tried to define all of the various meetings or regularly occurring events that potentially conflicted with ISP meetings, including, for example, PNMT meetings, medical and dental appointments, specialty clinics, psychiatric reviews, Department meetings, etc. As noted in the Monitoring Team's last report, a database had been set up to assist with tracking attendance at ISP meetings. Beginning in June 2011, it was being populated with information related to team members' attendance at meetings. However, the Facility recognized that this data was not yet reliable, and as a result, time had not been spent analyzing it. This made sense, because at this point, it remained unclear how a determination was made regarding whether a team member's attendance was required or not. In an effort to address the issue of defining the team members who needed to participate in the annual meetings, the State Office had begun to train teams to use the third quarterly meeting as a planning meeting for the annual ISP, including defining team participation. The Facility provided documentation that on 9/1/11, some of the QDDPs had attended a Webinar that the State Office offered on the new PFA, which was part of what teams were to discuss at the third quarterly meeting, and would provide some of the basis for the assessments that would be completed, and the areas of focus for the assessments. In addition, the Facility provided documentation of training on the third quarterly meeting, and the PFA. The QDDP Coordinator had provided this training to the majority of QDDPs on 10/28/11. Some signatures showed other dates in November on	Noncompliance

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		which the QDDPs were trained. The third quarterly meeting template was included as part of the training materials. It showed that teams were to check off the team members expected to attend the ISP meeting. What was not clear was what criteria teams would use, or whether or not teams were expected to provide an explanation for not including a team member, specifically if the individual had needs in a particular area, but the team decided the team member's presence was not necessary. This will be important moving forward to justify team members' decisions. The criteria for determining when a team member's attendance at an ISP meeting is required should be defined, and incorporated into the attendance database to ensure its reliability. More specifically, the Settlement Agreement requires that: "Other persons who participate in IDT meetings shall be dictated by the individual's preferences and needs." As the Monitoring Team reviews individuals' ISPs, as well as the related assessments, if needs are identified for which the presence of a team member was warranted, but the requisite team member was not in attendance and no justification was provided, then the conclusion is drawn that a duly constituted team was not present. Teams will need to do a better job of justifying team composition, but might need guidance in order to make appropriate decisions. Based on the sample of 22 ISPs the Monitoring Team reviewed, sign-in sheets were provided for 22. Of these 22, for none (0%) it appeared that a duly constituted team was in attendance. Currently, none of the PFAs reviewed (0%) defined the composition of the team. Often, the individual presented issues requiring the attendance of specific team members, but these team members were not in attendance. In addition, although the individual and/or LAR often were present, some sign-in sheets did not show their presence, and no explanation was provided in the narrative of the ISP (e.g., Individual #527, and Individual #139). Examples of concerns related to team composition have been provided in previous reports, and issues were similar during this review. Some progress had been made in that the Facility had developed a workgroup to address some of the challenges related to attendance at ISP meetings, and training had occurred on defining attendance at annual meetings during the third quarterly review. However, the Facility remained out of compliance with this provision.	
F1c	Conduct comprehensive assessments, routinely and in response to significant changes in the individual's life, of sufficient quality to reliably identify the individual's strengths, preferences and needs.	Progress had been made and/or sustained with regard to the conduct of assessments. Positive developments included: ▪ DADS Policy #004 defined "assessment" to include identification of the individual's strengths, weaknesses, preferences and needs, as well as recommendations to achieve his/her goals, and overcome obstacles to community integration. ▪ At noted in the Monitoring Team's last report, some further direction had been	Noncompliance

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		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 first point had been further emphasized in training that the State and QDDP Coordinator had been provided in September and October regarding the role of the third quarterly meeting in establishing priorities based on the individuals' preferences and "optimistic, realistic vision of preferred living environment, work/jobs, relationships with others, leisure activities, and participation in organizations/clubs." These priorities were supposed to help shape the assessment process. However, based on review of some of the most recent plans, this was not yet occurring. ▪ As noted in the Monitoring Team's last report, 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. In addition, a routing system was in place, which allowed tracking of assessments from the time disciplines submitted them until they were filed in the active record. 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 ISPs. Based on a review of 22 ISP files, areas in which improvements should be made in order to achieve compliance, included: ▪ For one of the individuals (5%), it appeared that all the various types of assessments necessary to address the individuals' strengths, needs, and preferences had been completed (i.e., Individual #414). Since the last review, the QDDPs had been trained on the new PFA and third quarterly review process, which included a process for determining the assessments needed for the ISP. Unfortunately, at the time of this review, none of the PFAs identified which assessments should have been completed. Often the narrative sections of individuals' ISPs identified issues of concerns for which assessments were not found. This was often the case with regard to individuals' medical and psychiatric needs, for which updated assessments did not appear to be available to the team at the time of the ISP meeting. Another assessment that frequently was missing was for individuals' day and/or vocational needs. Sometimes PBSPs were present in the assessment packages, but no psychological assessment was present (e.g., Individual #463, Individual #98, and Individual #284). At times, what appeared to be key assessments due to an individual's needs were not present (e.g., for Individual #498, who had a recent hospitalization for aspiration pneumonia, no assessments were included from the PNMT, even though a PNMT member was present at the meeting, and the ISP did not specifically identify the	

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		status of the PNMT review). 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. ▪ For none of the individuals (0%), the quality of the assessments was adequate, including clear identification of the individuals' strengths, needs, and preferences. Some assessments did this better than others, such as the newer vocational assessments (as is discussed in further detail with regard to Section S.2). However, with most assessments, this information was integrated throughout the report, and no analysis or listing of the information was provided. In other instances, assessments clearly did not provide the team with the information it needed to develop adequate plans for the individual. 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' ISPs, it is essential that adequate assessments be completed that identify individuals' preferences, strengths, and needs. ▪ Assessments also frequently did not include adequate recommendations. Some of the issues noted included: o Some assessments typically included no or limited specific recommendations (e.g., nursing, the Functional Skills Assessments, and dental). Others included an incomplete list of recommendations. For example, assessments stating that no changes were needed, did not provide the team with an adequate set of recommendations regarding what supports continued to be necessary. o Recommendations frequently were not oriented to the development of action plans. For example, a recommendation that read: "It is recommended that the IDT continue to seek ways for [Individual] to have a full schedule of preferred activities, as he is more likely to engage in target behaviors during unstructured time in the home" was not	

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		sufficient to describe what supports the individual needed. In this case, the team needed more information about what a "full schedule of preferred activities" should entail, what staffing ratio was necessary to accomplish this based on this particular individuals' needs, what preferences the assessor had identified on which the team could capitalize, etc. ▪ There were no cases (0%) in which all assessments had been completed in a timely manner (i.e., at least 10 working days prior to the ISP meeting). In some cases assessments were being done days after the ISP meeting (i.e., psychological assessments for Individual #81, Individual #313, and Individual #272). Although staff reported that they had seen some increased compliance with timely submission of assessments, based on the review of records, concerns still existed. ▪ Some further direction had been provided to staff responsible for assessments, including that each assessment should include a statement regarding whether or not an individual could transition to the community, as well as the supports needed. If not, the assessor needed to identify the reasons. Based on the review of sample plans, this was not occurring consistently, but was seen in a number of assessments. Some confusion also appeared to exist with regard to which assessments needed to include such recommendations. This is discussed in further detail with regard to Section F.1.e. Overall, assessments were either not present or inadequate to guide teams properly in developing adequate ISPs. 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 ISP 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 ISPs. The following summarizes concerns related to the incorporation of assessments into ISPs: ▪ In none of the 22 plans (0%) were all recommendations resulting from assessments addressed in the ISPs either by incorporation, or evidence that the team had considered the recommendation and justified not incorporating it. The revised ISP template included a section that read: "Review Any Assessment Recommendations not already addressed in the ISP." A chart followed this header with the following columns: Assessment/Date, Recommendation, and Deliberations/Actions. Under the Deliberations/Actions header, teams were asked to document their deliberations. Then, if the recommendation was to be implemented, they were to write an action plan, but if it was not to be implemented, the team was to write its rationale. This should assist teams in	Noncompliance

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		ensuring that all recommendations are addressed adequately in the ISP document. ▪ At times, 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. ▪ Two major factors negatively impacting the Facility's ability to ensure that assessment results were used to develop, implement, and revise, as necessary, a ISP that outlined the protections, services and supports provided to the individual were: 1) based on observations and review of documentation in ISPs, there was a lack of consistent interdisciplinary discussion and coordination in the development of ISPs. 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. The State and the Facility should ensure that person-centered concepts are incorporated with the need to develop comprehensive, integrated plans. Person-centered planning is not a reason for not having plans that are adequate. Many individuals require plans with multiple supports. The State, working in conjunction with the Facility, should figure out ways to have adequate, technical team discussions and incorporate such discussions into comprehensive ISPs, 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. A total of 11 plans were reviewed including those for: Individual #284, Individual #202, Individual #463, Individual #414, Individual #498, Individual #46, Individual #126, Individual #139, Individual #181, Individual #527, Individual #162. To highlight some of the issues of concern: ▪ Teams were not consistently providing independent assessments of individuals' ability to transition to a more integrated setting. In two of the 11 plans reviewed (18%) (i.e., Individual #414, and Individual #284) teams specified a recommendation independent of the individual or guardian.	Noncompliance

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		▪ In addition, as noted above with regard to Section F.1.c, some confusion also appeared to exist with regard to which assessments needed to include such recommendations. Specifically, it had been interpreted that only clinicians needed to include recommendations in their assessments. The professional team members should include all ABSSLC staff on the team, including, for example, residential and day/vocational staff. Assessments such as vocational assessments, and functional assessments should include such recommendations. During ISP meetings, when the team members' opinions are sought, this also should include all ABSSLC staff on the individual's team (e.g., QDDP, residential staff, day vocational staff, direct support professionals, etc.). ▪ 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. However, on 12/16/11, the Admissions Placement Coordinator provided training to QDDPs on "Identifying Obstacles and Supports and Services." The training included a component designed to assist the QDDPs to identify current weaknesses in the process. A sample of actual ISPs was selected, and identifying information removed. QDDPs that did not work with the individuals whose plans they were assigned were asked to review the plans. They were asked to identify the necessary supports and services, as well as the obstacles to transition. When looking at ISPs that other QDDPs wrote, it became more apparent how difficult this was given the information currently provided. This was a creative approach to address the issues identified.	
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		

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	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." 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. <u>Identification and Use of Individuals' Preferences and Strengths</u> As noted in the Monitoring Team's previous reports, teams were making efforts to identify individuals' preferences. The 22 ISPs reviewed generally included some information regarding the individual's preferences. However, the following concerns were noted with regard to the identification and incorporation of preferences and strengths into ISPs: ▪ Although all 22 of the ISPs reviewed included a listing of individuals' preferences, none of the individuals' teams (0%) had effectively incorporated their preferences into related action plans. For a number of individuals, teams made no reference to preferences in the action plans (e.g., Individual #527, or Individual #126, even though the ISP narrative indicated intent to incorporate preferences into this individual's action plans). Some teams had developed action plans that appeared to be designed to ensure that individuals had access to some of their preferred activities or items (e.g., Individual #139 who like to walk home from work, or Individual #162 for whom the team merely listed each preference in an action plan without measurable objectives or any apparent attempt to integrate them with other supports). However, in none (0%) was it apparent that teams had reviewed individuals' preferences to determine if they could be used to motivate changes (e.g., Individual #181, who did not like working, but had a number of preferences that the team could have incorporated to try to motivate involvement in work or day activities, such as cooking, dogs, aquatics, etc.) or expand individuals' horizons (e.g., additional vocational opportunities, living options, or leisure activities that would encourage integration with people outside of the Facility). ▪ 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	Noncompliance

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		environments, work, relationships, past or future experiences, routines, interactions with others, etc. ▪ Little, if any, information about individuals' specific strengths was discussed in ISP documents. Strengths were not regularly built upon to address need areas. <u>Prioritization of Needs and Explanation for Any Need or Barrier Not Addressed</u> None of the 22 plans reviewed (0%) included a list of priority needs. In none of the plans was an explanation provided of how the team had determined which supports or training needed to be prioritized over other needs. For example, no rationale was provided regarding why one of the individual's specific needs (e.g., one daily living skill as opposed to another, or a particular medical need) took precedence. In addition, although anecdotally, teams were concerned about lack of staffing or transportation to address individuals' needs, careful delineation of barriers to addressing needs was generally not found. Moreover, teams often cited individuals' behaviors or attitudes as preventing them from participating in activities (e.g., work), but teams had not clearly defined such issues as barriers, and/or implemented plans to address them. More specifically, in none of the 22 ISPs reviewed (0%) were barriers identified and addressed. <u>Identification of Supports Needed to Encourage Community Integration</u> In reviewing objectives related to individuals' involvement in the community, they continued to be extremely limited. Four of the 22 ISPs (18%) reviewed included specific skill acquisition action plans for implementation in the community. Some individuals had "community" checked as the place in which the action plan would be implemented. However, often these were overall supports that needed to be provided wherever the individual was (e.g., implementation of BSP). In other cases, no specific requirements were included for the community being the venue for the objective's implementation, because it was listed as one of many (e.g., making a purchase or crossing the street safely). This is discussed in further detail with regard to Section S.3.b. In addition, only three individuals' ISP (14%) included a measurable objective for general community participation (i.e., Individual #414's ISP included an objective for weekly participation in community activities, Individual #541's ISP included an objective to attend community events at least once per month, and Individual #202's ISP included an objective for community activities once every three months, which set an extremely low expectation). Even these objectives were not adequately individualized to ensure that such activities were related to the individuals' interests, and/or that they met certain criteria (i.e., not just a van ride in the community). Other individuals' ISPs included general action plans for community activities, but they were not measurable (e.g., Individual #527, Individual #139, Individual #498, and Individual #463). For example,	

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		they included timeframes such as "as scheduled," or "ongoing." As a result, it was difficult to conclude that such objectives "encouraged community participation," because they could potentially occur once a year as opposed to on any regular basis. 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. However, as noted above, teams had not identified such barriers in individuals' ISPs. The Facility remained out of compliance with 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 ISP 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, and recognizes that this was an area in which the Facility was working with the State's ISP Consultants to improve. The following summarizes the concerns related to action plans: ▪ As noted in the last monitoring report, ISPs 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. ▪ However, none of the 22 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 #527 had objectives that read: "Nutrition" and "Nursing Care Plan for Hepatitis B;" for Individual #181, an objective that read: "continuation of BSP;" or Individual #139 had objectives such as "attend work for short periods," "Recreation," and "Dental"). Most of the time, necessary objectives, supports, and services simply were not included in action plans [as a few examples, none of the individuals had risk action plans incorporated into their ISPs; Individual #139 had no objectives for implementation of her health management plans (HMPs), or psychiatric treatment plan; Individual #162 overall had extremely limited and inadequate action plans; or Individual #463 had no objectives	Noncompliance

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		related to the PBSP, psychiatric care plan, HMPs, PNMP, or rights restrictions]. ▪ Individualized, measurable goals and objectives were not defined in individuals' ISPs to support the implementation of essential plans, such as nursing plans, psychiatric treatment plans, PBSPs, and physical and nutritional support plans. For example, in order to provide health care or behavioral supports to individuals served, direct support professionals as well as clinical 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' ISPs. Clinical staff also should have defined specific responsibilities, including but not limited to training staff, monitoring implementation of programs, reviewing data, etc. In addition, ISPs 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 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 ISP. ▪ 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. This also required the development of action plans in ISPs. In summary, the Facility was at the very initial stages of complying with this component of the Settlement Agreement. 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 ISPs. ISPs appeared to integrate some, but not all protections, services and supports that individuals required, as this provision of the Settlement Agreement clearly requires. None of the 22 plans reviewed (0%) integrated all of the protections, services and supports, treatment plans, clinical care plans, and other interventions provided for the individual. Action plans did not comprehensively address these various plans in a way that showed integration was occurring. For example: ▪ The medical, psychiatric, counseling, habilitation therapy, PBSPs, and nursing care/health management plans frequently still were separate plans that were	Noncompliance

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		not integrated in any measurable way into the ISP, through, for example, measurable objectives, and did not show an integration of various disciplines and team members. ▪ Action plans often did not recognize the multiple staff and disciplines that needed to be involved in the training of staff, implementation of the programs/plans, monitoring of the implementation, and updating/maintenance of the plans and/or related equipment. Frequently action plans simply stated what would happen without detailing all of the steps and the staff who needed to work in an integrated fashion to achieve the stated outcome. For example: o The action step stating: "psychiatric follow-up," or "continue PNMP" did not detail all of the various roles of staff who needed to work in an integrated fashion to accomplish the ultimate objectives for these individuals of maintaining good health. Often the persons responsible for these broad outcomes were "nursing," or "the PNMP Coordinator and QDDP." Again, this did not recognize the need for such supports to be integrated with the roles of many disciplines, including direct support professionals. o Although some ISPs had action plans to implement the PBSPs, no related measurable, behavioral objectives were included in the ISPs. Often the action plans did not even include objectives that the PBSPs would be implemented as written. No detailed action steps were included related to staff training, monitoring of the plans, sharing of information with the psychiatrist, etc. o Although ISPs occasionally included an objective to implement the PNMPs, PNMPs lacked measurable outcomes, and, as a result, these were not included in ISPs. In addition, generally no detail was provided in relation to all of the various roles of team members necessary to ensure full implementation, including, for example, integration with nursing and dental plans. ▪ Examples of issues related to the lack of integration were found between nursing, dental, and physical and nutritional supports to incorporate PNMPs with medication administration and dental work, and dental and psychology to develop and implement desensitization plans. As just a few examples, Individual #139 had a number of issues for which psychology staff should have been involved, but were not, such as a fast eating pace that could result in choking, and some behaviors at work that likely would prevent further growth and/or a job outside of the work center. Similarly, Individual #126 was at risk due to behaviors during meals, but psychology did not appear to be involved in addressing this issue. Rather, mealtime appeared to be under the domain of Habilitation Therapies. Individual #284 had sustained numerous injuries due to self-injurious behavior (SIB). Although the ISP mentioned review of this issue in	

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		"Grand Rounds," the ISP showed little, if any, integration between psychiatry and psychology, or any other disciplines to address this issue. All of these are examples of coordination and integration that should be occurring as part of the individual planning process, but were not. Numerous individual-specific examples of these concerns have been provided in previous reports. The Facility remained out of compliance with this provision.	
	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, the timeframes often were confusing, because the ISPs frequently did not distinguish between timeframes for implementation of action steps, and monitoring or oversight of implementation. In addition, many ISPs reviewed included timeframes such as "ongoing," or "as scheduled." Generally, these were insufficient to allow teams to measure whether or not the objective had been achieved. Methods for implementation often were not adequate or present. In other words, the "how" was not provided. In none of the 22 plans reviewed (0%) was the methodology sufficiently described for the action plans included. For example, action steps that read: "continue to attend day activity center" without any indication of what the individual was expected to learn or gain from such attendance, "ensure dental follow-up" for an individual who required desensitization according to the ISP narrative, "nutrition" for an individual who had unexpectedly lost 10% of her body weight over the last year, or "Continue health maintenance plans" with no delineation of who would be responsible for what. Each of these examples should have resulted in the integration of numerous supports, which should have been detailed in the ISPs, but were not. In addition, as is discussed with regard to Section I, action plans for individuals that had been identified as being at risk were not included in the ISPs. In addition, they did not include adequate methodologies to reduce the at-risk factors to the extent possible. The plans included in individuals' risk action plans 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. In addition, staff responsible often did not include direct support professionals, when they should have been identified. Even when they were mentioned, their specific role was not always identified. For example, they often were listed along with numerous other staff (e.g., nurse, psychologist, QDDP), and it was unclear what each person's role was. The specific roles of direct support professionals in plan implementation, as well as clinical staff's roles should be set forth in the action plans.	Noncompliance

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	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 22 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. 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. Very occasionally, individuals had an objective related to housekeeping or yard work, which would be typical activities for independent adults, such as a "setting the table" objective (e.g., Individual #181). 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). 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.	Noncompliance
	6. Identifies the data to be collected and/or documentation to be maintained and the frequency of data collection in order to permit the objective analysis of the individual's progress, the person(s) responsible for the data collection, and the person(s) responsible for the	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. Consistent with the previous reviews, for the goals and objectives included in ISPs, generally, the ISPs specified data to be collected and/or documentation to be maintained, and specified a frequency for data collection. 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' ISPs, or other treatment plans that should have been integrated into the ISP (e.g., risk action plans, health management plans, PNMPs, psychiatric treatment plans, etc.). As a result, appropriate	Noncompliance

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	data review.	data was not being collected to assist teams in decision-making. Even when plans included objectives, such as PBSPs, individuals' ISPs did not consistently identify the data to be collected, the frequency, and/or the persons responsible for such data collection. In addition, the ISPs 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 two different people would play these two different roles. 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 ISP did not make this distinction, and often when two positions were listed, it was not clear what each one's responsibilities were. Based on a review of the revised ISP template, as well as the ISP for Individual #34, the action plan format had been revised to distinguish between the roles of implementing plans/collecting data, and developing and monitoring the plan. This was a positive improvement. None of the 22 ISPs 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 ISPs 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.	
F2b	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that goals, objectives, anticipated outcomes, services, supports, and treatments are coordinated in the ISP.	As noted in the previous reports, and based on the current review of ISPs, this was an area that required substantial improvement. As is discussed in other sections of this 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 ISPs generally showed a multidisciplinary as opposed to interdisciplinary approach.	Noncompliance
F2c	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that each ISP is accessible and comprehensible to the staff responsible for implementing it.	DADS Policy #004.II.D.m required the ISP to be accessible and comprehensible to staff who must implement it. At the time of the review, the ISP 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. Improvements were seen in the manner in which plans were written to facilitate direct	Noncompliance

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		support professionals' understanding. Less clinical jargon was used in general, but occasionally, an ISP appeared to have been largely cut and pasted from assessment information, resulting in significant use of clinical terminology that would make it difficult for direct support professionals to understand (e.g., Individual #139). Another issue related to comprehensibility of the 22 ISPs 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 ISPs 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. In addition, the ISPs 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 ISP. This is necessary to provide one document that clearly identifies all of the protections, supports, and services that need to be provided to the individual, and clearly identifies the responsibilities of various team members.	
F2d	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that, at least monthly, and more often as needed, the responsible interdisciplinary team member(s) for each program or support included in the ISP assess the progress and efficacy of the related interventions. If there is a lack of expected progress, the responsible IDT member(s) shall take action as needed. If a significant change in the individual's status has occurred, the interdisciplinary team shall meet to determine if the ISP needs to be modified, and shall modify the ISP, as appropriate.	DADS Policy #004 at III addressed personal support plan monitoring, including the requirements of the Settlement Agreement. This was confirmed through document review. Based on the sample of 22 records reviewed, none (0%) had monthly reviews each month for the previous three months. All of the ISPs had been completed in October through early December 2011. Therefore, at the time of the review in February 2012, at least one, if not two or three monthly reviews should have been available. The past two quarterly reviews also were requested. Based on the sample of 22 records, none (0%) had quarterly reviews. As a result of the lack of documentation, the Monitoring Team could not assess the quality of the reviews, and/or related follow-up activities. However, 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, there were times when a team member(s) identified a need for a change, but individuals' ISPs were not consistently modified to reflect such changes.	Noncompliance

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F2e	No later than 18 months from the Effective Date hereof, the Facility shall require all staff responsible for the development of individuals' ISPs to successfully complete related competency-based training. Once this initial training is completed, the Facility shall require such staff to successfully complete related competency-based training, commensurate with their duties. Such training shall occur upon staff's initial employment, on an as-needed basis, and on a refresher basis at least every 12 months thereafter. Staff responsible for implementing ISPs shall receive competency-based training on the implementation of the individuals' plans for which they are responsible and staff shall receive updated competency- based training when the plans are revised.	As reported in previous reports, training on ISPs had been standardized across the SSLCs. Supporting Visions: Personal Support Planning was the standard training curriculum for personal supports planning. As indicated above, since the last review, additional training sessions and resources had been initiated. These included: ▪ As new QDDPs were hired, they participated in the initial "Q Construction: Facilitating for Success" 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. ▪ In November 2011, the QDDP Coordinator, four QDDPs, and the Program Compliance Monitor (PCM) attended training that the State Office offered. It included further instruction on the use of the "Q Construction: Facilitating for Success QMRP Facilitation Skills Performance Tool." Since then, this team had been observing ISP meetings in pairs. Based on interview, the QDDP Coordinator and PCM often observed meetings together, and completed the forms independently of one another. Results then were compared. ▪ As noted above, on 12/16/11, the Admissions Placement Coordinator provided training to QDDPs on "Identifying Obstacles and Supports and Services." The training included a component designed to assist the QDDPs to identify current weaknesses in the process. A sample of actual ISPs was selected, and identifying information removed. QDDPs that did not work with the individuals whose plans they were assigned were asked to review the plans. They were asked to identify the necessary supports and services, as well as the obstacles to transition. When looking at ISPs that other QDDPs wrote, it became more apparent how difficult this was given the information currently provided. This was a creative approach to address the issues identified. ▪ The State had hired consultants to provide training, and work hands-on with teams on the ISP process. Prior to the Monitoring Team's last review, the consultants had provided some basic training to ABSSLC IDTs. 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. Since the last review, on 1/3/12, one of the consultants had returned and provided additional training to the QDDPs, and had sat in on ISP meetings, and provided technical assistance to QDDPs and teams. This group continued to develop a revised ISP template designed to help structure teams' work holding ISP	Noncompliance

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		meetings and QDDPs' roles in drafting ISPs. ▪ QDDPs also had participated in training on a couple of specialized topics, including using abuse, neglect, and exploitation and incident data in individuals' ISPs, and the new change of status flow chart. On 9/1/11, they participated in training on the new PFA process, and on 9/30/11, on the at-risk process. On 12/21/11, QDDPs participated in training on skill acquisition programs. Monthly QDDP meetings also were being held at which various topics were discussed, and training provided. These were all positive initiatives to provide QDDPs with the skills and knowledge needed to do their jobs. ▪ As noted previously, based on a limited number of observations of ISP meetings while onsite, improvements had begun to be seen with regard to the team process. As would be expected, the results of this training were not yet reflected in the ISP documents that the Monitoring Team reviewed. Areas in which additional work was needed to reach compliance with the Settlement Agreement included: ▪ As indicated in previous reports, QDDPs should be required to demonstrate competency in meeting facilitation and the development of an appropriate ISP 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, based on a list dated 10/28/11, the Facility reported that eight of the 20 QDDPs had successfully completed the competency check-off. Unfortunately, based on the Monitoring Team's review of ISPs that a number of these eight QDDPs had developed in November and December 2011, it was not obvious from the documents that the QDDPs were competent in facilitation of the meetings. As noted throughout this section of the report, numerous concerns were identified with a lack of discussion and/or documentation of relevant issues, integration between team members, and development of relevant action plans. It was unclear from the documentation available to the Monitoring Team if these deficiencies in the written plans resulted from a lack of adequate facilitation, ineffective documentation of the teams' work during the ISP meeting, or other factors. 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 was observing the same ISP 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. ▪ The Facility had not yet begun to implement competency-based measures for the	

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		writing of ISPs. ▪ 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. ▪ 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 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. ▪ 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. ▪ 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. ▪ 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 ISPs, such as behavior support plans, physical and nutritional management plans, indirect therapy plans, use of alternative and augmentative communication, and/or skill acquisition plans. 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 ISP 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	Based on the list of individuals with their most recent and previous ISP dates, 420 out of 432 plans (97%) were completed within one year. The 12 plans that had been overdue were late on average by 14 days, ranging between four and 64 days late. While it is possible that extensions were granted for some of the 12 plans, this was not evident on the provided list. Discussions with staff indicated that the expectation was that the plan would be finalized	Noncompliance

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	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.	within 30 days of the meeting, and filed in the active record to allow timely implementation. As noted in the Monitoring Team's last report, at the time of the August 2011 review, the Facility just recently had put a process in place for tracking when an ISP was filed. The Records Department had developed the Policy for Routing Reports/Documents, dated 6/15/11. QDDPs had completed training on 7/8/11, and implementation of this policy would allow dates to be tracked to ensure the ISP was in the record within the 30-day time limit. The Facility provided information that indicated 73 ISPs (16%) were filed in charts more than 30 days after the ISP meeting. As is noted in other sections of this report, IDTs did not consistently meet to make changes to ISPs 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.	DADS Policy #004.V continued to address quality assurance processes to ensure ISPs were developed and implemented consistent with the provisions of the Settlement Agreement. Based on the documentation provided, it was difficult for the Monitoring Team to determine if progress had been made and/or sustained with regard to the implementation of quality assurance processes to identify and remediate problems, and ensure that ISPs were developed consistent with this section of the Settlement Agreement. More specifically, ABSSLC included copies of the following monitoring tools in response to a request for the tools it used: ▪ The Settlement Agreement Cross Referenced with ICF/MR Standards Section F: Integrated Protections, Services, Treatments and Supports audit tool; ▪ The Settlement Agreement Cross Referenced with ICF/MR Standards Section S: Habilitation, Training, Education, and Skill Acquisition; and ▪ The Q Construction: Facilitating for Success – Qualified Mental Retardation Professional Facilitation Skills Performance Tool. However, in response to the Monitoring Team's request for the last 10 tools that the QDDP Coordinator had completed, and the last 10 tools the QA Department completed, the only documents provided were copies of completed Q Construction: Facilitating for Success – Qualified Mental Retardation Professional Facilitation Skills Performance Tool. These were not really monitoring tools that could be used to aggregate and analyze information about ISP meeting, but rather were tools used to determine the competency of specific QDDPs with regard exclusively to meeting facilitation. The Facility did not provide any completed samples of the other two monitoring tools. However, in reviewing the Facility's self-assessment, it appeared that some of these tools had been completed. In addition, based on interview with both the QA Director and the QDDP	Noncompliance

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		Coordinator, a sample was being reviewed each month using the Section F and Section S tools. Reportedly, four QDDPs reviewed a total of 16 ISPs each month. The QDDP Coordinator and PCM then reviewed one of the ISPs that each of the four QDDPs had reviewed. This was an improvement since the last review when all QDDPs were monitoring ISPs. By narrowing the scope of staff conducting the reviews, it allowed more efforts to establish inter-rater reliability, and obtain more valid results. On a positive note, largely using information from the Monitoring Team's reports and recommendations as well as some of its own data, some areas in which problems had been identified were targeted for the development and implementation of corrective action plans. These action plans included some specific steps to operationalize recommendations that the Monitoring Team had made or to address areas of concern the Facility had identified. These plans generally showed good insight into areas and issues that needed to be addressed to effectuate change (e.g., specific training on change of status process in relation to ISP, evaluation of QDDPs' skills and targeted coaching or training, etc.). However, the Facility was at the beginning stages of this process, as is discussed in further detail below. Areas in which improvements should continue to be made in order to achieve compliance, included: ▪ 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. However, as discussed during the onsite review, plans were being discussed to revise the monitoring tools to better reflect the new template, and new expectations that State Office was setting. From the Monitoring Team's perspective, this would seem to make sense. ▪ Although some efforts had been made in this regard, for the various monitoring/audit tools, inter-rater reliability needed to be established with the QA and programmatic staff (i.e., QDDP Coordinator and select QDDPs) 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. ▪ As discussed in previous reports, if the current tools were going to continue to be used, the guidelines/instructions for the audit tools required modification, and any new tools should included detailed instructions. This will be essential to improve the accuracy of the monitoring results (validity), as well as the	

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		congruence between various auditors (reliability). ▪ Although the Program Compliance Monitor had begun meeting monthly with staff from the QDDP Department to review monitoring results and analyze the data collected, minutes from these meetings were not maintained. As a result, the Facility had no way to track decisions made, or plans developed or recommended to make improvements. This would be important information, for example, for the group to maintain to share with the QA/QI Council. ▪ As noted above, the Facility was at the beginning stages of utilizing the data collected to identify areas in need of remediation, and to develop action plans to address them. The action plans that were submitted for Section F appeared to be based largely on recommendations from the Monitoring Team's reports. Although this was a positive first step, over time, the Facility's data should be used to identify areas in which change is needed. In addition, the Monitoring Team recognizes that the Facility continues to work on a comprehensive action plan for Section F. However, the action plans did not yet address all areas of noncompliance. In its Self-Assessment, 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 Individual 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 an ISP meeting is required should be defined, and incorporated into the attendance database to ensure its reliability. Such criteria should take into consideration the Settlement Agreement requirement that: "Other persons who participate in IDT meetings shall be dictated by the individual's preferences and needs." Although this is an issue that should be carefully coordinated with the State Office, now that risk levels are being established for individuals, this might be one mechanism that teams could use to determine which team members should attend an individual's annual planning meeting. (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' ISPs. This should include ensuring that assessments consistently and concisely identify individuals' strengths, needs, and preferences. (Section F.1.c)
5. 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)

6. Assessments should include a full set of recommendations that are designed to assist the teams in developing action plans that describe the array of protections, supports and services that the individual requires. As appropriate, assessments should recommend specific areas of focus for skill acquisition programs, as well as detail data that needs to be collected and roles and responsibilities of various staff. (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 ISPs, 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. ISPs should integrate the recommendations from assessments, not just reference them, and make the health care, therapeutic, and behavior support plans a part of the ISP, rather than stand-alone documents. The IDT should review and approve all related plans, and the specific plan that has been approved should be referenced in the ISP, including the title and date of the plan. The team should approve any modifications of the approved plans through an ISPA. IDTs also should include a set of objectives in the ISP related to each of the plans, including, but not limited to the expected outcomes for the plans, any related skill acquisition plans, as well as defining what supports need to be implemented, who is responsible, how success will be measured, who is responsible for data collection, as well as who is responsible for monitoring and/or data review. (Sections F.1.d, F.2.a.2, and F.2.a.3)
9. With regard to independent assessments of individuals' ability to transition to a more integrated setting, the professional team members should include all ABSSLC staff on the team, including, for example, residential and day/vocational staff. Assessments such as vocational assessments, and functional assessments should include related recommendations. During ISP meetings, when the team members' opinions are sought, this also should include all ABSSLC staff on the individual's team (e.g., QDDP, residential staff, day vocational staff, direct support professionals, etc.). (Section F.1.e)
10. 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)
11. 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' ISPs should identify these clearly, if they are barriers to providing the individual with adequate supports and services. (Section F.2.a.1)
12. 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)
13. Individualized, measurable goals and objectives should be defined in individuals' ISPs 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, ISPs 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)
14. As teams continue to receive training on the new ISP 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)
15. 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)

16. ISPs should delineate clearly: 1) persons responsible for data collection; and b) persons responsible for data review. (Section F.2.a.6)
17. Given the responsibilities that direct support professionals have in implementing the plans, efforts need to be made to ensure that ISPs and all of their various components are comprehensible, while still containing the necessary clinical requirements, and that they clearly delineate the roles of direct support professionals. (Section F.2.c)
18. As the Facility develops/finalizes its monthly review process, it should ensure that the following basic requirements are met:
    a. It includes a process for each team member to conduct monthly reviews of the programs which he/she is responsible that results in easy access for all team members to the information;
    b. 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
    c. QDDPs should document clearly follow-up activity and/or changes that are made to ISPs as a result of these reviews. (Section F.2.d)
19. QDDPs should be required to demonstrate competence in both meeting facilitation, and the development of an appropriate ISP 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)
20. 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 reviews understanding of the indicators.
    c. Two areas of quality that the checklist 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)
21. Ongoing training and technical assistance should be provided to address gaps in knowledge regarding the new ISP process, as well as to enhance the various team members' skills. (Section F.2.e)
22. Consideration should be given to adding examples of ISPs 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)
23. IDTs should complete 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)
24. 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)
25. As has been recommended in previous reports, the Facility's Quality Assurance processes with regard to ISPs should include reviews to ensure that all of the components of the Settlement Agreement with regard to ISPs 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 ISP;
    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 and Facility Self-Assessment)

26. 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.2.g and Facility Self-Assessment)
27. The 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.2.g and Facility Self-Assessment)
28. 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)
29. Meeting minutes should be maintained for the monthly meetings between the Quality Assurance Department and the QDDP Department. These minutes do not have to be lengthy, but should capture decisions made, as well as any recommendations, including recommendations for corrective action plans for the QA/QI Council's consideration. (Section F.2.g)
30. As the Facility expands its self-assessment activities, the Self-Assessment should indicate how the Facility has used its data to identify problematic trends, and develop corresponding corrective actions. (Facility Self-Assessment)

SECTION G: Integrated Clinical Services	
Each Facility shall provide integrated clinical services to individuals consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o Consult/procedure reports with corresponding Integrated Progress Note (IPN), and ISPA(s) for the following: Individual #267 - neurology 9/12/11; Individual #126 - neurology 9/26/11; Individual #305 – gastroenterology 9/6/11; Individual #151 – radiology 1/3/12; Individual #216 – neurology 12/12/11, neurology 9/12/11, wound care 8/30/11, and wound care 8/25/11; Individual #147 - endocrinology 9/22/11, dermatology 9/21/11, podiatry 9/20/11, ophthalmology 10/20/11, and neurology 12/13/11; Individual #468 - gynecology 9/14/11, neurology 11/14/11, and radiology 11/15/11; Individual #129 – dermatology; Individual #351 - cardiology 12/6/11, and podiatry 10/18/11; Individual #81 – ophthalmology 10/18/11; Individual #196 - rheumatology 1/3/12, rheumatology 12/27/11, podiatry 11/15/11; and podiatry 12/20/11; Individual #42 – urology 12/15/11, and gastroenterology 11/10/11; Individual #293 - neurology 9/26/11, neurology 11/28/11, podiatry 9/20/11, and ophthalmology 10/3/11; Individual #107 - ophthalmology 12/1/11, ophthalmology 12/6/11, endocrinology 8/26/11, endocrinology 9/22/11, endocrinology 10/12/11, and endocrinology 12/1/11; Individual #210 - podiatry 11/15/11; Individual #465 - dermatology 12/14/11, neurology 11/14/11; Individual #332 - neurology 11/28/11; Individual #73 - radiology 9/20/11, neurology 9/26/11, and neurology 12/12/11; Individual #94 - neurology 11/28/11; Individual #139 - endocrinology 9/29/11; Individual #98 - neurology 11/14/11; and Individual #59 - neurology 9/12/11; o Presentation Book for Section G; o Section G: Self-Assessment, updated 2/1/12; o Provision Action Information, Section G, updated 1/30/12; o Infirmary Rounds minutes from 9/1/11 to 9/30/11, and 1/2/12 to 1/31/12; o Medical Provider Quality Assurance Audit: Compliance by Question Category, Audits for Round 4, External Audit Summary January 2012; and o Medical Provider Quality Assurance Audit: Compliance by Question Category: Audits by Question Category, Audits for Round 2, Internal Audit Summary September to November 2011. ▪ **Interviews with**: o Richard Chengson, MD, Medical Director. ▪ **Observations:** o Morning medical meetings on 2/16/12, 2/17/12, and 2/21/12.
	Facility Self-Assessment: Based on the Facility's Self-Assessment, the Facility believed that the Medical Department continued to make progress in demonstrating integration of clinical services through the morning medical meeting. Additionally, the Facility noted improvement in the primary care practitioners' (PCPs) review of consultant reports.

	According to the Facility's Self-Assessment, the Medical Department had conducted the following reviews using measurable criteria: ▪ Attendance by different departments was tracked at the morning medical meetings. The Facility self-identified gaps in departments that did not attend the morning medical meeting. The Facility noted improved attendance by three quarters of the clinical departments. ▪ The internal medical audit process indicated improvement in consultant recommendations being addressed in the integrated progress notes within five business days after the report was received. The Facility determined there was improvement, but additional progress was needed. ▪ From the external and internal audits, improvement was also noted, but challenges remained in other areas, such as updating active problem lists, and in processing diagnostic test results. However, the Facility was not collecting data to reflect the progress and goals of the morning medical meeting (e.g., how many of the concerns needing closure remained outstanding at any point in time, how many concerns addressed steps to prevent a repeat hospitalization or emergency room (ER) visits per month, what was the length of time between the committee identifying the concern and documentation of closure for that concern, how many concerns were identified per month, and/or a breakdown of categorization of types of concerns). No information was provided about the impact of the concerns on the ISPA process, or feedback to the committee indicating what decisions were made by the IDT, and which were initiated by the morning medical meeting. In addition, the information that the Facility included for this section of the self-assessment focused on the role of the Medical Department, which was pivotal, but all clinical departments are essential in providing integrated clinical care, and each clinical department should provide the needed evidence of their participation and impact in integrated care. This should include development of measurable indicators for each department that would reflect the integration of care across the campus. The role of the IDT is essential, and measuring the quality of the ISP document and the discussion at the IDT meetings would provide evidence related to the quality of integrated services. In the current Self-Assessment, the Facility focused on indicators related to the attendance of various departments at the morning medical meeting. However, there is considerable potential to demonstrate integrated clinical care in the risk rating process, including the quality of the Integrated Risk Rating Form, the Risk Action Plans, the implementation steps taken, and the outcomes. This could be tracked for stable conditions as well as changes in health status. At the time of the Monitoring's team visit, the Facility was not collecting and/or analyzing data concerning many of these aspects that demonstrate integrated clinical care. The Facility indicated in its Self-Assessment that it remained out of compliance with this section. This was consistent with the Monitoring Team's findings.
	Summary of Monitor's Assessment: The morning medical meeting provided an important contribution to integrated clinical services. Reportedly, there was a process for identifying concerns discussed at the meeting, with follow-up on a weekly basis. However, during the Monitoring Team's visit, this was not demonstrated. The concerns the group addressed focused on acute changes in health care status. The

	scope of the morning meeting had expanded to include individuals in the residences that required a call to the on-call physician, those admitted to the Infirmary, and those hospitalized. The attendance had expanded and become interdisciplinary. The Medical Department continued to attempt to recruit other disciplines to the meeting. However, despite the significant number of issues and individual changes in health status discussed at the morning meeting, few concerns were raised to the level of needing closure. Critical thinking about ways to improve individuals' health and/or prevent negative outcomes, such as hospitalizations, often was not occurring to the extent necessary. Evidence also was not provided that the recommendations or decisions/concerns identified during the morning meeting were then communicated to the QDDP, and followed by the IDT convening an ISPA meeting, with information being returned to the morning meeting for follow up and eventual closure. From the information submitted, few ISPAs resulted from a morning medical meeting recommendation or concern. The morning meeting had great potential to be influential in health care through the IDT process, but this was not demonstrated. Similarly, the PCPs had improved their documentation of review of consultation reports. However, there was little information concerning whether these reports were communicated to the IDT, and whether they were discussed and reflected in ISPAs. There was a clear need for the Quality Assurance Department to develop measurement tools for these processes and to monitor for improvement over time.

#	Provision	Assessment of Status	Compliance
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.	One of the main forums for integrated clinical services was through the morning medical meeting. Since the Monitoring Team's last visit, substantial progress had been made in this area. A morning medical meeting occurred every business day of the week. It generally preceded any rounding done in the Infirmary or in other residences. Attendance included a number of other disciplines besides the PCPs, including psychiatry, dentistry, clinical pharmacy, PNMT nursing, infection control nursing, hospital liaison nursing, and Infirmary nursing. According to the Facility Self-Assessment, attendance was tracked. The Facility noted that attendance by psychiatry, infection control nursing, and the PNMP nurse improved. Nursing administration's attendance at the meetings decreased. The Facility had the goal of other departmental participation, such as from dietary, physical therapy, and occupational therapy, but this had not occurred yet. As laboratory services were on site, a periodic report of any refusals or difficult blood draws would be potentially helpful to the Medical Department. Likewise, the morning medical meeting would be a forum for brief reports at intervals from other departments or groups, such as the PNMT. Lack of follow-through on PNMT recommendations, or lack of training to carry out these recommendations would be important topics for discussion. The QA Department might benefit from periodic	Noncompliance

#	Provision	Assessment of Status	Compliance
		attendance to assist in creating indicator tools for measuring integrated discussion and care. Attendance tracking data was used in the self-assessment process, but the actual data was not shared with the Monitoring Team. Graphs trending departments' participation would provide guidance to Facility Administration in this area. The discussion at the morning meeting had expanded from concerns related to those individuals in the Infirmary to other individuals, including those hospitalized, those for whom the on-call PCP was notified and called related to orders or concerns of acute problems, and for on-going concerns in the residence. A detailed narrative was dictated and typed. Depending on the concern, the members from various departments contributed background information, opinions, recommendations, and updates for each individual. Discussion during the meetings that the Monitoring Team attended were interdisciplinary and indicated integrated clinical care. However, the group often did not ask critical questions concerning the care and treatment of the individual to challenge the group and take advantage of the interactive culture of the meeting. Some concerns were then tracked to closure, but for many concerns, no closure was documented. Some of the closure steps would have involved other disciplines, and would have been examples of integrated clinical care follow-up. No formal process was in place by which the information from the morning medical meeting minutes was shared with the various IDTs or Facility Administration. The integrated discussion did not necessarily move beyond the morning meeting. The Facility should create a system in which the appropriate Facility department addresses in a timely manner any questions/concerns/next steps/updates determined at the morning meeting, with closure information brought back to the morning medical meeting. At the time of the Monitoring Team's review, no tracking of the health status changes occurred through the ISPA process. The ISPA meeting minutes should reflect the information and recommendations/conclusions of the morning medical meeting. If the IDT had new information or made decisions based on the morning medical meeting's recommendations, or if the IDT needed to provide a response, this also should be routed back to the morning medical meeting. However, no process was in place to include the QDDP or the IDT, and the role of the ISPA follow-up process for medical issues was not defined and/or used effectively. In addition, no one was assigned to track closure of concerns from the morning medical meeting. Tracking closure would identify those areas that could be directly closed, and areas in which an ISPA was needed to document team involvement and resolution of the concern. If ISPAs reflecting closure of concerns were tracked at the morning medical meeting, this would provide potentially important evidence of successful integration of services. QA staff might need to assist in creating goals and clinical indicators to measure success	

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		with regard to integrated clinical services. Some examples might include a list of disciplines asked to provide closure, with information brought back to the meeting; or ISPAs that provide evidence of closure of concerns discussed at the morning meeting. Other clinical indicators might include the number of ISPAs based on discussion/minutes of the morning medical meeting that led to changes in PCP orders, new testing, new consultations, new medication order, changes in nursing care plans, changes in level of supervision, increased participation of the PNMT or psychology services, etc. Internal to the morning medical meeting, it is recommended that QA staff also create indicators to measure the impact of the morning medical meetings, such as the number of concerns per month that needed closure, and/or the number that were closed and the number that remained outstanding at the end of the month or quarter, categorized by department responsible or assigned the task of closure. Clinical indicators to measure the effectiveness of the morning medical meeting might also include steps taken on an individual or systemic level to prevent ER visits or hospitalizations. No tracking was completed of each department's attendance and participation in required meetings, or cooperation in completing forms and assessments in a timely manner. For the PCPs, for example, by listing meetings the Facility had determined as mandatory for PCP attendance (either partial or complete attendance), and tracking attendance quarterly, compliance could be measured. The Facility could assign this goal to every department on campus. Clinical departments for which this would be one measure of compliance with Section G.1 would include the Dental Department, Pharmacy Department, Medical Department, PNMT, Habilitation Therapies, Psychiatry Department, Psychology Department, and Dietary Department. Section G1 involves the Medical Department, but is inclusive of all clinical departments. Evidence from each clinical department of sufficient participation in integrated clinical services is necessary for compliance. The Facility remained out of compliance with this provision.	
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	The Facility submitted consultant reports for one individual from each residence, as well as any IPNs commenting on the consultant reports. Consultations for 23 individuals were submitted, with a range of one to six consultations per individual. A total of 47 consultant reports/consultant procedures were submitted. These are listed above in the documents reviewed section. Review of these documents revealed the following: ▪ Of the 47 reviewed, 36 (77%) had the PCP initials, and 30 (64%) included the date of the signature/review. ▪ To determine whether there was agreement or not concerning consultant recommendations, follow-up IPNs were reviewed. Of the 47 reviewed, 27 (57%)	Noncompliance

#	Provision	Assessment of Status	Compliance
	refer the recommendations to the IDT for integration with existing supports and services.	consults included documentation of agreement or not with the consultant recommendations. This was a lower compliance score compared to the 1/13/12 score of 95% obtained through the non-facility external audit. ▪ For one of 47 (2%), the Facility submitted an ISPA addressing the consultation. Copies of ISPAs concerning consultations were requested, but not submitted for the other 46 consultant reports. There remained little evidence that consultant reports, once reviewed by the physician, were forwarded to members of the IDT for eventual inclusion into the IDT process of interdisciplinary discussion and integration of care. As noted with regard to Section G.1, this is an important aspect of providing integrated clinical care. The IDTs should meet based on the need to learn and discuss new information concerning the individual. A stronger link should be developed between consultation reports and communication to the QDDP and IDT. As appropriate, teams should revise the integrated risk rating based on this information, create a new or amended action plan, or address a decision or respond to recommendations made at the morning medical meeting. The Facility should develop a tracking system for consultation reports, including review and interpretation by the PCP, followed by communication of the information to the QDDP and IDT, with meeting minutes and potential ISPAs, changes in risk rating, and changes in risk action plan, as appropriate. Providing a method for measuring each step of the process would allow the Facility to analyze the resulting data to ensure efficiency, effectiveness, and integration of clinical care. The Facility remained out of compliance with this provision.	

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

1. The morning medical meeting should have a signed attendance sheet each morning to verify actual attendance. The current tracking of attendance by each discipline, and analysis of this information is important and should continue. (Section G.1)
2. QA Department staff should periodically attend the morning medical meetings. (Section G.1)
3. The morning medical meeting should be used as a forum for follow-through on PNMT recommendations, including ensuring training has been provided that is sufficient to carry out these recommendations. (Section G.1)
4. As laboratory services are on site, a periodic report during the morning medical meetings of any refusals or difficult blood draws would be helpful to the Medical Department. (Section G.1)
5. All clinical departments should increase their focus on asking critical questions concerning care of the individual. (Section G.1)
6. Concerns that are discussed at the morning medical meeting should have documentation of closure as it occurs. A list of disciplines requested to provide closure, with documentation of information brought back to the meeting, would assist in providing evidence of integrated clinical services. (Section G.1)
7. As part of the impact of the morning medical meeting, the clinical decisions and recommendations should be communicated to the QDDP and IDT. As appropriate, ISPA meetings should be held that reflect these decisions and discussion of the recommendations. ISPAs that provide

evidence of closure to concerns discussed at the morning meeting should be tracked as evidence of closure. (Section G.1)

8. The QA Department should create tools to measure the impact of the morning medical meetings. Such clinical indicators could include the number of ISPAs based on discussions/minutes of the morning medical meeting that have led to change in PCP orders, new testing, new consultations, new medication orders, changes in nursing care plans, changes in level of supervision, increased participation of the PNMT or psychology services, etc. Other indicators that might measure the impact of the morning medical meetings could include concerns per month that needed closure, and the number closed and the number that remained outstanding at the end of the month or quarter, categorized by department responsible or assigned the task of closure. Clinical indicators also could be designed to measure steps taken for the individual or systemically to prevent ER visits or hospitalization. (Section G.1)
9. The Facility should determine mandatory attendance for each department at the various Facility meetings, and track attendance and participation by those departments. (Section G.1)
10. The Facility's information systems also should be used to track the timely completion of annual, quarterly, monthly, etc. assessments required by each clinical department. The Facility QA Department then should provide quarterly reports analyzing this information, and requesting corrective action for any weaknesses identified. (Section G.1)
11. All clinical disciplines should develop measurement tools to record and track their participation and impact on integrated clinical services. This section has focused on the Medical Department, but is inclusive of all clinical departments and will require demonstration of integrated clinical services from all clinical departments. (Section G.1)
12. The Facility should develop a tracking system for consultation reports, including review and interpretation by the PCP, followed by communication of the information to the QDDP and IDT, with meeting minutes and potential ISPAs, changes in risk rating, and changes in risk action plan, as appropriate. (Section G.2)

SECTION H: Minimum Common Elements of Clinical Care	
Each Facility shall provide clinical services to individuals consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o Presentation Book for Section H; o Medical Provider Quality Assurance Audit Tool; o Medical Provider Quality Assurance Audit: compliance by Question Category: Audits for Round 4, External audit, January 2012; o Medical Provider Quality Assurance Audit Compliance by Question Category, Audits for Round 2, internal audit, 1st quarter FY 2012; o Section H - Plan of Improvement, Action Plan, undated; o Self-Assessment for Section H, updated 2/1/12; o Provision Action Information, updated 1/30/12; and o Section H - Action plans, updated 2/2/12. ▪ **Interviews with**: o Richard Chengson, MD, Medical Director.
	Facility Self-Assessment: Many of the building blocks of common elements of clinical care were becoming established at ABSSLC, including the morning medical meetings, and more accurate integrated risk ratings. Based on the Facility's Self-Assessment, the Medical Department had undergone both external and internal audits that began to track progress in these areas. For example, the PCPs had begun to complete quarterly medical assessments. The Medical Department's analysis of its tracking system indicated a need for an improved completion rate. In attempting to determine if the diagnoses were clinically consistent with the completed evaluations, a series of questions from the audit were utilized to track progress in this area. Medication orders for acute conditions were tracked to determine if they included indications and durations for all medications. The statistics indicated considerable improvement over time. The Department also tracked whether diagnostic tests and/or therapeutic procedures were medically appropriate, and found improvement. The Department tracked whether appropriate consultations were ordered based on need and diagnosis, and progress was made in this area. Annual medical assessments were also tracked, and indicated compliance had improved to 100%. However, the Monitoring Team's data did not indicate improvement in the rates of annual medical assessment. This was reviewed with regard to Section L1, and the compliance rate was only 16%. In addition, for the random active records reviewed, there were no quarterly medical assessments. There was no data collection to provide evidence that the diagnoses fit the evaluations and physical findings of the individual, and met established International Classification of Diseases (ICD) criteria or guidelines from nationally recognized professional organizations. Common clinical elements of care include all clinical departments, not just the Medical Department. There was no data to demonstrate other departments were providing necessary clinical care according to their specialties (e.g., nursing, PT, OT, speech, psychology). The number of recommendations from each

	department that were agreed upon by the IDT and included in the ISP could not be determined as one potential measure of the impact of each department across campus in the lives of the individuals. The Facility did not submit any data to determine efficiency and effectiveness for each department in meeting the needs of the individuals, especially individuals with changes of health status or behavioral status. For newly identified concerns, the five-day window to begin the assessment process was not monitored for compliance according to each department's participation. To ensure no gaps in clinical services, the Facility should track the implementation of each risk action plan, and analyze data by clinical department. Some areas such as frequent falling, decubiti, or pica would require many departmental services, and others less. Similarly, for changes in health status, the clinical services the IDT determined to be necessary should be tracked to ensure these elements of clinical care are offered. At this time, there remained no evidence that a minimum of necessary clinical services were provided to address the individuals' needs and minimize to the extent possible the risks to individuals' health. The Facility indicated in its Self-Assessment that it remained noncompliant with this section. This was consistent with the Monitoring Team's findings.
	Summary of Monitor's Assessment: Although the building blocks for measurement related to compliance with Section H were being created, there was limited evidence of measurement of minimum common elements of clinical care. Additionally, to date, the information the Facility submitted focused on the Medical Department, but other departments were not reflected in the data. The Facility should ensure that all clinical departments measure the services they provide to ensure each individual needing care has benefitted from the expertise of that department. The Medical Department had high rates of overdue annual medical assessments, and had only begun to attempt to complete quarterly medical reviews. The Pharmacy Department did not appear to closely track the QDRRs for timeliness. The Medical Department utilized many of the responses to the external and internal medical audits to provide measurement of some key areas of Section H. However, these audit tools did not address the full spectrum of evidence needed to fulfill Section H. The clinical indicators to measure quality of care and improvement in health had not been determined at ABSSLC. The State Office clinical guidelines did not appear to have been reviewed or implemented. These guidelines also could be used to identify measures of the quality of the risk action plans and outcomes for individuals. However, despite their great potential for assisting the Facility to identify measurable objectives and clinical indicators, they had not been incorporated into the process. The Facility needed to develop an organizational structure of committees as well as a policy structure. These were necessary to ensure integration between the various departments, that the various committees were not overlapping in responsibility and covered all aspects of health care, and that policies guided each step of this process. The Facility also needed to develop an evidence base that reflected that all essential elements of clinical care were implemented in a timely manner. To date the Facility had not provided evidence for this section beyond the Medical Department.

#	Provision	Assessment of Status	Compliance
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.	The PCPs had the responsibility to complete the annual medical assessment at 365-day intervals, and the quarterly medical review at 90-day intervals. A small sample indicated that 16% of the annual evaluations and 11% of the annual physical exams had been completed in a timely manner. From a random sample of medical records, no quarterly medical reviews had been completed (as discussed in further detail with regard to Section L.1). This indicated the continuing need to review the priorities and structure of the Medical Department to ensure essential aspects of care are completed in a timely manner. In the Self-Assessment, the Medical Department indicated it had begun quarterly medical assessments, completing 63 in the October through December quarter. With the shortage of PCPs on staff, this will be a continuing challenge. Health care status change reflected in acute care was reviewed clinically. There appeared to be timely and appropriate treatment by the PCPs. However, the PCPs required timely notification and accurate information to respond to health care status changes. Issues related to the nursing aspects of this part of integrated clinical care are discussed in detail with regard to Section M. Minimum common elements of clinical care require active participation of all clinical departments. Each clinical department should develop an evidence-based process to reflect timely completion of assessments and evaluations that can be utilized by the IDT. Each of the evaluations should be followed by documentation of interdisciplinary discussion, with synthesis of the information. This should result in the clinical issues important to the individual being summarized in an integrated approach, rather than by department. It is recommended that QA staff review ISPs to determine if the summaries are only by department, or if they are focused on the risks of the individual with integration reflected in the summary. Similarly, when there is a change of status, assessments from each relevant department should be updated, and the IDT should review the information and synthesize the information based on the clinical challenge. The QA Department should develop mechanisms to evaluate whether common elements of clinical care are being provided in a timely manner. For example, delays in decisions based on lack of information from one or more department could be measured to identify and strengthen areas needing assistance and guidance.	Noncompliance
H2	Commencing within six months of the Effective Date hereof and with full implementation within one year, diagnoses shall clinically fit the	The Facility documented no in-services were provided to the PCPs concerning ICD or Diagnostic and Statistical Manual (DSM) diagnostic criteria in the prior six months. The purpose of the training would be to periodically review common diagnoses, and review the diagnostic choices for these broad common diagnoses, to ensure that diagnoses were	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	as specific as possible. This would allow the staff completing the medical coding to provide a more exact code, which will build a more accurate database for future use. As the PCPs learn to choose the most appropriate diagnosis from the ICD-9 categories, diagnoses ending with "NOS" (not otherwise specified) or "NEC" (not elsewhere classified) should potentially occur only rarely. The external monitoring tool assisted in providing measurement of some aspects of this area. To assess whether the diagnoses had appropriate assessments or evaluations, the Facility utilized Question #17: "Are the diagnostic tests and/or therapeutic procedures medically appropriate," and Question #25: "Has the provider ordered appropriate consultations for identified need and diagnosis?" Additional questions that were used in measuring this section included Question #16: "Do the medication orders for acute conditions include indication and duration for all medications prescribed, Question #23: "Is the provider's clinical assessments documentation organized in appropriate SOAP format," and Question #24: "Do individual progress notes regarding acute medical problems contain pertinent positive and negative findings?" Some of these questions approached this subject directly and others were more tangential. It is recommended that the Medical Department create clear evidence that the diagnoses listed on the active problem list and DG1 have evidence confirming the diagnosis. This could be done in a number of ways, such as including this information at the time of the annual assessment, or conducting a review of a sample of records to ensure the diagnoses have supportive evidence in the record. These should be brief entries, such as evidence of elevated blood pressure readings, or normal pressure on maintenance medication to affirm the diagnosis of hypertension, appropriate abnormal values on thyroid testing to confirm hypothyroidism, elevated lipid tests prior to pharmacological treatment, scoliosis confirmed by physical exam, etc., to confirm the diagnosis is consistent with criteria/definitions recognized by national specialty organizations/working groups/task forces, etc., and is consistent with ICD criteria and nomenclature. Without solid evidence, the Facility will remain out of compliance with this section. Additionally, the State Office recently distributed several clinical guidelines/pathways that began to address diagnoses frequently identified at the SSLCs. As a component of each guideline were criteria used in making a diagnosis, and the tests that could be ordered to support that diagnosis. However, these guidelines remained in the draft stage, and had not been implemented at ABSSLC as a Facility policy/guideline. It is recommended that these clinical guidelines be reviewed at medical staff meetings, and incorporated into the clinical practice at ABSSLC.	
H3	Commencing within six months of the Effective Date hereof and with full implementation within two	Although Question 30 of the external audit: "If a medical treatment was ordered during an acute illness or injury was it documented in the progress note?" was listed as a measure of Section H.2, the treatment focus would be applicable to this section. The	Noncompliance

#	Provision	Assessment of Status	Compliance
	years, treatments and interventions shall be timely and clinically appropriate based upon assessments and diagnoses.	progress note that should be in SOAP format would explain the findings that justify the assessment diagnosis and lead to the appropriate treatment. However, no evidence was provided by the Facility of compliance in this section. The State Office recently distributed several clinical guidelines/pathways that began to address diagnoses frequently identified at the SSLCs. These included options for treatments and interventions along with a timeframe of implementation. These protocols would provide the framework to measure timeliness of treatment and clinical appropriateness of treatment based on an adequate work-up and diagnosis, as well as current findings. In addition, these provided excellent guidance for the Medical Department's internal audits. The Medical Department should review these protocols, and use them in the clinical care of the individuals. Additionally, the State Office recently created a set of questions for the external and internal medical provider audits for clinical concerns, such as aspiration, constipation, diabetes, osteoporosis, seizures, and urinary tract infections (UTIs). The results of these survey questions will provide a set of information that can be analyzed to determine whether treatments are appropriate and timely. However, these will not be implemented until February 2012.	
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.	The State Office clinical guidelines, if sufficiently detailed, could provide a number of clinical indicators for clinical success. These would need to be discussed among the PCPs to determine how these clinical indicators could be used in the PCPs' clinical practice to measure successful treatment. However, the State Office clinical guidelines did not cover all diagnoses, and the Medical Department might need to develop clinical indicators for use by the QA Department or an internal audit to determine efficacy of treatment. Some measurements for certain diagnoses might be physical findings (e.g., reduction of edema and clear lung sounds in those with congestive heart failure), or improvement in lab data [e.g., a Thyroid Stimulating Hormone (TSH) in normal range for hypothyroidism]. Likewise, the risk action plans (discussed with regard to Section I) should identify risks and measurable objectives in achieving a clinical outcome. These measurable objectives can be tracked, and the clinical outcome or clinical indicator of health also could be followed to determine whether treatment is adequate, needs to be changed, or needs to be augmented in some way. At the time of the Monitoring Team's review, systems to measure such clinical indicators were not yet in place. As a result, the Facility remained out of compliance with this provision.	Noncompliance

#	Provision	Assessment of Status	Compliance
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.	Monitoring of health status should include a focus on preventive steps to ensure health status is maintained. When individuals' health status changes, early intervention is necessary to minimize long-term sequelae of acute illness, and prevent permanent physical and functional loss when possible. The morning medical meeting did include review of acute changes in health. This occurred with the review of phone calls and on-site evaluations by the on-call PCP. There was a review of the history and findings, with appropriate background information, and initial treatment steps. The morning medical meeting could be used more effectively to monitor health status change by providing a forum for critical questioning, which should lead to discussions of prevention or potential interventions/diagnostic tests/ consultation requests, etc. Based on the resulting recommendations, closure might require further information or a test being ordered, or treatment ordered or changed, as well as evidence that health is restored (e.g., fever resolved, laceration healed/sutures removed, weight is stabilized, oxygen supplementation is no longer needed, etc.). Tracking and documentation of such closure activities would provide the Facility with a tool to track changes in health status and the resulting changes in treatment. As part of the monitoring process, serial assessments by all clinical departments are also imperative. In this area, the quarterly medical review, quarterly nursing assessment, PNMT progress notes, etc. should be completed in a timely manner. However, it is not clear how this information was distilled and utilized. Whether this needs to be reviewed by the PCPs or RN case managers, the psychiatry clinic, or the IDT, etc. remained unclear. It is recommended that the Facility develop a flow chart/protocol/policy outlining the monitoring of health status (both the early clinical intervention, and system data to determine if health status is being maintained), utilizing the various clinical departments and clinical meetings currently in place to develop an efficient and effective monitoring system for health status. There appeared to be little data concerning maintenance of health status [i.e., has the adaptive daily living (ADL) capacity of the individuals been maintained, or the percentage declined], or the departments that had been involved in re-assessment and implementation of new strategies. Monitoring of health status will require evidence to ensure compliance with this section. Over time, early intervention in health status change might be reflected in less ER visits, less hospitalizations, less chemical restraints, etc. Challenges remained in the Nursing Department and in the residential services in identifying health status change at an early stage, and providing appropriate monitoring once a concern was identified. As a result of these various deficiencies, the Facility remained out of compliance with this provision.	Noncompliance
H6	Commencing within six months of	The Facility submitted no information to the Monitoring Team with regard to this	Noncompliance

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	the Effective Date hereof and with full implementation within two years, treatments and interventions shall be modified in response to clinical indicators.	provision. The State Office clinical guidelines would provide guidance, along with nationally recognized recommendations from specialty organizations/task forces. The new internal audit guidelines included a clinical component of several diagnoses frequently treated in the SSLC populations. These new clinical components along with the clinical guidelines already distributed provided important guidance in this area. However, no information was submitted to indicate ABSSLC had approved and implemented any of these new guidelines, or reviewed the new internal audit clinical areas in a formal medical staff meeting.	
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.	The Facility had not developed the organizational ladder of policies, procedures, guidelines, and committees to provide the framework to ensure each of the subsections of Section H are in place and are successful. Accurate and complete assessments performed in a timely manner for both acute and chronic illness, determination of appropriate diagnoses based on nationally recognized criteria, verification of timely and clinically appropriate treatments and interventions, appropriate clinical indicators to measure success of treatment, a system to monitor health status of each individual and to monitor early changes in health status, and modification of treatments and interventions in a timely manner based on changes in health status will require clinical acumen and integration of clinical disciplines. However, to ensure there is no overlap and to improve efficiency and effectiveness, the Facility should provide the framework and clarify the roles of the various clinical departments in ensuring all aspects/elements of quality clinical care. As an example of lack of oversight, as mentioned with regard to Section L.1, skin integrity was an area of concern for which there appeared to be little ongoing monitoring. This was an area that required clear delineation of responsibilities of the various disciplines to ensure adequate, appropriate, timely, and integrated care. Additionally, it is recommended that the QA Department develop and implement a monitoring tool to measure the effectiveness of the various committees, to ensure they are efficient, that they monitor the domains assigned to them, meet at a frequency commensurate with their responsibilities, and provide quality oversight and guidance to the clinical areas they monitor/oversee.	Noncompliance

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

1. Each clinical department should develop mechanisms to measure timely completion of assessments and evaluations that are utilized by the IDT. (Section H.1)
2. The QA Department should develop mechanisms to evaluate whether common elements of clinical care are being provided in a timely manner. For example:

a. The QA Department should review the ISPs to determine if the summaries are by department only, or are focused on the risks of the individual with an integrated clinical summary.
b. A similar system is recommended for review of ISPA developed for individuals with a change in health status.
c. Delays in decisions based on lack of information from one or more department could be measured to identify and strengthen areas needing assistance and guidance. (Section H.1)

3. For the diagnoses listed on the active problem list and DG1, the Medical Department should provide clear evidence confirming the diagnosis, as well as evidence that the criteria used for the diagnosis are consistent with criteria/definitions recognized by national specialty organizations/working groups/task forces, etc., and is consistent with ICD criteria and nomenclature. (Section H.2)
4. The clinical guidelines should be reviewed at medical staff meetings, and incorporated into the clinical practice at ABSSLC. (Section H.2)
5. As the State Office clinical guidelines do not cover all diagnoses, the Medical Department might need to develop clinical indicators that can be used by QA staff or an internal audit to determine efficacy of treatment for other clinical diagnoses or concerns. These clinical indicators would provide guidance to QA in measuring timely treatment and success in treatment, and would require discussion and agreement by the medical staff. (Section H.4)
6. The Facility should develop and implement a process to measure the timely completion of assessments and steps implemented by each department in response to health status change. The Facility should consider developing a flow chart/policy/protocol to outline the role and expectations of each clinical department, along with assigned timeframes, to monitor change in health status and measure whether common elements of clinical care are occurring efficiently, effectively, and timely. (Section H.5)
7. The Facility also should consider using functional decline as a measure of maintaining health status in an individual, and more systemically, if the functional independence of individuals in a residence or across the campus is being maintained. For those with decline, the Facility might then measure the effectiveness of the departments involved in re-assessment and implementation of new strategies. (Section H.5)
8. As a number of new State Office guidelines and internal clinical audits are being developed, and as the internal and external peer review is generating data, the Medical Department should have formal medical staff meetings with recorded minutes. These should be used to ensure Department staff remain updated on this information, learn of areas of measurement being undertaken which might have an impact on them, and provide a forum for their participation in implementation of these guidelines and corrective action plans. (Section H.6)
9. The Facility should develop an organization ladder of policies, procedures, guidelines, and committees with oversight responsibilities clearly defined to ensure all elements of clinical care are ongoing. (Section H.7)
10. The QA Department should develop and implement a monitoring tool to measure the effectiveness of the various committees, to ensure they are efficient, that they monitor the domains assigned to them, meet at a frequency commensurate with their responsibilities, and provide quality oversight and guidance to the clinical areas they monitor/oversee. (Section H.7)

SECTION I: At-Risk Individuals	
Each Facility shall provide services with respect to at-risk individuals consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o DADS SSLC "Risk Guidelines" laminated record; o ABSSLC Presentation Book for Section I; o ABSSLC Self-Assessment, Action Plan and Provision Action Information for Section I; o ABSSLC At-Risk Individuals List, dated 2/13/12; o ABSSLC Presentation for 2/13/12 for Section I; o ABSSLC training rosters; o ABSSLC Section I: At-Risk Guidelines and tool; o ISP Meeting (Facilitation and Documentation) draft training outline, and curriculum; o Section I Workgroup minutes dated 10/6/11, 10/27/11, and 12/8/11; o Integrated Risk Rating Forms, Action Plans for Risk Assessments, ISPs and/or ISP Addendums, Comprehensive Nursing Assessments, and Health Management Plans for the following: Individual #119, Individual #25, Individual #199, Individual #126, Individual #163, Individual #87, Individual #95, Individual #393, Individual #184, Individual #147, Individual #235, Individual #511, Individual #447, Individual #538, Individual #139, Individual #35, Individual #397, Individual #57, Individual #31, and Individual #465; o The following documents: Occupational Therapy (OT)/Physical Therapy (PT) Assessments, Speech Language Pathology (SLP) Assessments, Integrated Risk Rating Forms, Action Plans for Risk Assessments, ISPs and/or ISP Addendums for the past year the following 15 individuals: Individual #458, Individual #253, Individual #283, Individual #468, Individual #297, Individual #91, Individual #42, Individual #311, Individual #395, Individual #471, Individual #385, Individual #492, Individual #403, Individual #350, and Individual #362; and o The following documents: PNMT assessment, PNMT Risk Action Plan, Integrated Risk Rating Form, ISPs and ISPAs for the past year for the following six individuals: Individual #407, Individual #6, Individual #212, Individuals #103, Individuals #452, and Individual #498. o Integrated risk rating form and attendance roster, risk action plan, most current ISP and subsequent addendums, most current annual medical assessment, most current quarterly nursing assessment, one year of physician orders, one year of IPNs, one year of consultant reports, lab, radiographic reports, any hospital discharge summary or ER report from the past year, copy of most recent BSP, DG1, preventive care flow sheet for following individuals: Individual #23, Individual #26, Individual #417, Individual #110, Individual #8, and Individual #323; o Settlement Agreement Cross referenced with ICF/MR standards, revised February 2011; o Settlement Agreement Compliance report: At-Risk Individuals, from 9/1/11 to 12/31/11; o ABSSLC Section I: At risk- Facility Practice, dated 12/2011: Aspiration pneumonia/enteral nutrition evaluation (APEN), with flow diagram for aspiration pneumonia, Annual ISP process, Change of Status process, and Review of Risk process;

	○ At-Risk Coordinator Presentation, dated 11/2011; and ○ Change of status flow chart, and change of status notification flow chart. ▪ **Interviews with**: ○ Amy Jo Bramlett, LVN, At-Risk Coordinator; ○ Richard Chengson, MD, Medical Director; ○ Bobbie Holden, OT, Director of Habilitation Therapies; ○ Debbie Sessions, SLP, PNMT Coordinator, SLP; ○ Connie Horton, Consultant, Family Nurse Practitioner; ○ Sally Schultz, State Consultant; ○ Karen Hardwick, State Office Coordinator for Specialized Services; ○ Rick Savage, State Consultant; ○ Jim Sibley, State Consultant; ○ Donna Jesse, DADS Director of Operations for SSLCs; ○ Linda Hinshaw, Facility Director; and ○ Jolene Willis, Assistant Director of Programs. ▪ **Observations of**: ○ ISP Meeting for Individual #101, on 2/13/12; ○ ISP Meeting for Individual #76, on 2/15/12; ○ ISP Meeting for Individual #468, on 2/15/11; and ○ ISP Meeting for Individual #148, on 2/16/11.
	Facility Self-Assessment: Since the Monitoring Team's previous review, the Facility had made changes to the way it presented its self-assessment information. Using a new format from State Office, the Facility had identified activities engaged in to conduct the self-assessment, the results of the self-assessment, and a self-rating. Although a number of concerns continued to exist with the Facility's self-assessment process, over time, this format should be helpful in substantiating the Facility's findings with regard to compliance, and most importantly, assist the Facility in identifying and proactively addressing areas in need of improvement. The following is an example for Section I.1 for the steps the Facility had been taken to assess the At-Risk process, and its self rating: "Activities engaged in to conduct the self-assessment: *1. Since 09/2011, the At Risk Coordinator reviewed 33 of 143 ISPs in regards to At Risk. Program Compliance Monitor reviewed 2.5% of the 33 ISPs to ensure inter-rater reliability. Monitoring was completed with use of State Office monitoring tool for Section I: At Risk. Monitoring indicator labeled I.2.1.a is considered a Provision I.1 indicator.* *2. Beginning 12/01/2011, At Risk Coordinator tracks via facility At Risk database that regular risk screening, assessment and management occurred in conjunction with annual ISP* *The results of the self-assessment:* *1. Results from monitoring of Provision I.1 shows approximately 55% compliance. Analysis was calculated from the compliance percentage of indicator I.2.1.a* *2. At this time there is not sufficient data to analyze the tracking of regular risk screening, assessment*

	and management that occurred in conjunction with annual ISP. *<u>Self-rating</u>:* *Based on monitoring self-assessment, this provision is not in compliance due to lack of minimum compliance of regular risk screening, assessment and management that occurred in conjunction with annual ISP."* Although the Monitoring Team's findings supported the Facility's finding that it was not in substantial compliance with the Settlement Agreement requirements for Section I, it was not clear from the Facility's Self Assessment what specific criteria was used to determine compliance, and how the samples for review were selected. In addition, no explanation was provided regarding what specifically the 55% compliance score represented or reflected regarding areas of strengths and weaknesses. Although the data that were provided in the Section I Presentation Book included compliance scores for each item on the Facility's monitoring tool, the scores were noted to be an average for four months (September through December 2011), and not reflective of increases or decreases in compliance by item by month. Consequently, the Facility's data could not be accurately interpreted.
	Summary of Monitor's Assessment: The Facility continued to make progress in this area, and continued to focus on training staff to help staff understand the risk process. Additionally, the Facility identified change of health status as an important area requiring additional structure and training. The quality of the data submitted on the Integrated Risk Rating Form, and the quality of the decision-making process was highly variable from team to team, and continued training and mentoring was needed to ensure a quality process was developed. There was little data to support the requirement that assessments began within five working days of a risk determination. The risk action plans generally had little focus on prevention, or minimizing risk through additional assessments (e.g., labs, radiographic testing, consultations). No data was submitted to verify that implementation of action plans occurred in a timely manner. Functional and measurable objectives were not part of the Risk Action Plans, nor were clinical indicators identified to monitor progress. The Facility had no data to begin to track risk reduction.

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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.	Based on an interview with the Facility's At-Risk Coordinator, and review of the Facility's Provision Action Information, the following were steps forward that the Facility had made in addressing the At-Risk process: ▪ In September 2011, the At-Risk Coordinator developed a tracking tool to ensure that the at-risk meetings were conducted in a timely manner regarding changes in status; ▪ In October 2011, the Facility implemented a workgroup for Section I to assist in addressing the At-Risk system, and in December 2011, finalized the Facility's At-Risk Practices procedure. A review of the minutes of the workgroup found that promising discussions occurred regarding clarifying and simplifying the Facility's At-Risk process;	Noncompliance

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		▪ In November 2011, the nurses received training on implementation and usage of the new Change of Status Notification form and process. However, no training rosters or description of the training was provided; ▪ In December 2011, the Facility implemented a tracking system for changes in status. At the time of the review, the process addressing changes of status had not been fully implemented, and thus, it could not be evaluated during this review; ▪ In January 2012, the Facility began to develop a draft monitoring tool addressing risk plans; and ▪ A State Consultant provided ISP training. The curriculum for this training was very comprehensive. However, there was no indication from the training rosters as to how many staff were required to attend (N), and how many actually attended the training (n) to accurately determine a compliance percentage for training. During observations of ISPs while on site, the Monitoring Team noted some improvement regarding the ISP process. ▪ The Facility also created a document dated 12/20/11 for "Definitive Diagnosis of Aspiration Pneumonia," which was a flow diagram of necessary steps to be completed, with responsible staff and task assigned. Of note, in the 12/8/11 minutes of the Section I Workgroup, there was the notation that "discussion arose that clinical indicators are addressed in other documents such as care plans, BSP, PNMP, etc., and question tabled if Risk Action Plan can refer to other documents." Based on the Monitoring Team's previous reports and recommendations, as well as the review of six medical records discussed later in this section, it is recommended that the Risk Action Plan be spelled out in one document. To expect staff to search the active records to determine the references and then read through the reference document to find the action step needed would provide barriers to progress in meeting compliance. Additionally, from a monitoring perspective, one of the six records reviewed simply indicated to check other documents (mostly in a nursing section), but these were then not copied, and a review of quality could not be completed. As the risk action plan needs to be a useful tool for improved quality care, it should stand on its own. Reference to other materials might be helpful in footnotes, but such references should not replace the body of the text. Although the Facility had implemented a number of thoughtful and positive steps in its efforts to move forward regarding this requirement, the Monitoring Team found that a significant amount of work was yet to be done to achieve compliance regarding the requirements of the Settlement Agreement addressing the At-Risk Individuals. In addition, from discussions with the State's Consultants, the State was considering a number of changes regarding the current At-Risk process. These would alter some of	

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		ABSSLC's procedures regarding the At-Risk process. To assess the Facility's risk screening process, members of the Monitoring Team observed four individuals' ISPs meetings (i.e., for Individual #101, Individual #76, Individual #468, and Individual #148) while on site. Specifically, the observations of the ISPs indicated that: ▪ All appropriate disciplines were present at three (75%) of the observed ISPs. The individual's ISP that did not have all appropriate disciplines present was for Individual #111. No physician or physical therapist were present. ▪ The staff present at the ISPs meetings were the actual staff that worked with the individual, and not substitute staff sitting in for other staff members for all (100%) of the ISPs. ▪ The individual was present at three (75%) of the ISPs meetings observed. Staff reported that Individual #101 was not able to attend the ISP due to the cold weather, and problematic issues with hypothermia. However, it was not clear why the team could not hold the meeting at the individual's residence. Due to the length of time of the ISPs for Individual #76, and Individual #148, the Monitoring Team did not observe the discussion of the risk indicators. Thus, the findings for the following indicators addressing risk are based on the ISPs for Individual #101 and Individual #468: ▪ The IDT consistently used the Risk Level Guidelines when determining risk levels at one (50%) of the ISP meetings. The IDT for Individual #101 did not consistently use the Risk Level Guidelines to determine risk levels. ▪ The IDT consistently used supporting clinical data when determining risks levels for one of the ISPs observed (50%). The individual's IDT that did not consistently use supporting clinical data when determining risk levels was for Individual #101. However, although not consistent, the Monitoring Team did note that there was improvement for this indicator. Compliance scores for this indicator reflect the consistency of the use of supporting clinical data when designating risk levels. ▪ Overall, the risk levels the IDTs designated were appropriate for each category for one of the ISPs observed (50%) based on information and data provided by the IDTs. The individual's IDT that did not consistently designate appropriate risk levels for each risk category was for Individual #101. ▪ There was adequate and appropriate clinical discussion among appropriate team members in decisions regarding risk levels in none (0%) of the ISP meetings observed. ▪ Team disagreements regarding risk levels were noted in neither of the ISPs for Individual #101, or Individual #468. Thus, the Monitoring Team did not observe the process of resolving issues. In evaluating this indicator, when team	

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		disagreements are observed, the Monitoring Team evaluates 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. ▪ Based on all four ISPs observed by the Monitoring Team, the PSP facilitator kept the team focused in all (100%) of the ISPs meetings observed. Areas for continued focus included time management, since some of the ISPs observed were exceptionally lengthy and increasing team discussions of risk indicators. In addition, other positive observations from the Monitoring Team included: ▪ The input of the psychiatrist at the ISP for Individual #76 was very valuable in informing the team of specific issues regarding the individual that would have been missed had the psychiatrist not been present; ▪ The guardian for Individual #468 was able to take part in the ISP via conference call, and was kept engaged and well informed by the QDDP; ▪ The IDT facilitator for Individual #148 did an excellent job in promoting team participation, as well as in preparing materials with the use of graphics; ▪ There was an increase in the use of specific clinical data to support risk ratings; and ▪ The IDT facilitator for Individual #101 kept the meeting focused and encouraged the team members to participate. Problematic areas needing focus or improvement included: ▪ The IDT for Individual #101 was noted to have little discussion regarding the health risk indicators. In addition, it was unclear why the QDDP presented all of the information regarding the risk indicators during the ISP rather than the appropriate clinical disciplines. Also, the team had a number of clinical questions regarding some of the individual's medical issues that the nurse was unable to accurately answer. The absence of the Primary Care Practitioner (PCP) at the ISP left these questions unresolved; ▪ The IDT for Individual #468 discussed that although a fundoplication had been done in the past, the individual might have been experiencing reflux with formula found in the mouth after receiving enteral nutrition. However, until the therapist recommended that a specific test be conducted to determine the cause of the problem, it was unclear why the individual's PCP had not suggested any type of evaluation of the problem. In addition, it was not clear if all the assessments had been completed prior to the ISP; ▪ The IDT for Individual #101 had limited and incomplete discussions of action plans related to the high and medium risk ratings. In several cases, the objectives were not functional and/or measurable, and adequate preventative measures were not discussed; and	

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		▪ Overall, any action plans that were developed in the ISPs were weak, objectives were not discussed by the IDTs in order to establish a measure of success or failure of the action plans developed, and the interventions did not reflect the clinical intensity commensurate with the level of risk designated by the teams. To further assess the Facility's screening of those with high-risk health concerns, six active records of individuals with high-risk ratings in one or more health domains were reviewed. Information included a copy of the integrated risk rating form and attendance roster, risk action plan, most current ISP and subsequent addendums, most current annual medical assessment, most current quarterly nursing assessment, one year of physician orders, one year of IPNs, one year of consultant reports, lab, radiographic reports, any hospital discharge summary or ER report, copy of most recent BSP, DG1, and preventive care flow sheet. Individuals are listed in the documents reviewed section above. The following summarizes the results of this review: ▪ For two out of six (33%) active records, the appropriate disciplines were present at the ISP meeting. ▪ For five out of six (83%) active records, the individual was present at the ISP meeting. ▪ For four out of six (67%) active records, the IDT used the Risk Level Guidelines when determining risk levels. ▪ For four out of six (67%) active records, the IDT used supporting clinical data when determining risk levels. ▪ For three out of six (50%) active records, the designated risk levels were appropriate for each category (i.e., the team provided adequate justification). Examples in which justification was not adequate or the risk level was not appropriate included the following: o Individual #23 was rated low risk for respiratory compromise, yet was hospitalized in September 2010 for pneumonia, and in October 2011 had aspiration pneumonia. He was also considered medium risk for aspiration, but there was no updated information that would have reflected a modified barium swallow study (MBS) in October 2011, and a change in diet to include thickened liquids. He was 20% over his recommended weight range, but was rated medium risk. He was rated as low risk for cardiac disease, yet had a pacemaker, and was considered hypertensive. He was rated as low risk for osteoporosis, but the risk rating was not updated when he was subsequently found to have a T score of -4.3 when a DEXA scan was completed. He was considered low risk for infections, yet was a Hepatitis B carrier. o Individual #417 had a diagnosis of peptic ulcer from an esophagogastroduodenoscopy (EGD) completed in February 2011, yet	

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		the team considered her medium risk for gastrointestinal concerns. There appeared to be no updating by the team, as she developed pneumonia in April 2011 requiring admission to the Infirmary. This would have made her high risk, but the team did not appear to review the risk rating based on her Infirmary admission. The team considered her low risk for skin integrity concerns, but her hemoglobin A1C was consistently over six at the time. She subsequently developed a heel blister, but the team did not meet to review her risk for skin integrity, and her risk remained rated as low. As a positive example, justification of risk categorization appeared to be adequate and appropriate for Individual #8. There were several high-risk areas, including cardiac disease, diabetes mellitus, osteoporosis, polypharmacy and falls, and each had appropriate rationale documented, and risk levels consistent with State Office guidelines. The Facility indicated that it was not in compliance with the requirements of this provision of the Settlement Agreement. This comports with the findings of the Monitoring Team. From the Monitoring Team's observations, some progress had been made regarding revising the structure and format of the ISPs, although these changes were not seen in the documents yet, and the increase in use of supporting clinical data when assessing risk levels. However, significantly more efforts should be made to ensure that a system addressing the reassessment of risk factors for individuals experiencing significant changes in status is implemented. In addition, ABSSLC should also continue to provide training and mentoring for the ISPs regarding the At-Risk process.	
I2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall perform an interdisciplinary assessment of services and supports after an individual is identified as at risk and in response to changes in an at-risk individual's condition, as measured by established at- risk criteria. In each instance, the IDT will start the assessment process as soon as possible but within five working days of the individual being identified as at risk.	Based on a review of records for 20 individuals determined to be at risk (i.e., Individual #119, Individual #25, Individual #199, Individual #126, Individual #163, Individual #87, Individual #95, Individual #393, Individual #184, Individual #147, Individual #235, Individual #511, Individual #447, Individual #538, Individual #139, Individual #35, Individual #397, Individual #57, Individual #31, and Individual #465), there was documentation that the IDT started the assessment process as soon as possible, but within five working days of the individuals being identified as at risk for six of these (30%) individuals. For the remaining individuals, there was no indication that assessments addressing risks issues were initiated (Individual #119, Individual #25, Individual #126, Individual #163, Individual #87, Individual #95, Individual #184, Individual #511, Individual #538, Individual #139, Individual #397, Individual #57, Individual #31, and Individual #465). Due to the following problematic issues it was not possible to determine what assessments had been done before or after the risk screening process for many of the individuals in the sample: ▪ Integrated Risk Rating forms did not consistently include specific clinical data supporting the risk ratings for the health indicators;	Noncompliance

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		▪ There were inconsistencies found between the risk levels found on the individuals' Risk Rating forms and the ABSSLC's At-Risk Individuals list; ▪ Integrated Risk Rating forms were noted to have been completed up to nine months prior to Risk Action Plans or ISPs without being reviewed, and updated; and ▪ Integrated Risk Rating forms were not completed or left totally blank. <u>Nursing Assessments</u> Based on a review of 20 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 #119, Individual #25, Individual #199, Individual #126, Individual #163, Individual #87, Individual #95, Individual #393, Individual #184, Individual #147, Individual #235, Individual #511, Individual #447, Individual #538, Individual #139, Individual #35, Individual #397, Individual #57, Individual #31, and Individual #465. As noted during previous reviews, the Facility continued to use the last quarterly or annual Comprehensive Nursing Assessment to meet the nursing assessment requirement noted in the current At-Risk Individuals policy, even if it had been completed months prior to or after the meeting determining risk levels. Also as noted from past reviews, these Comprehensive Nursing Assessments were not adequate regarding addressing the health risks of the individuals reviewed. As noted from the Monitoring Team's previous four reviews, a review of the quarterly or annual Comprehensive Nursing Assessments for the above 20 Individuals found that none of them (0%) contained an adequate assessments of the specific high-risk health indicators or provided any type of analysis of the high-risk health indicators in the Summary Section. No specific procedure was in place defining the process regarding nursing assessments for risk indicators. From discussions with State Office Consultants while on site, the State was in the process of reviewing, and refining the At-Risk process in efforts to clarify the process, and expectations for documentation. However, at the time of the review, no changes had yet been made to the existing at-risk process. Regarding nursing, as noted from previous reviews, the Facility, in conjunction with the State, should specifically define the nursing assessment and documentation process regarding at-risk individuals. <u>Physical and Nutritional Management and/or OT/PT/SLP Assessments</u> Based on a review of six individuals' records (i.e., Individual #407, Individual #6, Individual #212, Individuals #103, Individuals #452, and Individual #498), for which a PNMT assessment had been completed to address the individuals' at-risk conditions,	

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		none of the six individuals (0%) had an adequate PNMT assessment to assist the team in developing an appropriate risk action plan. The PNMT assessments did not incorporate the results of a completed Integrated Risk Rating form as part of the PNMT assessment process to adequately assess all relevant risk factors. Additional concerns related to PNMT assessments are discussed in detail with regard to Section O. Based on a review of 15 individuals' records for which OT/PT assessments were to be completed to address the individuals' risk conditions, none of the 15 individuals (i.e., Individual #458, Individual #253, Individual #283, Individual #468, Individual #297, Individual #91, Individual #42, Individual #311, Individual #395, Individual #471, Individual #385, Individual #492, Individual #403, Individual #350, and Individual #362) had an adequate OT/PT assessment to assist IDT members in assessing individual's risk levels. Problematic issues that resulted in noncompliance included: ▪ OT/PT assessments were not timely. For example, OT/PT assessment dates for individuals occurred in 2002 (Individual #471), and 2004 (Individual #385, Individual #492, and Individual #283). ▪ OT/PT assessments did not adequately assess medium and high-risk areas that required services and support from Habilitation Therapies. ▪ ISP and/or Integrated Risk Rating attendance sheets did not confirm attendance by an OT or PT to offer their clinical expertise during the interdisciplinary risk assessment and planning process. Based on a review of 15 individuals' records for which SLP assessments were to be completed to address the individuals' at risk conditions, none of the 15 records (0%) included an adequate SLP assessment to assist the IDT members in assessing an individual's risk ratings. Problematic issues that resulted in noncompliance included: ▪ SLP assessments were not timely. For example, assessments occurred in the following years: 2002 (Individual #283), 2003 (Individual #311), 2004 (Individual #362), 2006 (Individual #350, Individual #42, and Individual #385), 2007 (Individual #492), and 2008 (Individual #91). ▪ SLP assessments did not adequately assess medium and high-risk areas that required services and support from Habilitation Therapies. ▪ ISP and/or Integrated Risk Rating attendance sheets did not confirm attendance by SLPs to offer their clinical expertise during the interdisciplinary risk assessment process. As discussed in further detail with regard to Section R, the SLP assessment format had been revised. The revised assessment template instructions directed therapists to address medium and high-risk areas that required services and supports, the rationale and efficacy for services and supports, and identification of individual's triggers that would alert staff to a change in status. The incorporation of the assessment of risk levels	

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		and related services in the SLP assessment process was a promising addition, and should provide relevant information to assist individuals' IDTs in the development of a risk action plan. However, SLP assessments reviewed did not consistently address these risk level revisions. The State-established OT/PT assessment format had not been adopted by the HT Department. Based on interview, the therapists were reviewing the format and had not reached a decision on a final OT/PT assessment format. Consequently, the OT/PT assessments reviewed did not follow the State-established risk level guidelines. Audits should be conducted to assess the quality of OT/PT, SLP and PNMT assessments and risk action plans. The absence of OTs, PTs, and SLPs at annual ISP meetings and at ISPA meetings for individuals who experienced a change in health status did not support an interdisciplinary assessment of an individual's risk levels. To move forward in achieving compliance within this section, therapists should attend annual ISPs and ISPA meetings. But, most importantly, individuals who have experienced a change in health status should have representation by these clinicians to ensure adequate PNMPs and related services and supports are integrated into their risk action plans. <u>Medical Assessments</u> Based on a review of six individuals for whom assessments had been completed to address the individuals' at risk conditions (i.e., Individual #23, Individual #26, Individual #417, Individual #110, Individual #8, and Individual #323), two (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 #23, Individual #26, Individual #417, and Individual #323. The following provides examples of assessments that were not comprehensive: ▪ Individual #23 was hospitalized twice in the past year. Based on the submitted information, several areas would have benefited from additional review, diagnostic work-up, and/or further consultation. He was hospitalized twice for ileus/small bowel obstruction, which resolved spontaneously. During one of these admissions, he was noted to have aspirated, and developed pneumonia, due in part possibly from vomiting. It was not clear if the aspiration pneumonia preceded the ileus, or whether the ileus initiated the downhill clinical course, with subsequent aspiration from vomiting. For one of these two admissions, and from prior hospital admissions, he was noted to be constipated. An x-ray during one admission noted a distended stomach without distention of the small bowel, suggesting the possibility of gastroparesis or gastric outlet obstruction. The continued severe Gastroesophageal Reflux Disease (GERD) remained problematic, and there was no further discussion of further medical/surgical	

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		interventions. Intensified monitoring to ensure appropriate positioning was not discussed. It did not appear as though the PNMT had been consulted. Although he was noted to have hypertension and was on medication for this, his blood pressure at the time of the annual was normal to low normal. It was also not listed in the active problem list, which may have confused the IDT, although this was not questioned. Hypotension in this individual could potentially have negative consequences. If there was occasional low or underperfusion of the mesenteric circulation, this could have intermittent adverse effects on motility, and produce discomfort from potential ischemia. Some hypertensive medications may also aggravate constipation. Although he had significant constipation, and was on several medications to improve bowel motility and reduce constipation, this remained a challenge. There did not appear to be consideration of maximization of medications for his bowel management program. If constipation remained despite maximized medication regimen, other diagnostic studies such as colon motility studies would provide further assessment, or other diagnostic procedures would be indicated. Further assessment by the clinical pharmacist would have been helpful. ▪ On 2/3/12, Individual #417 was noted to have a coughing spell with respiratory distress when lying down. She had known GERD and a hiatal hernia. She had a G- tube. There was no consideration of need of a HOBE evaluation by PNMT. PNMT did not appear to be consulted. Considering her history of peptic ulcer disease discovered by EGD in February 2011, there did not appear to be discussion of need for re-evaluation to confirm healing. Despite the addition of Miralax on 3/1/11, she was noted to have a fecal impaction on admission to the Infirmary on 4/20/11. Assessment of her drug regimen for any medication that aggravates constipation was not discussed, nor was consideration given to other potential reasons for constipation that might require further diagnostic evaluation. There was also the concern of adequate monitoring in the residence for constipation, as the impaction was discovered in the Infirmary. Nursing review of bowel movement logs for completeness and accuracy would have been indicated, with further training of direct support staff, if appropriate. As a positive example, Individual #8 had appropriate assessments in place to guide the team in completing a risk rating and action plan. Although this individual was an insulin-dependent diabetic with challenges in wide swings in blood sugar, with several episodes of hypoglycemia, the individual appeared to be closely followed and monitored appropriately. The individual saw an endocrinologist, and a neurologist. In 2011, the individual underwent a kidney biopsy. One of this individual's more challenging issues was frequent falling. However, the team met promptly, and the ISPAs reviewed the prior falls, and addressed the current fall in context of prior falls, the current environment, behaviors and moods, etc. There were two falls in which ISPAs were completed, and	

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		both provided appropriate and thorough reviews of the fall focusing on steps to prevent another fall. The Facility indicated that it was not in compliance with the requirements of the Settlement Agreement for this provision. This comports with the findings of the Monitoring Team.	
I3	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall establish and implement a plan within fourteen days of the plan's finalization, for each individual, as appropriate, to meet needs identified by the interdisciplinary assessment, including preventive interventions to minimize the condition of risk, except that the Facility shall take more immediate action when the risk to the individual warrants. Such plans shall be integrated into the ISP and shall include the clinical indicators to be monitored and the frequency of monitoring.	Based on a review of 41 records for individuals determined to be at risk (i.e., Individual #119, Individual #25, Individual #199, Individual #126, Individual #163, Individual #87, Individual #95, Individual #393, Individual #184, Individual #147, Individual #235, Individual #511, Individual #447, Individual #538, Individual #139, Individual #35, Individual #397, Individual #57, Individual #31, and Individual #465, Individual #458, Individual #253, Individual #283, Individual #468, Individual #297, Individual #91, Individual #42, Individual #311, Individual #395, Individual #471, Individual #385, Individual #492, Individual #403, Individual #350, Individual #362 Individual #407, Individual #6, Individual #212, Individuals #103, Individuals #452, and Individual #498), there was documentation that the Facility: ▪ Established an appropriate plan within fourteen days of the plan's finalization, for each individual, as appropriate, in all 0 (0%) cases reviewed. ▪ Implemented a plan within fourteen days of the plan's finalization for each individual, as appropriate in none (0%) of the cases reviewed. Although the Action Plans included a date of implementation, there was no supporting documentation verifying that the action steps contained in the plan had, in fact, been implemented. In addition, a number of the action steps were nonspecific and thus, impossible to verify. ▪ Implemented a plan that met the needs identified by the IDT assessment in none of these cases (0%). ▪ Included preventative interventions in the plan to minimize the condition of risk in none of the cases (0%). ▪ When the risk to the individual warranted, took immediate action in none of the cases (0%). ▪ Integrated the plans into the ISPs in none of the cases (0%). ▪ None (0%) of the plans showed adequate integration between all of the appropriate disciplines, as dictated by the individual's needs. ▪ None of the plans (0%) had appropriate, functional, and measurable objectives incorporated into the ISP to allow the team to measure the efficacy of the plan. ▪ None of the plans (0%) included the specific clinical indicators to be monitored. ▪ The frequency of monitoring was included in the plans for none of the individuals (0%). Although the Action Plans contained a heading addressing "Monitoring Frequency," the frequency was noted generally as daily or weekly	Noncompliance

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		without the specific shift or day included to ensure accountability. In addition, other problematic issues that resulted in noncompliance with the above compliance indicators included: ▪ Risk Action Plans were not completed or included with the requested documentation by the Monitoring Team for nine individuals (i.e., Individual #25, Individual #126, Individual #163, Individual #87, Individual #95, Individual #184, Individual #39, Individual #31, and Individual #465; ▪ Risk Action Plans were generic, and non-specific in addressing the health risks of the individual; ▪ Preventative interventions were not included in the Risk Action Plans; ▪ ISPs were not completed or included with the requested documentation by the Monitoring Team for two individuals (i.e., Individual #163, and Individual #511); ▪ Interventions listed on the Risk Action Plans did not include specific clinical indicators to be monitored or the specific frequency of monitoring; ▪ Risk Action Plans were noted to have been completed months prior to the dates of the Integrated Risk Rating forms, and the plans had not been reviewed, and updated; and ▪ The interventions listed on the Risk Action Plans were not in alignment with the designated risk rating of high or medium risks. At the time of the review, the Facility indicated it was not in compliance with the requirements of this provision of the Settlement Agreement. This comported with the findings of the Monitoring Team. By the next review, ABSSLC should continue to focus its efforts on the process of developing specific and clinically appropriate risk action plans for each individual. The Risk Action Plans should meet the individuals' needs, contain functional, and measurable objectives, include clinical indicators to be monitored and the specific frequency of that monitoring, include preventative interventions, and be fully integrated into the ISPs.	

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

1. All significant components of the Risk Action Plan should be listed in the document, so that it could stand alone and not rely on staff finding other documents/references. (Section I.1)
2. Medical diagnoses, PT concerns, OT concerns, etc. should not be separately compartmentalized in the ISP. An individual's medical risk should be the focus, not separate departmental views. Integration of departmental expertise in defining the medical concern, developing plans for monitoring and improving the health condition, and defining appropriate measures to indicate success or progress should be a general outline used in each area of risk. (Section I.1, I.2, I.3)
3. In prioritizing involvement in the ISP/at-risk process, PCPs should be expected to attend the at-risk discussion to ensure teams arrive at

clinically appropriate conclusions. (Section I.1)

4. The PCP should provide background information concerning the diagnostic tests already completed, the dates of completion, with a brief entry concerning results. The IDTs cannot arrive at correct risk ratings without sufficient information, nor can further assessments be recommended if it is not known what assessments have already been completed. (Section I.1)
5. 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)
6. The State Office should consider expanding the "infection" category to provide additional options to provide guidance to the IDTs. 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)
7. The risk guidelines should be reviewed to determine if further subcategories are needed to address the diverse topic of challenging behavior. (Section I.1)
8. Additional training on the at-risk process should be provided to the IDTs. 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)
9. To standardize the team process, one nurse and one behavior analyst should be trained on implementation of the new risk rating process, risk action plan development, and plan implementation process. These staff could then act as mentors for the risk process implementation, and attend as many of the IDT meetings as possible to ensure basic aspects of the new policy and procedure are followed. (Sections I.1, I.2, and I.3)
10. 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. Additionally, for those members of the team unable to attend an IDT risk rating and/or action plan meeting, background information should be prepared and discussed with the QDDP ahead of the scheduled meeting and the QDDP or designee should ensure all areas needing clarification are discussed and clarified, as the QDDP or designee will be the team member presenting that information. (Section I.1)
11. Each IDT member should obtain all relevant information ahead of the meeting, especially information on which the team will base a risk rating. (Section I.1)
12. There should be evidence to confirm the team's rationale for each category of risk reviewed. (Section I.1)
13. When there is a change in health status, the IDT 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 IDT should meet promptly to address any changes in health and functional status. (Sections I.1, I.2, and I.3)
14. 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)
15. 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. (Sections I.1 and I.2)
16. The Facility, in conjunction with the State, should define specifically the assessment process regarding at-risk individuals for all disciplines. (Section I.2)
17. OTs, PTs, and SLPs should attend annual ISP meetings as well as ISPA meetings for individuals who experienced a change in health status to assist the IDT in completing an interdisciplinary assessment of an individual's risk levels. (Section I.2)
18. Audits of OT/PT, SLP and PNMT assessments should be conducted to ensure therapists' compliance with the risk level assessment guidelines and the quality of the OT/PT, SLP, and PNMT assessments. (Section I.2)

19. Given that IDTs, at times, do not realize when more assessment is indicated, department heads should review IDT findings relevant to their department to ensure appropriate guidance is provided to the teams in determining needed assessments. (Section I.1, and I.2)
20. 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)
21. The Facility should monitor the ISPs to ensure the risk ratings and action plans are integrated into individuals' ISPs. (Sections I.1, I.2, and I.3)
22. The Facility QA Department should track a hospitalization or ER visit or Infirmary admission, through the morning medical meeting discussion, to the IDT meeting, to an ISPA and revised risk categorization with changes in the risk action plan, all documents which should be copied and sent to the morning medical meeting for wrap-up discussion and closure. (Sections I.1, I.2, and I.3)
23. To meet the timeline requirements of the Settlement Agreement, the Facility should develop system of tracking and oversight to ensure that the five-day requirement to begin assessments, and the 14-day requirement of implementation are successfully carried out. (Sections I.2, and I.3)
24. As the Facility's self-assessment processes evolve, additional data should be analyzed, addressed, and included in the Self-Assessment 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	
Each Facility shall provide psychiatric care and services to individuals consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o State-Supported Living Centers: Nursing Protocol for Pre-Treatment and Post-Sedation Monitoring; o An alphabetical spreadsheet of individuals who were prescribed psychotropic/psychiatric medication that included: a) name of individual; b) residence; c) psychiatric diagnoses, inclusive of Axis I, Axis II, and Axis III; and d) psychotropic medication regimen; o List of individuals prescribed benzodiazepines; o List of individuals prescribed anticholinergic medications that included the name of the medications prescribed; o List of individuals prescribed intraclass polypharmacy that included the names of medications prescribed; o Facility-wide data regarding polypharmacy; o List of individuals with tardive dyskinesia; o Spreadsheet of individuals who have been evaluated with the Monitoring of Side Effects Scale (MOSES) and the Dyskinesia Identification System: Condensed User Scale (DISCUS) scores, with dates of completion for the last six months; o List of individuals who are currently prescribed Reglan; o MOSES and DISCUS assessments for the past year for the following five individuals who were prescribed Reglan: Individual #25, Individual #333, Individual #498, Individual #21, and Individual #212; o List of individuals who were prescribed each of the following: a) anti-epileptic medication being used as a psychotropic medication; b) Lithium; c) Tricyclic antidepressants; d) Trazodone; e) Beta-blockers being used as a psychotropic medication; f) Clozaril/Clozapine; g) Mellaril; and h) Reglan; o List of individuals new admitted since July, 2011, and whether a Reiss screen was obtained; o Spreadsheet of all individuals who had had a Reiss screen completed, including the dates of completion; o List of individuals who have been referred for a Psychiatric Evaluation as a result of an elevated score on the Reiss screen since July 2011, inclusive of the Reiss Scoring Sheet and the results of any evaluation that was performed as a result of the Reiss Screening results; o List of all psychiatrists, including board status; o The caseload distribution for the Staff Psychiatrists; o Curricula Vitae (CVs) of all psychiatrists; o Spreadsheet of the status of individuals selected for Desensitization Plans; o Documents related to the following three Psychiatric Clinics: 6350 First Street, on 2/16/12; 6750 Circle Drive, on 2/15/12; and 6760 Circle Drive, on 2/14/12; o Summary of the information compiled by the Chief Psychiatrist for the individuals

	reviewed at the 2/13/12 Neurology Clinic; o For the past six months, minutes from the committee that addresses polypharmacy; o Chemical Restraint Trend Analysis; o Documentation related to the administration of chemical restraint for the following five individuals: Individual #137 on 12/15/11, Individual #31 on 12/13/11, Individual #59 on 12/12/11, Individual #95 on 11/1211, and Individual #284 on 11/6/11; o List of all individuals age 18 or younger who were receiving psychotropic medication; o Documents reviewed in the context of the 12/14/11 Psychotropic Polypharmacy Meeting; o Documents reviewed in the context of the 2/15/12 Pharmacy and Therapeutics Committee Meeting; o Documents and related materials for the ISP for Individual #76, on 2/15/12; o Spreadsheet of oral pre-treatment sedation medications used for medical and dental appointments, from July through December 2011; o Data related to the utilization of oral sedation and general anesthesia for dental appointments, from July through December 2011; o The following sections of the active records: a) Data Record; b) Social History Evaluation; c) Personal Support Plan section; d) Positive Behavior Support Plan, including addendums; e) Annual Medical Summary; f) Active Problem List; g) Inactive Problem List; h) Psychiatric Problem List; i) Hospital Admission; j) Health Risk Assessment Rating, only most recent tool and team meeting sheet; k) Psychiatry section, inclusive of the most recent Comprehensive Psychiatric Assessment; l) MOSES/DISCUS screenings; m) Quarterly Drug Regimen Reviews; n) Neurology Consultation; o) documentation and consultations regarding the use of pre-treatment sedation medication (i.e. Treatment Plan, guardian approval, HRC approval, etc.); and p) Human Rights section, including a copy of the signed consents were requested for the following four samples of individuals who were receiving psychotropic medication: 1. The Facility provided the records of the following ten individuals as part of the pre-review document request: Individual #164, Individual #544, Individual #83, Individual #325, Individual #180, Individual #315, Individual #9, Individual #216, Individual #263, and Individual #3; 2. The records of the following two individuals were chosen as having been admitted to ABSSLC within the last seven months: Individual #137, and Individual #197; 3. The records of the following five individuals were selected, because they were 18 years of age or less: Individual #163, Individual #81, Individual #455, Individual #135, and Individual #274; and 4. The records of the following 13 individuals were selected because of their psychiatric acuity: Individual #108, Individual #313, Individual #59, Individual #87, Individual #300, Individual #332, Individual #76, Individual #460, Individual #293, Individual #365, Individual #301, Individual #384, and Individual #125.

	▪ **Interviews with**: o Toni Wilson, R.N., Psychiatric Nurse, and Amy Hodge, Psychology Assistant, within the context of the 2/13/12 Psychiatric Clinic; o Michael Murray, M.D., Chief Psychiatrist, on 2/13/12 and 2/16/12; o Richard Chengson, M.D., Medical Director, on 2/13/12; o Jerry Griffen, D.D.S., Director of Dental Services, on 2/13/12; o Marla Knight, Pharm. D., Clinical Pharmacist, on 2/13/12; o Ron Manns, Director of Behavioral Services, on 2/13/12; o Shay Butts, Human Rights Officer, on 2/14/12; o Trina Cormack, M.D., Staff Psychiatrist, on 2/15/12; o Tracyl Gandee, Settlement Agreement Coordinator, on 2/15/12; and o Brian Luster, Program Compliance Monitor, on 2/15/12. ▪ **Observations of**: o Neurology Clinic, conducted by the Consulting Neurologist, Dr. Rex Anderson, on 2/13/12; o Psychiatric Clinic for 6760 Circle Drive, on 2/14/12; o Psychiatric Clinic for 6750 Circle Drive, on 2/15/12; o Psychiatric Clinic for 6350 First Street, on 2/16/12; o Human Rights Committee Meeting, on 2/14/12; o Psychotropic Polypharmacy Committee Meeting, on 2/14/12; o Pharmacy and Therapeutics Committee Meeting, on 2/15/12; o ISP meeting for Individual #76, on 2/15/12; o Observations of the following individuals at Neurology Clinic, on 2/13/12: Individual #92, Individual #18, Individual #27, Individual #195, Individual #312, Individual #519, Individual #217, Individual #535, Individual #1, Individual #513, Individual #75, Individual #514, Individual #119, Individual #378, Individual #437, Individual #370, Individual #168, Individual #494, Individual #165, Individual #504, Individual #61, Individual #348, Individual #447, Individual #199, Individual #304, Individual #463, Individual #489, and Individual #485; o Observations of the following individuals in the context of the Psychiatric Clinic at 6760 Circle Drive, on 2/14/12: Individual #313, Individual #87, Individual #371, Individual #301, Individual #245, Individual #396, and Individual #300; o Observations of the following individuals in the context of the Psychiatric Clinic at 6760 Circle Drive, on 2/15/12: Individual #365, Individual #332, Individual #522, Individual #22, Individual #393, Individual #159, Individual #108, and Individual #460; o Observations of the following individuals in the context of the Psychiatric Clinic at 6350 First Street, on 2/16/12: Individual #272, Individual #165, Individual #440, Individual #125, Individual #286, Individual #88, Individual #280, Individual #303, Individual #137, and Individual #384; and o Observations of the following individuals in the context of the tour of the Vocational Workshops, on 2/16/12: Individual #544, Individual #328, Individual #325, Individual #397, Individual #530, Individual #136, Individual #67, Individual #462, Individual #442, Individual #396, Individual #374, Individual #425, Individual #231, Individual #444,

	Individual #371, and Individual #405.
	Facility Self-Assessment: The review of the Facility Self-Assessment was facilitated by an interview with the Program Compliance Monitor, on 2/15/12 as well as a separate interview with the Chief Psychiatrist, on 2/16/12. The Presentation Book for Psychiatry also was reviewed with the Chief Psychiatrist at that time. The Program Compliance Monitor indicated that he reviewed eight individual records per month, four of which were selected randomly from a list of individuals who were reviewed in the Quarterly Psychiatric Reviews during the prior month. The other four individual records were selected randomly from the entire population of individuals who were receiving psychotropic medication. He also reviewed two individual records in conjunction with the Chief Psychiatrist in order to obtain an assessment of inter-rater reliability. The Program Compliance Monitor indicated that he did not score items that were related to specific provisions that would require clinical judgment. For example, he would document that a psychiatric diagnosis was present, but would not rate whether the necessary clinical justification was present for that diagnosis. The items the Program Compliance Monitor did not address were "grayed out" on the tool that was used in the Facility Self-Assessment process to score the individual records for their compliance status. The review of the "QA/Q1 Data Summary, Section J, completed on 12/16/11 by Brian P. Luster, PCM, FY12Q1" indicated that a total of 74 indicators were monitored for 13 provisions of Section J. The "Data Summary" provided both an overall "Compliance Score," and compared these results to those the internal psychiatry review process produced. As has been noted in the Monitoring Team's previous reports, an "overall score" provides little meaningful information when calculated based on monitoring tools for which individual indicators have not been weighted. However, the Data Summary provided information on specific items that were consistently scored as being below a score of 70%. Thus, although the Program Compliance Monitor cannot score for items that required a clinical assessment, these reports provided valuable information. Section J was not yet integrated into the central office QADS P0I System and, thus, the Facility was maintaining the data in an Excel spreadsheet format at the Facility. ABSSLC was developing a plan that would allow them to produce even more detailed reports in the future. During the 2/16/12 interview, the Chief Psychiatrist indicated that each month the Psychiatry Department reviewed eight individual records. The Psychiatry Support Staff (two Psychiatric Assistants and one Psychiatric Nurse) each completed two record audits, and the two Staff Psychiatrists also each reviewed one individual record. The Chief Psychiatrist and the Program Compliance Monitor provided additional reviews of two of the eight described above to assess for inter-rater reliability. The statistical methods that were utilized to assess for inter-rater reliability seemed to be a simple comparison of the percentage completion scores of the two raters for the items on their instrument that were rated by both observers. This would naturally be limited to some degree by the observation that the Program Compliance Monitor did not rate those items that would require an assessment of the clinical quality of the material. There did not appear to be a more rigorous effort to statistically validate the inter-rater reliability or to assess the inter-rater reliability of the other raters. The monitoring tool was derived from the specifications of each provision of the Settlement Agreement and thus the prompts for how to score the individual records closely followed the terminology of the Settlement Agreement. As noted above the Program Compliance

	Monitor did not score items that required clinical assessment. The principal author of the Facility's Self-Assessment for Section J was the Chief Psychiatrist. During the 2/16/12 interview, a member of the Monitoring Team reviewed both the methodology and results of the Facility Self-Assessment for each of the 15 provisions of Section J. Two primary strategies were employed, including a data-based approach and the sampling strategy, as described above. For example, for provisions such as Section J.2 and Section J.6, the Facility assessed its progress in completing the CPEs, and for Section J.11, it analyzed its progress in decreasing the rates of polypharmacy. However, the Facility used the sampling of individual records, as described above, to assess compliance for the majority of the provisions. The discussion of the Facility's rating of each provision indicated that when the Chief Psychiatrist prepared the summary for each individual section, he tried to take into account the aspects related to the clinical quality of the material that was found in the individual records. However since the Program Compliance Monitor did not rate the clinical material for quality, by definition there was no basis for a calculation of inter-rater reliability for those aspects of the internal reviews. The review of the Facility's findings for each provision indicated that they were derived from the results of the sampling process and were, thus, data based. Although the percentage completion rates for individual items, such as an adequate risk-benefit determination, side effect monitoring completion rates, the quality of the CPEs etc., differed from those of the Monitoring Team's review, this could largely be explained by the statistical differences that would be expected by the different composition of the two sample sets, as well as different assessments of the quality of some of the underlying clinical documentation. In light of the similarity in the statistical methods utilized on both the internal and the Monitoring Team's review, it is not surprising that there was 100 percent congruence between the overall compliance results of both reviews pertaining to the cumulative compliance status for each of the 15 provisions contained in Section J of the Settlement Agreement. The observation that the Facility utilized a different subset of records each month should, over time, strengthen the reliability of their results. The efforts to continually reassess for inter-rater reliability should also contribute to the overall reliability of the self-assessment process in the future.
	Summary of Monitor's Assessment: ABSSLC now had three full-time Psychiatrists, who continued to be supported by one Psychiatric Nurse and two Psychiatric Assistants. The Chief Psychiatrist completed an analysis of the workload distribution among the Psychiatrists, which took into account the requirements of the Settlement Agreement. Based on this analysis, it appeared that this number of Psychiatrists should be adequate. The progress with regard to the completion of the Comprehensive Psychiatric Evaluations (CPEs) had continued. The data available indicated that CPEs, which the Facility believed complied with the criteria set forth in the Settlement Agreement, had been completed for 116 of the 199 individuals (58%) who received psychotropic medication. The current plan was to complete these in conjunction with the annual ISP, and then also perform the annual updates to coincide with the annual ISP, which would make the process self-sustaining. The Psychiatrists also had begun to attend the ISPs on a selected basis. The Facility had ceased performing routine monthly Psychiatric Clinic Reviews for individuals who were

	stable on their medication. However, the monthly reviews continued for individuals undergoing changes in their medications and/or experiencing an exacerbation of their psychiatric disorder. This appeared to be a reasonable change from a time-management perspective, because the Settlement Agreement only specified quarterly reviews, coupled with a direct observation. Observation of the Psychiatric Clinics of all three Psychiatrists indicated that the Psychiatric Nurse or Psychiatric Assistant, the Nurse Case Manager, the QDDP, and the Psychologist, who played a key role in the meeting, routinely attended them. On some units, direct support professionals attended the meetings, but this was not universal. The primary care practitioner (PCPs) only attended by invitation for specific situations. The documentation that accompanied the Quarterly Psychiatric Reviews had been expanded to four pages. Examples of information that had been added to the Quarterly Psychiatric Reviews included differentiation of the behaviors that were symptoms of the psychiatric disorder, as opposed to being present on a behavioral basis or represented an overlap of both of these factors, and a much more detailed description of the symptoms that justified the psychiatric diagnosis. There was also an expanded risk-benefit section. The teams were experiencing some difficulties in implementing these tools, because they were attempting to view the Risk-Benefit Assessment as a static assessment when, in practice, it is a dynamic process that evolves over time. The Psychiatry Department, working in conjunction with the Psychology Department and Human Rights Committee (HRC), also had initiated a process to allow for a separate review of the psychotropic medications, apart from the Behavioral Support Plan. In order to facilitate that process, the Chief Psychiatrist had developed a Physician Psychotropic Medication Treatment Plan. During the onsite review, members of the Monitoring Team attended a HRC Meeting, and it was clear that the Committee had a number of questions about the new process. To some degree, this confusion related back to the aforementioned issue of viewing the risk-assessment process as a static, one-time assessment, rather than a dynamic process. The Psychiatry Department had agreed to work more closely with the HRC in implementing the new system. Progress continued in decreasing the rates of polypharmacy at ABSSLC, which had been reduced to approximately 25% of those who received psychoactive medications. In addition, a number of individuals had active tapering schedules. The Psychiatry Department made a distinction between those individuals whose medications were being actively tapered, and those for whom the continued use of the medication was thought to be essential for their continued stability. The Facility will need to assemble the necessary documentation to justify the efficacy of psychotropic medications that they maintain are essential for the individuals' continued stability. The Chief Psychiatrist also had begun to attend the Neurology Clinics in an attempt to develop a system that would address the issues related to Section J.15. Thus, in summary, there had been significant progress in a number of areas that were directly related to the provisions of Section J of the Settlement Agreement. However, the impact of many of these initiatives was not evident in the current review, but

	should positively affect the results of the next review cycle.

#	Provision	Assessment of Status	Compliance
J1	Effective immediately, each Facility shall provide psychiatric services only by persons who are qualified professionals.	At the time of the prior review, 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. Dr. Murray had continued his work at ABSSLC, and had assumed the position of Chief Psychiatrist. Dr. John Crawley, who was a psychiatric Consultant to the Facility, recently terminated his work there. Dr. Trina Cormack, who was a full-time Staff Psychiatrist at the time of the February 2011 review, returned to a full-time position following the July 2011 onsite review. Dr. Cormack's extensive experience in clinical work with individuals who have intellectual and developmental disabilities (ID/DD) was reviewed in the Monitoring Team's report related to the February 2011 review. In addition to being Board Certified in Adult Psychiatry, she also was certified in Family Practice, and had served as the Medical Director at the San Angelo State Supported Living Center for two years. A third full-time Staff Psychiatrist, Dr. Robert Brimmer, joined the Psychiatry Department in November 2011. He completed his training in Adult Psychiatry at the Vanderbilt College of Medicine in Nashville, Tennessee. Dr. Brimmer had worked in the public sector and held psychiatric positions in Texas for approximately 15 years, in a number of different Mental Health and Department of Corrections facilities. This work had included periods of time when he was responsible for the psychiatric treatment of individuals with ID/DD including a two-year period of service at the Mexia State Supported Living Center. Based on the qualifications of the psychiatrists treating individuals at ABSSLC, the Facility was determined to be in substantial compliance with this provision.	Substantial Compliance
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	As noted above, at the time of the review, the Psychiatrists who diagnosed and treated the individuals who resided at ABSSLC were all Board Certified in Adult Psychiatry by the American Board of Psychiatry and Neurology. The Psychiatrists had extensive amounts of prior experience in the diagnosis and treatment of psychiatric disorders in individuals with ID/DD. The documents in the individual records that provided the most complete	Noncompliance

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	psychotropic medication without having been evaluated and diagnosed, in a clinically justifiable manner, by a board-certified or board-eligible psychiatrist.	description of the psychiatric evaluation process required by this section of the Settlement Agreement were the Comprehensive Psychiatric Evaluations. As noted in the prior reviews, the Facility had begun an initiative to complete a thorough CPE that would comply with the terms of the Settlement Agreement for all of the individuals who were receiving psychotropic medication. At ABSSLC, a total of 199 individuals were prescribed psychotropic medication. A sample of individuals was selected for review, as defined in the section above listing the documents reviewed. This included 30 individuals, or 15% of those prescribed psychotropic medication. The Monitoring Team's review of the records of these 30 individuals indicated that the records of the following 11 individuals did not contain a CPE that had been completed within the past year: Individual #164, Individual #163, Individual #263, Individual #88, Individual #216, Individual #3, Individual #274, Individual #460, Individual #300, Individual #135, and Individual #455. Additionally although the records of three individuals (i.e., Individual #9, Individual #544, and Individual #332) contained a CPE completed within the past year, pages were missing from these documents, which made it impossible to determine if they met the criteria defined in the Settlement Agreement. The records of four individuals contained a CPE that had been completed within the last year, but which did not comply with the specifications described in the Settlement Agreement. The deficits that were found in these records included a format that left out certain topics specified in the Settlement Agreement and/or material that did not meet the quality requirements of the Settlement Agreement. Such concerns were related primarily to the justification of the Psychiatric Diagnosis, as well as the overall individual summary that appeared in the Bio-Psycho-Social-Spiritual Formulation. The specific records that fit this category were those of Individual #384, Individual #315, Individual #81, and Individual #125. Thus, all together, 18 individual records (60%) did not meet the requirements of the Settlement Agreement. The records of 12 individuals (40%) contained a CPE that had been completed within the past year, and complied with the specifications set forth in the Settlement Agreement. The 12 individuals whose records contained a CPE that met both of these criteria were as follows: Individual #180, Individual #325, Individual #293, Individual #87, Individual #365, Individual #59, Individual #83, Individual #197, Individual #137, Individual #108, Individual #76, and Individual #313. At the time of the prior review, the corresponding frequency of individuals who were found to have a recently completed CPE that met the criteria of the Settlement Agreement was 29 percent (nine of 31 individuals). The Psychiatry Department's list of individuals evaluated with a CPE indicated that 116 had been completed to date, and 199 individuals were receiving psychotropic medication	

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		(58%). As noted above, of those that had been completed, some were outdated, and some did not meet the Settlement Agreement requirements. Given the importance of these documents to the successful adherence to the provisions of the Settlement Agreement, the adequate completion of CPEs for those individuals receiving psychotropic medication should be a priority for the Psychiatry Department. The finding of noncompliance for this section to the Facility not completing these evaluations for the majority of individuals prescribed psychotropic medication at ABSSLC. In addition, based on the analysis of the sample of 30 individuals, not all of the CPEs that have been completed within the past year were found to comply with the requirements of the Settlement Agreement.	
J3	Commencing within six months of the Effective Date hereof and with full implementation within one year, psychotropic medications shall not be used as a substitute for a treatment program; in the absence of a psychiatric diagnosis, neuropsychiatric diagnosis, or specific behavioral-pharmacological hypothesis; or for the convenience of staff, and effective immediately, psychotropic medications shall not be used as punishment.	The individual interviews with the Psychiatrists, and the direct observations of the Psychiatry Clinics, as well as the review of the records of 30 individuals who were receiving psychotropic medication, did not reveal any evidence that psychotropic medication was being overtly used for the convenience of the staff, or as a form of punishment. During the course of the onsite review, a member of the Monitoring Team directly observed approximately 28% of the 199 individuals receiving psychotropic medication. These observations did not reveal individuals who appeared to be sedated or grossly over-medicated. The presence of an appropriate psychiatric diagnosis that would warrant the use of psychotropic medication is discussed in more detail with regard to Sections J.2 and J.13. However, as noted in those sections, the Monitoring Team's review of records revealed individuals for whom psychotropic medication had been prescribed in the absence of a clinically justified diagnosis. The 30 records that were reviewed indicated that there was an active Positive Behavior Support Plan (PBSP) for each individual who was prescribed psychotropic medication. However, the behaviors identified as the "target behaviors" of the psychotropic medication also often were identified in the Functional Analysis and related PBSP as being present on a behavioral basis and/or related to environmental factors. This finding will be discussed in greater detail below with regard to Section J.9 of the Settlement Agreement. The dual classification of behaviors suggested that, for these individuals, the prescribed psychotropic medication could be construed as having been utilized to suppress behaviors that were not directly derived from a psychiatric diagnosis, which would not be consistent with the terms of the Settlement Agreement. In other words, they potentially were being used in the absence of adequate behavioral treatments or interventions, which could be construed as being "for the convenience of staff," who were not equipped to respond with the appropriate behavioral interventions. In addition, concerns related to the quality of PBSPs are discussed with regard to Section	Noncompliance

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		K.9 of the Settlement Agreement. Although in past reports, chemical restraint was not included in the assessment of J.3, in order to be consistent with the other two Monitoring Teams, this has been added to the assessment process. The use of chemical restraint also could be construed as punishment, because it frequently involved the oral or intramuscular (IM) injection of a psychotropic medication against an individual's will. Thus, the description of the circumstances surrounding the involuntary administration of chemical restraint was extremely important in differentiating between the necessary uses of these interventions to prevent physical harm to the individual and/or others, as opposed to being used to punish an individual for aggressive behavior, or for the convenience of staff in responding to a difficult situation. In order to further investigate the use of mechanical restraint at ABSSLC, the following sample of chemical restraint data was reviewed: INDIVIDUAL # DATE TIME MEDICATION Individual #137 12/15/11 8:43 Lorazepam 2 milligram (mg) by mouth (p.o.) Individual #313 12/13/11 10:21 Xanax 0.5 mg p.o. Individual #59 12/12/11 18:30 Zyprexa 10 mg IM Individual #95 11/12/11 15:59 Thorazine 100 mg IM Individual #284 11/6/11 13:55 Ativan 2 mg IM The individual restraint data was reviewed for the presence and quality of the six components of the documentation that the Facility utilized to record the events preceding, during, and following the administration of chemical restraint. These sections and the results of this review are as follows: 1. The information contained in the section of the form following the prompt to: "Describe events leading to behavior that resulted in restraint" was reviewed. This section of the documentation was present for all five of these individuals. However, the documentation for these individuals only described the overt behavior that necessitated the restraint, and not the "events" that precipitated this behavior for four of these individuals: Individual #137, Individual #59, Individual #95, and Individual #284. The corresponding documentation for Individual #313 adequately described the antecedent events. Thus, the documentation was completed correctly for only one of the five individuals (20%). 2. The section that followed the prompt to describe: "Interventions attempted to avoid restraint" also was reviewed. This section had been completed for all five of these individuals. It was completed appropriately for three individuals: Individual #137, Individual #313, and Individual #59 (60%). The material contained in the documentation for Individual #95, and Individual #284 was not responsive to the prompt. For these, insufficient detail was provided to	

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		determine what, if any, specific attempts had been made to avoid the use of chemical restraint. For example, vague references were made to "redirection" or similar strategies without a specific account of what was actually done in an attempt to avoid using restraint for this individual at this particular point in time. As with the issue above, the solution to this problem might be as simple as training the staff members involved on how to correctly fill out the forms, and instructing them to avoid using global nonspecific responses that do not actually provide a sense of what actually occurred with this individual during this crucial period of time. 3. The portion of the documentation in which the physiological post-restraint monitoring was recorded was completed for all of the individuals in this sample (100%). 4. The face-to-face post-restraint debriefing was not present in the documentation for Individual #59 and Individual #284, but was completed for the following three individuals: Individual #95, Individual #313, and Individual #137 (60%). 5. The Facility had developed a form entitled, "Administration of Emergency Medication Protocol – Chemical Restraint." This document addressed a number of key steps regarding the administration of the chemical restraint process, but was both present and completed in the documentation for only the following three individuals: Individual #137, Individual #3313, and Individual #59 (60%). It was not present for Individual #95, and Individual #284. 6. The Chemical Restraint Clinical Review Form was completed for all five individuals (100%). The interval between the administration of the chemical restraint and the completion of this Clinical Review had been completed within three days for three of the individuals (60%): Individual #284, Individual #95, and Individual #59. The interval for Individual #313 was six days (12/13/11 to 12/19/11); and 12 days for Individual #137 (12/15/11 to 12/27/11). Although this information was completed for all five individuals, it was completed timely for only three individuals (60%). These reviews included comments by the individual's Psychiatrist as well as the Clinical Pharmacist. They were uniformly detailed and clinically relevant. Thus, these essential elements of the documentation needed to verify the appropriate utilization of the involuntary administration of chemical restraint were adequately completed for none of the five individuals in this sample (0%). Although no instances were found in which the documentation showed chemical restraint was definitively used as punishment, the documentation should be improved to allow Facility staff as well as external reviewers to determine that it was not used as punishment or for the convenience of staff. As noted above, the chemical restraint documentation was deficient, and without this it	

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		was not possible to conclude that chemical restraint was not being inappropriately used for punishment or, in some cases, for the convenience of staff. In addition, individuals were identified for whom psychotropic medication had been prescribed in the absence of a clinically justified diagnosis, and psychotropic medications potentially were being used in the absence of adequate behavioral treatments or interventions. Thus, ABSSLC was not in compliance with this provision.	
J4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, if pre-treatment sedation is to be used for routine medical or dental care for an individual, the ISP for that individual shall include treatments or strategies to minimize or eliminate the need for pre-treatment sedation. The pre-treatment sedation shall be coordinated with other medications, supports and services including as appropriate psychiatric, pharmacy and medical services, and shall be monitored and assessed, including for side effects.	The Dental Department was coordinating the implementation of the Behavioral Desensitization Plans for dental and medical appointments at ABSSLC. However, the Psychology Department was responsible for actually developing the Desensitization Plans. On 2/13/12, the discussion with the Director of Dental Services indicated that an initial group of 49 individuals had been identified as candidates for dental Desensitization Plans, and 40 of these individuals were currently "actively engaged" in the process. The "Desensitization Tracking Worksheet," dated 2/8/12, contained information that was consistent with the summary the Director of Dental Services provided. Concerns related to the quality of the desensitization plans are discussed with regard to Section C.4 of the Settlement Agreement. The Dental Services Department had been maintaining data on the frequency with which general anesthesia and pre-treatment oral sedation were required to accomplish successful dental appointments. This data for the prior six months was as follows: MONTHS 2011 / % APPTS. NO SEDATION REQUIRED / % APPTS. ORAL PRE-TREATMENT SEDATION REQUIRED / % APPTS. GENERAL ANESTHESIA UTILIZED July: 95.7% / 2.3% / 2% August: 98.3% / 0 / 1.7% September: 98.7% / 0 / 1.3% October: 98% / 2% / 0 November: 98.1% / 1.9% / 1% December: 98.7% / 0 / 1.3% The review of the Facility orders for pre-treatment sedation for medical and dental appointments from July to December 2011, confirmed that during that time period, the orders were primarily for Ativan (Lorazepam), in a range from two to four mg. The second most utilized agent was Chloral Hydrate in a range of one gram (gm) to 2 gm. During the 2/13/12 interview, the Director of Dental Services indicated that if standard, conservative dosages of sedative medications were not effective, the Psychiatry staff and/or the Pharmacy would be consulted for additional recommendations. The general	Noncompliance

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		anesthesia monitoring was, naturally, very detailed, and was performed by the Consultant who actually administered the anesthesia. The monitoring for the physiological effects of the oral pre-treatment sedation occurred in three different settings. The medication was administered at the individual's residence approximately one hour before the dental appointment. Thus, the post-administration monitoring was performed at the residence, and then transitioned to the Dental Office at the time of the appointment. After the work in the Dental Office was completed, each individual was transferred to the Infirmary for further monitoring, and then was released back to their residence at the discretion of the Infirmary Unit Nursing Staff. Therefore, in order to track the physiological monitoring, it was necessary to review data from three different sources: the individual's residence, the Dental Office, and the Infirmary. The topic of the physiological monitoring related to the use of pre-treatment sedation for dental appointments is discussed in more detail in Section Q of this report. As noted above, the Facility had devoted a great deal of attention to minimizing and monitoring the use of pre-treatment sedation for dental procedures. However, the documentation detailing the utilization of pre-treatment sedation from July to December 2011 indicated that the majority of pre-treatment sedation at ABSSLC was utilized for medical appointments. The spreadsheet listed 81 specific administrations of pre-treatment sedation, of which only four (5%) were utilized in preparation for dental appointments. The issue of Pre-Treatment Sedation Desensitization Plans for medical procedures was discussed separately with the Director of Psychological Services, the Director of Dental Services, and the Medical Director. These discussions indicated that some effort was directed toward developing Desensitization Plans for medical appointments for selected situations, but no organized Facility-wide initiative was in place similar to that for dental procedures. The development of Pre-Treatment Sedation Desensitization Plans for medical procedures, as well as the issue of physiological monitoring following the administration of pre-treatment sedation medication for medical procedures would appear to be topics for the Facility to address in the near future. Thus, although the Facility had put a great deal of effort into the development of Pre-Treatment Sedation Desensitization Plans for dental procedures, only 40 of these Plans were currently in the process of development and implementation. In addition, the use of pre-treatment sedation for medical procedures had not been extensively reviewed or investigated. Accordingly, the Facility was found to be in noncompliance with this	

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		provision of the Settlement Agreement.	
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 February 2012 onsite review, 199 individuals were receiving psychotropic medication at ABSSLC. This number was slightly lower than those identified in the Monitoring Team's prior reports of 219 individuals in August 2011, 222 individuals in February 2011, and 225 individuals in August 2010. As indicated in the prior reports, 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 resided at the Facility. This would equate to a caseload of approximately 65 to 70 individuals for each psychiatrist. As indicated in the narrative related to Section J.1, the Psychiatry Department currently had three full-time psychiatrists. The Chief Psychiatrist also had performed an analysis of the time allocation for each of the three Psychiatrists that would be required to meet all of the requirements specified in the Settlement Agreement, and determined that the current number of psychiatrists was adequate. A member of the Monitoring Team did not directly inspect this analysis. However, the discussion with the Chief Psychiatrist indicated that in compiling the analysis he took into account time-consuming activities, such as the attendance of the psychiatrist at the individual's annual ISP meeting, as well as the completion and annual update of the individual's CPE. In addition, he had accounted for the time to attend the Quarterly Medication review meetings and other regularly scheduled routine activities. The psychiatrists also 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. Given that the Facility employed a sufficient number of skilled psychiatrists to provide the appropriate clinical services to the individuals who reside at ABSSLC, a finding of substantial compliance with this section of the Settlement Agreement has been made.	Substantial Compliance
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 indicated above, the Facility had developed an initiative to complete a thorough CPE for each individual receiving psychotropic medication, which they believed would meet the standards set forth in the Settlement Agreement. The review of the medical records of 30 individuals receiving psychotropic medication identified a recently completed CPE that met the criteria set forth in the Settlement Agreement for 12 of the 30 individuals in the sample (40%). The Facility's internal compilation of individuals with completed CPEs indicated that, to date, they only had been able to complete these documents for 116 individuals (58%) of the 199 individuals prescribed psychotropic medication. Data regarding the Facility's progress in completing the CPEs is discussed in further detail above with regard to	Noncompliance

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		Section J.2. However, given the deficiencies noted in the sample of records reviewed, the Facility's estimate of 58 percent completion of adequate and timely CPEs likely was high. Given that the Facility had not been able to complete these evaluations for the majority of individuals who were prescribed psychotropic medication, and that not all of the evaluations that had been completed met the standards of the Settlement Agreement, the Facility remained out of compliance with this provision.	
J7	Commencing within six months of the Effective Date hereof and with full implementation within two years, as part of the comprehensive functional assessment process, each Facility shall use the Reiss Screen for Maladaptive Behavior to screen each individual upon admission, and each individual residing at the Facility on the Effective Date hereof, for possible psychiatric disorders, except that individuals who have a current psychiatric assessment need not be screened. The Facility shall ensure that identified individuals, including all individuals admitted with a psychiatric diagnosis or prescribed psychotropic medication, receive a comprehensive psychiatric assessment and diagnosis (if a psychiatric diagnosis is warranted) in a clinically justifiable manner.	A spreadsheet listed the individuals who had been administered the Reiss Screen for Maladaptive Behavior from 1/7/09 (earliest date) to 9/9/11 (most recent date). Each of the Monitoring Team's initial three reports included the results of an analysis of a distinct 20 percent sample of individuals who had been administered the Reiss Screening instrument. This methodology verified the accuracy of the data by comparing the information contained in the spreadsheet to a copy of the actual Reiss scoring sheet for each individual in the sample. Each of these prior reviews confirmed that the information in the spreadsheet was 100 percent accurate and, thus, a similar study was not repeated again this time. The Monitoring Team's previous report discussed problems with adherence to the portion of this provision that related to individuals who had scores on the Reiss Screen that were above the clinical cut-off score and had not been evaluated with a CPE, or had been evaluated with a CPE that did not meet the requirements of the Settlement Agreement. The current review focused on those individuals for whom the Reiss Screen had been administered since the prior monitoring review. Since the last review, the Reiss Screen was administered to all individuals who were admitted to ABSSLC who were not receiving psychotropic medication at the time of their admission. Those individuals who were receiving psychotropic medication at the time of their admission to ABSSLC were evaluated with a CPE. The individuals who had been administered the Reiss Screening instrument within the time frame described above were: <u>Individual #70</u>: Reiss Screen administered 9/20/11 (Total Reiss score = 5) Outcome: This score was below the clinical cut-off score of nine, which would have prompted a CPE. The Reiss Screening evaluation had been obtained due to a change in the individual's presentation that had raised concerns. <u>Individual #147</u>: Reiss Screen administered 9/24/11 (Total Reiss score = 8) CPE completed by Psychiatry Department on 10/4/11.	Substantial Compliance

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		Outcome: The Reiss was administered due to concerns about a change in the individual's status. The Reiss Score was below the clinical cut-off score of nine. However, because this score was so close to the clinical cut-off score, a CPE was performed on 10/4/11. Individual #147 was being treated with antidepressant medication at the time of the CPE. The change in status appeared to be related to clinical improvement in her psychiatric disorder, which was diagnosed as a major depressive episode. The CPE noted that Individual #147 had shown improvement, but concluded that the most prudent clinical course was to continue to treat her with the antidepressant, with further follow-up in the Psychiatric Clinic on her Living Unit. This CPE was found to comply with the content and quality standards set forth in the Settlement Agreement, and thus included a discussion of the clinical justification for the decision that continued treatment with the antidepressant medication was warranted. <u>Individual #142</u>: Reiss Screen administered 2/1/12 (Total Reiss score = 12) Outcome: This individual had been admitted to ABSSLC recently, and was not receiving psychotropic medication at the time of admission. The Reiss Score of 12 was above the clinical cut-off score of nine, which would have prompted a CPE. However, this individual's guardian refused to have any involvement with the Psychiatry Department and, thus, a CPE was not performed. The Chief Psychiatrist indicated that the Reiss Score, and the overall presentation of Individual #142 was not of sufficient concern to attempt to override the guardian's decision or to challenge the guardianship. The Monitoring Team's prior report identified seven individuals who had Reiss Screen scores that were above the clinical cut-off score that would have required a CPE. The Chief Psychiatrist included detailed information in the Psychiatry Presentation Book describing the remedial actions taken to remedy these deficits for each of the seven individuals. These remedial actions were found to be effective in addressing the deficits identified. The Monitoring Team appreciates the Psychiatry Department's attention to the previous report and efforts to make these improvements. The specific individual material described above indicated that the Reiss Screen was being performed for individuals experiencing a change in status that raised questions about the potential utility of psychotropic medication. The Facility should consider explicitly identifying the criteria that they utilize to identify the clinical parameters that warrant administering the Reiss Screening instrument for a change in an individual's clinical status. Further, those individuals whose scores on the Reiss Screen were above the clinical cut-off subsequently had received a thorough CPE in a timely manner. The only exception was Individual #142, who had extenuating circumstances, as described above. Individuals admitted to the Facility and not receiving psychotropic medications also were evaluated with the Reiss Screen. Accordingly, the Facility was found to be in	

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		substantial compliance with this provision 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.	The integration between Psychiatry and Psychology Services was apparent in the interviews with the three Psychiatrists, as well as the interview with the Director of Psychology Services. These interactions also were visible in the observation of the Psychiatry Clinics of each of the three Psychiatrists, where it was apparent that the Psychologist had a central role in both the conduct of the meeting, and the analysis of the behavioral data upon which key decisions related to changes in the psychotropic medications were based. The observations of the Psychiatry Clinics and the related documents that were produced illustrated the active collaboration between the two disciplines. However, a persistent deficit in this collaboration, in terms of case formulation, was the co-identification of the same behaviors as being both a target behavior of the prescribed psychotropic medication, and as also being present on a learned or behavioral basis in the Functional Analysis and the PBSP. It is entirely possible that a given behavior could be co-determined by both biological and behavioral factors, but the rationale for this determination should be delineated clearly. Developing a system to integrate pharmacological treatments with behavioral and other interventions through combined assessment and case formulation, as stipulated in this provision, would provide a mechanism to address this problem. This subject is also relevant to Section J.9 of the Settlement Agreement, where it is discussed in more detail. Section J.9 also contained the terminology "integrate pharmacological treatments with behavioral and other interventions through combined assessments and case formulation." The primary disciplines that attended the Psychiatry Clinics were nursing, psychiatry, psychology, direct support professionals, and the Qualified Developmental Disabilities Professional. Disciplines such as Occupational Therapy and Physical Therapy were, of course, not able to attend the Psychiatry Clinics, because several were held every week. However, these disciplines often did attend the individual ISP meetings. At the time of the prior review, the full-time Psychiatrist at ABSSLC had considered attending the ISP meetings to the extent possible in the future. To determine the current status of the Psychiatry Department's involvement in annual planning meetings, attendance at these meetings, as well as the content of the ISP documents, was reviewed for the 30 individuals in the identified sample. This review indicated that a member of the Psychiatry Department had attended the most recent individual ISP meeting for two of the 30 individuals (7%). The specific records containing this documentation were those of: Individual #76 and Individual #313. During the onsite review, a member of the Monitoring Team attended the annual ISP for Individual #76, as did the Psychiatrist. However, the documentation related to the ISP of	Noncompliance

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		Individual #76 could not have been prepared and filed in time to appear in the individual's record when it was reviewed as part of the current sample. Therefore, the finding for Individual #76 was made based on observation, not document review. In any of the 30 records reviewed, the ISP documentation did not fully reflect the psychiatric aspects of the individuals' treatment. There was a discussion of the psychological treatment plan and reference to the individuals' psychotropic medication, but no information was found that reflected the psychiatric aspects of the individual's presentation. It will be important to ensure that the documentation related to these meetings reflects both the Psychiatrists' contribution to the meetings, and also contains a reference to the primary components of the psychiatric medication treatment plan, as well as the integration of this treatment with other treatments, supports, and services. Thus, the integration of psychiatric supports with other supports was not evident in the individuals' ISPs. In summary, although the Psychiatry Department had begun to have the Psychiatrist attend the individual ISP meetings, this still had not been accomplished on a regular basis for the majority of individuals who were prescribed psychotropic medication, and psychiatric treatment plans were not incorporated into the ISPs or integrated with other supports and services. In addition, the Facility had not yet developed and implemented a system to integrate pharmacological treatments with behavioral and other interventions through combined assessment and case formulation. As a result, ABSSLC continued to be out of compliance with this provision.	
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	As noted above with regard to Section J.8 of the Settlement Agreement, the integration of psychiatric and psychological behavioral services was evident in the conduct of the Psychiatric Clinics, as well as to a certain extent in the documentation that was found in the sample of 30 records of individuals receiving psychotropic medication. The Psychiatrist relied heavily upon the data related to the frequency of those behaviors that had been identified as the target behaviors of the prescribed psychotropic medication, when making decisions about potential changes in an individual's psychotropic medication. A significant deficiency in this process related to the degree to which behaviors that were identified as being targets of a psychotropic medication also were identified in the Functional Analysis and the PBSP as being present on a learned/behavioral basis and/or as being related to environmental factors. It is entirely feasible that a given behavior could be co-determined by both biological and behavioral factors. However, the dual description of the behavior as both a target of the psychotropic medication, and as being present on a purely behavioral basis suggested that the medications were being used to suppress environmentally-determined behaviors, and/or that the Psychiatric Treatment Plans and the Positive Behavior Support Plans were developed through parallel processes that were not fully integrated.	Noncompliance

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	use of psychotropic medication, the ISP must also specify non-pharmacological treatment, interventions, or supports to address signs and symptoms in order to minimize the need for psychotropic medication to the degree possible.	The review of the sample of the records of 30 individuals receiving psychotropic medication identified 17 individuals (57%) for whom the dual classification of behaviors described above was present. The individuals' records that were identified as containing this dual reference to problematic behaviors were those of: Individual #384, Individual #163, Individual #164, Individual #455, Individual #180, Individual #81, Individual #325, Individual #274, Individual #9, Individual #88, Individual #3, Individual #460, Individual #125, Individual #137, Individual #135, Individual #87, and Individual #59. The records of the following 13 individuals (43%) contained an adequate differentiation of the behaviors that were present due to biological factors, as opposed to behavioral determinants: Individual #293, Individual #315, Individual #365, Individual #263, Individual #83, Individual #216, Individual #544, Individual #76, Individual #332, Individual #197, Individual #108, Individual #313 and Individual #300. The differentiation of the maladaptive behaviors that the individual presented with is directly related to the concluding comment in this provision addressing: "the need to minimize the need for psychotropic medication to the degree possible." The misidentification of behaviors that were in reality related to behavioral/environmental factors as being linked to a psychiatric disorder would increase the risk that the individual would be prescribed unnecessary psychotropic medication, and, in addition, the individual would not receive the behavioral supports appropriate to address the problem. The Chief Psychiatrist had modified the format for the Quarterly Psychiatric Reviews so that it would contain more explicit information concerning the linkage between the symptoms of the individual's psychiatric disorder and his/her other monitored target behaviors. These newly formatted Quarterly Review documents only recently had been incorporated into the records of the individuals prescribed psychotropic medication. Therefore, the addition of this information was not fully reflected in this review. This information also will need to be fully integrated into the psychological sections of the individual records. As noted above with regard to Section J.8, this information also had not been incorporated into the ISP documentation. Accordingly, although the progress of the Psychiatry Department in addressing these issues through the development of the new Quarterly Psychiatric Review documentation was noted, the Facility was found to be in noncompliance with this section of the Settlement Agreement.	
J10	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, before the non-emergency	This Section of the Settlement Agreement addresses the risk-versus-benefit considerations related to the use of psychotropic medications for a specific individual. The findings described in the Monitoring Team's previous reports indicated that the discussion of these factors primarily occurred in the Human Rights Committee section of	Noncompliance

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	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.	the record, as well as the PBSP. The prior reviews of these sections of the records indicated that these discussions always concluded that the benefits of the proposed medications outweighed the risks presented by their side effects. The descriptions of the benefits were formulaic in nature, and the benefits were uniformly described as a reduction in the behaviors that were identified as the targets of the psychotropic medication. In response to these findings and recommendations, the Facility developed a new system for documenting the risk-versus-benefit considerations. The Facility's system appeared to have been based on peer-reviewed publications that described a system predicated on a risk-determination process that examined the potential side-effect burden of the proposed medication, the likelihood that the medication would be effective, and the morbidity associated with the individual's psychiatric illness, if it was not treated. The new material appeared in the expanded Quarterly Psychiatric Review documentation. In its current review, the Monitoring Team found adequate discussion of the risk-versus-benefit analysis in 17 of the 30 individual records (57%). The records that did not contain an adequate risk versus benefit analysis were those of the following 13 individuals: Individual #163, Individual #164, Individual #125, Individual #274, Individual #180, Individual #184, Individual #9, Individual #88, Individual #460, Individual #137, Individual #135, Individual #455, and Individual #8. The records of the individuals that contained this information appeared in the newly expanded Quarterly Psychiatric Review documentation. However, this information was not yet fully reflected in the other sections of the individuals' records that discussed the risk-versus-benefit analysis. Specifically, the HRC review of the risk-versus-benefit analysis related to the approval of the use of psychotropic medication was not significantly different from that described in the Monitoring Team's prior reports (this process is further discussed with regard to Section J.14). Thus, a challenge for the Psychiatry Department will be to complete the risk-versus-benefit analysis for those individuals who have not yet undergone this analysis, and further, to facilitate the incorporation of this valuable information into the other sections of the individuals' records that rely on these formulations. During the 2/14/12 HRC meeting, the discussions between the Psychiatry Department representatives and members of the Human Rights Committee revealed some confusion regarding the implementation of the new risk-versus-benefit analysis system. This confusion seemed to derive from viewing the analysis of the risk-versus-benefit considerations related to the use of a specific medication as a static determination, while, in actual practice, it is a dynamic process. For example, the team identified an individual receiving a medication with a moderate-to-high risk side effect profile to address	

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		behaviors related to a psychiatric disorder that only caused a mild degree of risk to the individual themselves and/or others. This finding could represent a significant misalignment of the risk-versus-benefit equation, which would raise questions about the utility of the psychotropic medication prescribed, and should be addressed. However, in those situations where these observations related to a medication that had actually been in place for two years or more, it would be important to determine if the actual realized side effects of the medication had been as great as the projected potential side effects that, at the time of implementation, could only have been estimated from the published literature. The actual realized side effects for a specific medication vary widely from individual to individual. In a corresponding manner, it would be important to determine if the behavior that was derived from the psychiatric disorder, and which was currently rated as low intensity, had presented a much higher risk prior to the initiation of treatment with the medication. This would, of course, suggest that the medication had been effective, and, given the low degree of realized side effects, the risk-versus-benefit equation would be quite favorable for the continued use of the medication. This matter also was discussed with the Chief Psychiatrist during the onsite review. In summary, the instruments that the Facility had added to the risk-benefit process should augment the analysis of the factors that contribute to these decisions. However, the completion of these scales will not in and of themselves constitute a thorough determination of either the risk presented by a given medication or its benefit, and thus they should only be viewed as adjunctive aids to this process. The finding of noncompliance for this provision was related to the continued deficiencies noted above. However, progress in reforming the risk-versus-benefit assessment process had begun.	
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	ABSSLC had continued its policy of reviewing every individual whose psychotropic medication regimens met the criteria for polypharmacy on a monthly basis. The "Monthly Psychiatry Polypharmacy Reduction Meeting Notes" were reviewed for the previous six months. The Chief Psychiatrist, Director of Pharmacy Services, Clinical Pharm. D., Psychiatric Specialty Nurse, and the Medical Director attended these meetings, which the Pharm.D. facilitated. The Meeting Notes indicated that the group engaged in a detailed case-by-case discussion of individuals whose medication regimens met the criteria for polypharmacy. A member of the Monitoring Team observed the February meeting of this Committee, which occurred on 2/14/12. The meeting format included a brief review of the status of each individual whose profile met the criteria for polypharmacy. This discussion focused on the feasibility and current status of the attempts to reduce polypharmacy for each individual. Documentation from the 2/14/12 meeting provided a summary of the Facility's progress	Noncompliance

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<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>clinically justified, and that medications that are not clinically justified are eliminated.</td><td>toward minimizing polypharmacy as of January 2012. The total number of individuals who met the criteria for polypharmacy was 52 (26%) of the 199 individuals receiving psychotropic medication as of 1/31/12. Additional details regarding the number of individuals prescribed multiple medications were available for the month ending 12/31/11. This additional detail was not contained in the January 2012 summary. The 12/31/11 data indicated, at that time, the breakdown was as follows:
Three medications = 43 individuals;
Four medications = 13 individuals;
Five medications = 1 individual; and
Six medications = no individuals.
Historical data from several years ago was not available for comparison. However, monthly comparative data was available going back to January 2010. The Table that contained this information did not include the total number of individuals receiving psychotropic medication until August of that year. Tabular representation of this data is as follows:

<table><tr><th>DEFINITIONS OF POLYPHARMACY</th><th>8/10</th><th>12/11</th></tr><tr><td>Number of individuals receiving two or more medications from the same class</td><td>16</td><td>4</td></tr><tr><td>Number of individuals receiving three or more medications regardless of class or indication</td><td>108</td><td>57</td></tr><tr><td>Total number of individuals on polypharmacy</td><td>108</td><td>57</td></tr><tr><td>Total number of individuals receiving psychotropic medication</td><td>224</td><td>205</td></tr><tr><td>Polypharmacy as a percentage of individuals receiving psychotropic medication</td><td>48%</td><td>28%</td></tr></table>The number of individuals who were prescribed two or more psychotropic medications from the same class (intraclass polypharmacy) and who were not also prescribed three or more psychotropic medications was not reported in the tabular representation of the Facility's historical data. Thus, these figures for the total number of individuals who received polypharmacy with psychotropic medication assumed that all of the individuals who were prescribed intraclass pharmacy also received three or more psychotropic medications for purposes of this comparison, as that was usually true.

This provision of the Settlement Agreement also states that it is necessary "to ensure that the use of such medications is clinically justified, and that medications that are not clinically justified are eliminated." Thus, this provision also relates to the documentation that all prescribed medications can be empirically demonstrated to be effective. As indicated in the discussion related to Section J.13, only 30 percent of the Monitoring</td><td></td></tr>
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		Team's sample of 30 individuals' records contained sufficient documentation to empirically demonstrate that the medications had been effective. The discussions of the individuals whose psychotropic medication regimens continued to meet the criteria for polypharmacy, which took place during the 2/14/12 Polypharmacy Committee Meeting, indicated that the psychiatric team believed that many of these medications were essential for the individuals' stability. The most recent figures from the February meeting, which included the data as of 1/31/12, indicated that the total number of individuals whose psychotropic medications met the criteria for polypharmacy was 52 (26% of the 199 individuals prescribed psychotropic medication), of which ten met the criteria for intraclass polypharmacy. Eight of these ten also met the criteria for three or more psychotropic medications. Two individuals were only prescribed two medications from the same class, and did not receive additional psychotropic medication. The Facility had begun to make a distinction between individuals for whom one or more psychotropic medication was being actively tapered (active polypharmacy = AP), as opposed to those who were thought to require their current medications to maintain their continued stability (stable polypharmacy = SP). For these 52 individuals, the total number of individuals the Facility placed in the AP classification was 40, as compared to 11 in the stable polypharmacy group. In addition, one individual had been admitted within the past year from the community who was receiving medications that constituted polypharmacy. The Facility clearly had made a great deal of progress in reducing unnecessary polypharmacy. This effort also was reflected in the observations of the Psychiatric Clinics that took place during the onsite review, as it was evident that the question of whether all of the individuals' medications were necessary was a topic of discussion at each review that was observed. The current finding of noncompliance for this provision primarily relates to the continued number of individuals who received multiple psychotropic medications whose efficacy had not been empirically demonstrated. It is essential that the Facility provide empirical evidence to support the conclusion that specific medications are essential for an individual's continued stability.	
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,	This provision of the Settlement Agreement mandates systemic, quarterly monitoring for the emergence of motor side effects related to the utilization of antipsychotic medication with the Dyskinesia Identification System: Condensed User Scale, and the monitoring of more general systemic side effects related to psychotropic medication with the Monitoring of Side Effects Scale every six months. An additional component of this process was also the latency between the time the nurse completed the exam, and the	Noncompliance

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	and responding to side effects of psychotropic medication, based on the individual's current status and/or changing needs, but at least quarterly.	PCP reviewed and signed the documentation. The review of the sample of the records of 30 individuals prescribed psychotropic medication indicated the MOSES evaluation was current (completed within the last six months) and had been performed at least every six months for all but the following two individuals, who had missing documentation: Individual #544, for whom the two-page forms were all missing the second page that contained the signatures and dates, and Individual #384, for whom the documentation for the 11/7/11 evaluation was complete, but the essential second pages from the prior evaluations for the year were missing. Thus, documentation could be identified for 28 of the 30 individuals (93%). The records of 22 of the 30 individuals (73%) contained documentation that the PCP had reviewed the MOSES evaluation in a timely manner. The six individuals whose MOSES documentation was not reviewed in a timely manner (latency between dates) were those of: Individual #253 (11/8/11 - 11/28/11), Individual #274 (6/6/11 - 6/22/11), Individual #163 (10/4/11 - 10/24/11), and Individual #61 (6/1/11 - 6/22/11), Individual #296 (11/2/11 - 11/30/11), and Individual #125 (11/30/11 - 12/13/11). In addition, as noted above, the necessary information to document the interval between the evaluation and the PCP review was missing for Individual #54 and Individual #384, resulting in the overall completion rate of 73 percent. The purpose of the DISCUS is to detect the emergence of motor side effects related to the use of antipsychotic medication. The review of the records of the sample of 30 individuals indicated that the following ten individuals were not receiving antipsychotic medication at the time of the review: Individual #164, Individual #325, Individual #59, Individual #263, Individual #83, Individual #9, Individual #216, Individual #544, Individual #88, and Individual #460. Thus, monitoring with the DISCUS was not required. However, the review of the sample of 30 individuals indicated that the Facility's practice was to perform the DISCUS for all individuals who received psychotropic medication, because the results for these ten individuals did not differ from those of the other 20. Documentation that the DISCUS was current, and had been performed quarterly for the past year was identified for all but the following four individuals (date of most recent DISCUS evaluation): Individual #164 (most recent evaluation 9/19/11), Individual #216 (most recent evaluation 7/13/11), Individual #313 (interval of greater than 90 days between 6/16/11 and 10/5/11 evaluation), and Individual #59 (interval of greater than 90 days between 5/4/11 and 11/10/11 evaluations. Thus, the DISCUS had been performed as specified for 26 of the 30 individuals (87%) that the Facility included in their protocol for monitoring with the DISCUS. The documentation related to the DISCUS was reviewed with regard to the length of time	

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		between when the nurse performed the evaluation, and when the PCP reviewed it. Seven individuals' records indicated a significant delay between the date the nurse completed the DISCUS evaluation, and the PCP reviewed and signed it (latency before review), including: Individual #125 (11/30/11 - 12/15/11), Individual #263 (11/8/11 - 11/28/11), Individual #81 (6/1/11 - 6/22/11), Individual #163 (10/4/11 – 10/24/11), Individual #274 (12/27/11 - 1/13/12), Individual #293 (11/2/11 - 11/30/11), and Individual #9 (9/20/11 - 10/24/11). Thus, the PCP reviewed the DISCUS in a timely manner for 23 of the 30 individuals (77%). The numbers and specific information for the individuals whose records comprised this sample have been provided to enable the Psychiatry Department to ascertain if the missing documentation was due to the evaluation not being completed, clerical errors in filing, or omissions of documents in the process of assembling them for this review. Progress in completing these evaluations according to the timelines established in the Settlement Agreement will be monitored in future reviews. The DISCUS and MOSES also are necessary to monitor for the side effects of Reglan, which although prescribed for gastroesophageal reflux disease (GERD), has pharmacological properties that are similar to those of antipsychotic agents. A list was obtained from the Pharmacy of all individuals prescribed Reglan to develop the sample for this analysis. This list was then cross-referenced with the Facility-wide list of individuals receiving psychotropic medication in an effort to generate a list of individuals receiving Reglan, but not also prescribed psychotropic medication. The following sample of five individuals (21% of the 24 individuals who fit the above criteria) was selected: Individual #25, Individual #333, Individual #498, Individual #21, and Individual #212. The review of the records of these individuals indicated that the MOSES examination had been performed as required for the following: Individual #333, Individual #498, Individual #25, and Individual #21. No MOSES was included in the requested documentation for Individual #212. Thus, these evaluations had been completed as expected for 80 percent of the sample. With regard to the elapsed time between the nurse's completion of the evaluation and the PCP's review, timely review occurred for only one individual, Individual #498 (20%). No documentation was available in the record of Individual #212. The latency before the review for the other three was as follows: Individual #25 (1/12/12 - 1/31/12, and 10/19/11 - 11/7/11), Individual #333 (11/9/11 - 11/30/11, and 8/25/11 - 9/20/11), and Individual #71 (8/15/11 - 8/30/11). The same methodology was utilized to select the sample of individuals receiving Reglan for completion of the DISCUS. The results of this review indicated that these evaluations were completed as specified for only three of the five individuals: Individual #212,	

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		Individual #333, and Individual #21 (60%). The review of this documentation for the remainder of the sample indicated that there was a greater than 90-day interval between the 7/8/11 and 10/19/11 DISCUS for Individual #25. There was also a prolonged interval between the 9/28/11 and 1/20/12 DISCUS for Individual #498. For this sample of DISCUS evaluations, the PCP had conducted a timely review for only two individuals in the sample: Individual #212 and Individual #498 (40%). The prolonged intervals between the nurse's actual evaluation and the PCP's review were as follows: Individual #25 (1/12/11- 1/31/12), Individual #333 (11/9/11 - 11/30/11, and 8/25/11 - 9/15/11), and Individual #21 (8/15/11 - 8/30/11). During the Monitoring Team's prior reviews, the subject of the latency between the completion of the MOSES and DISCUS, and the date the PCP reviewed and signed them had been discussed with the Psychiatry Department. At that time, staff indicated that any abnormal findings on these examinations were reported immediately to the PCP. However, there did not appear to be any documentation of this process. To the extent that new abnormal findings on an evaluation are identified and reported immediately to the PCP, it would be useful to devise a mechanism to document this process. The mechanism to ensure routine evaluations are reviewed in a timely manner also will need to be improved. The monitoring of individuals prescribed Reglan, but not receiving a psychotropic agent also should be improved, because this medication can cause significant side effects. These might include acute extrapyramidal motor side effects (EPS), which could require treatment with anticholinergic agents, as well as tardive dyskinesia, which can be irreversible, if not promptly identified and addressed. Due to the deficiencies in the completion of these important side effect monitoring tools according to the schedules required by the Settlement Agreement and the numerous delays in the review of these documents by the PCP, the Facility remained out of compliance with this provision.	
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	This provision of the Settlement Agreement addresses processes that are essential for the appropriate use of psychotropic medication for individuals with ID/DD. The first of these relates to the integrity of the psychiatric diagnosis, as indicated by the following terminology: "The Treatment Plan for the psychotropic medication identifies a clinically justified diagnosis or a specific behavioral-pharmacological hypothesis." The review of the records of a sample of 30 individuals (15%) of the 199 individuals receiving psychotropic medication indicated that a description of the specific symptoms that would support the psychiatric diagnosis of record could be identified for 24 individuals (80%). The individual records in which this documentation could not be identified were those for the following six individuals: Individual #126, Individual #164, Individual #180, Individual #9, Individual #88, and Individual #137. The records for these	Noncompliance

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	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.	individuals did not contain adequate justification for the psychiatric diagnosis. Specifically, the documentation did not identify the specific symptoms to support the diagnosis. In the Monitoring Team's previous review, 52 percent of the records contained an adequate justification for the psychiatric diagnosis of record. The significant improvement that was observed in the current review largely related to the improvement in the Quarterly Review documentation. The newly formatted Psychiatric Quarterly Review Forms contained sections that discussed the diagnosis, including the Diagnostic and Statistical Manual (DSM) criteria for that diagnosis; past psychotropic medication trials; non-psychiatric medications that the individual received; pertinent laboratory and/or other medical information; the results of the most recent MOSES and DISCUS side effect monitoring; results of the mental status examination the Attending Psychiatrist performed at the time of the review; a discussion of the specific symptoms or diagnosis that each psychotropic medication was prescribed to address; and an empirically-based risk-versus-benefit analysis for each prescribed medication. The tables reporting the frequency of the monitored behaviors were augmented by graphs the Psychology Department had prepared. These graphs provided dose response data for the prescribed psychotropic medication, with phase lines to demarcate major environmental or pharmacological changes. These additions to the Quarterly Review documentation were substantial, and when fully implemented should have a significant positive impact on the Facility's ability to document the empirical basis for their clinical decisions. The criteria for this provision also addressed the need to identify "the objective psychiatric symptoms or behavioral characteristics that will be monitored to assess the treatments' efficacy." These "symptoms or behavioral characteristics" were referred to in the ABSSLC documentation as the "target behaviors" of the psychotropic medication. As noted above with regard to Sections J.8 and J.9 of the Settlement Agreement, a persistent problem with the documentation in the ABSSLC records was the dual identification of a specific behavior as being both a "target behavior" of the prescribed psychotropic medication, and also as being present on a learned or behavioral basis. This issue is discussed in more detail with regard to Section J.9. This provision also addressed the question of the efficacy of the prescribed psychotropic medication. In nine of the 30 records reviewed (30%), empirical evidence was found that the prescribed psychotropic medication had produced a significant diminution in the frequency of the monitored target behaviors. The 21 individuals for whom this evidence could not be found were as follows: Individual #274, Individual #164, Individual #163, Individual #180, Individual #9, Individual #293, Individual #460,	

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		Individual #76, Individual #384, Individual #125, Individual #332, Individual #88, Individual #197, Individual #108, Individual #137, Individual #313, Individual #300, Individual #81, Individual #455, Individual #87, and Individual #135. ABSSLC Psychiatry and Psychology Progress Notes routinely carried forward one to two years of objective behavioral data. The utility of this information could be greatly enhanced by including a summary of the contemporaneous behavioral data that would support the subjective rationale for medication changes. This database also would provide additional historical data points with which to make comparisons of current frequencies that would enable the Psychiatric Treatment Team to ascertain if a specific psychotropic medication could be determined to be effective from an empirical perspective. The final requirement of this provision relates to the frequency with which the Psychiatrist reviews individuals prescribed psychotropic medication. Based on review of the sample, Quarterly Reviews were performed as specified in this provision for 29 of the 30 individual records reviewed (97%). The single individual record that did not contain this information was that of Individual #180 (most recent Quarterly Review was dated 10/11/11). Documentation also was present to show that the Psychiatrist had directly observed the individual in conjunction with the Quarterly Review for 27 of the sample of 30 individuals (90%). The individuals whose records did not contain documentation of direct observation were those of Individual #544 (no observation noted in 10/12/11 review), and Individual #293 (no observation noted in 12/29/11 review). Also, as noted above, Individual #180's most recent Quarterly Review was dated 10/11/11, so quarterly observation had not occurred. The Psychiatry Department had made progress with regard to several of the requirements included in this provision of the Settlement Agreement. Much of this progress was related to the expanded Quarterly Review documentation for those individuals prescribed psychotropic medication. The finding of noncompliance for this provision directly related to the lack of documentation in those particular areas specified above, including, for example, the demonstration that the psychotropic medications had been effective. There had been significant improvement in the justification of the psychiatric diagnosis, but there continued to be individuals for whom the psychiatric diagnosis had not been justified, as well as a few individuals for whom documentation of a quarterly observation by the Psychiatrist could not be identified. In addition, a persistent problem was the dual identification of a specific behavior as being both a "target behavior" of the prescribed psychotropic medication, and also as being present on a learned or behavioral basis.	
J14	Commencing within six months of	The review of the Rights/Consents sections of the records for the sample of 30	Noncompliance

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	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.	individuals indicated that 19 individuals (63%) had a Guardian of the Person. Those individuals who did not have a guardian relied on the Facility Director to review the risk-versus-benefit information related to the utilization of psychotropic medication, and then provide the necessary consent. Review of the individual records showed consents for the use of psychotropic medications had been obtained in a timely manner for all of the 30 individuals in the sample (100%). However, as noted below, significant deficiencies were identified related to the consent process raising concerns about the degree to which these consents were truly "informed." As indicated with regard to Section J.10 of the Settlement Agreement, the risk-benefit analysis that was contained in the Psychiatry section of the record demonstrated that the Facility recently had implemented an initiative significantly improve this process. However, this system had not yet been fully implemented, nor had this process been extended to the Informed Consent process. The discussion of the side effects contained in the consent documentation continued to consist of a generic listing of side effects, which did not include a discussion of the frequency with which those side effects occurred in the general population, based on published data. During the onsite review, this issue was discussed with the Chief Psychiatrist. During that meeting, he was able to produce an impressive amount of detailed information that he indicated was routinely provided to the guardian as part of the consent process. Unfortunately, these documents were not reflected in the records of the individuals that constituted this sample. The information found in the records was identical to that described in the Monitoring Team's prior reports, which consisted of a brief generic listing of both the most serious and most common side effects. There was no reference to the probability of those side effects occurring, nor was there an indication as to whether or not the individual had experienced side effects from medications they already had been receiving for a considerable length of time. The general practice of the Psychiatry Department was for the psychiatrist to directly call the guardian, if possible, to discuss the rationale for the new medication and obtain verbal consent, after which the more detailed side effect information would be sent to the guardian for his/her review and written consent. The process for those individuals for whom consent was provided by the Facility Director routinely involved only the transmission and review of written documents. On 2/14/12, members of the Monitoring Team were able to attend the Human Rights Committee Meeting. The discussions that were observed at this meeting were detailed, and reflected contributions from all of the members of the Committee. The discussions were thoughtful and directly related to the mission of the Committee. However, the rigor	

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		of these discussions was not reflected in either the minutes of prior meetings, or in the Human Rights review documentation that should appear in the individual records. On 2/14/12, these observations were discussed with the Human Rights Officer in a meeting with members of the Monitoring Team. The observations of the Human Rights Committee Meeting also revealed that the members of the Committee were experiencing difficulties in the interpretation of the risk-versus-benefit analysis process that the Psychiatry Department recently implemented. Much of this confusion derived from the issues related to the implementation of the system, which was alluded to above in the discussion of Section J.10. In essence, this confusion related to the aforementioned problems that arose from viewing the risk-versus-benefit process as a static analysis, rather than a dynamic process. These issues also were discussed with the Chief Psychiatrist, who indicated that he would attend future Human Rights Committee Meetings to address those questions. The Human Rights Committee review of the psychotropic medication previously had been performed in conjunction with their approval of the PBSP. Within recent months, the Psychiatry Department had implemented a process of reviewing the psychotropic medications separately from the PBSP. Overall, this appeared to be a reasonable change that should provide for a more detailed analysis of the risk-versus-benefit considerations related to the use of psychotropic medication. However, it will take some time before the new system is fully implemented, and the effectiveness of this initiative will have to be assessed in future reviews. The above-referenced systemic deficits in the risk-versus-benefit discussion made it difficult, if not impossible, for a guardian or the Facility Director to render a truly informed consent regarding the use of psychotropic medication. The Psychiatry Department will also need to reconcile the discrepancy between the information that they have indicated was supplied to the guardian as part of the consent process, and the corresponding documentation that appears in the individuals' records. The finding of noncompliance for this provision of the Settlement Agreement is related to the current deficiencies as described above. Future reviews also will assess the degree of progress that the Facility has made in integrating the information obtained from the new risk-versus-benefit analysis format into the other aspects of the consent process.	
J15	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall ensure that the	In order to address this provision of the Settlement Agreement, at the time of the Monitoring Team's previous review, the Chief Psychiatrist began attending the Neurology Clinics. ABSSLC also had added a brief section to the Quarterly Review documentation that indicated the date of the last Neurology Consult and, depending on	Noncompliance

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	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 complexity of that Consult, would either provide a very brief summary, or simply document its occurrence. A member of the Monitoring Team attended the 2/13/12 Neurology Clinic with the Consulting Neurologist. The Chief Psychiatrist and the Facility Medical Director also attended the Neurology Clinic. The Neurologist was responsive to questions from the Chief Psychiatrist, and would spontaneously comment on findings of significance. The individuals who had a psychiatric disorder as well as a neurological disorder were not routinely separated from those who did not have a psychiatric diagnosis. Thus, the Chief Psychiatrist routinely attended the entire Clinic to make sure he was present for the reviews of the individuals with a psychiatric disorder. It would clearly be more efficient if the individuals who were jointly followed by both Neurology and Psychiatry were reviewed together rather than being randomly dispersed throughout the clinic. However in discussing this with the Chief Psychiatrist, it was noted that the Neurology Clinic schedule was primarily ordered according to the individual's living unit so as to make the process more efficient for the nursing and direct support professionals that accompany the individuals to the clinic. Thus, it might not be possible to change this without disrupting the continuity of the individuals' care on their living units. The methodology used to assess the degree to which the requirements set forth in this provision were being adhered to involved locating a recent (within the last year) Neurology Consultation Note in the Consultation section of the individual's record. The next step was to ascertain if the Psychiatrist had attended the meeting, and if there was adequate documentation of the discussion from the meeting. In order to determine if adequate coordination had occurred between the Consulting Neurologist and the Attending Psychiatrist, the Neurology Notes were assessed for reference to the individual's psychotropic medication, as well as other aspects of the individuals' psychiatric status. The existence of a corresponding reference to the Neurology Consultation in the Psychiatry section of the record also was assessed. The documentation that the Neurology Clinic had occurred appeared in the Psychiatric Quarterly Review Notes for all of the 15 individuals in the sample (100%) who had received a Neurological Consultation in the prior year. The Neurology Notes also referenced the psychotropic medications for all of these 15 individuals (100%). The Chief Psychiatrist had developed a system to disseminate a summary of the results of the Neurology Consultation to the other psychiatrists who did not attend the meeting. A member of the Monitoring Team, who had also attended the Clinic, conducted a brief onsite review of the summary that the Chief Psychiatrist prepared, based on the 2/13/12	

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		Neurology Clinic. The summaries conveyed the essence of the Neurologist's remarks. Unfortunately, these summaries, or a brief synopsis of these summaries, did not appear in the Quarterly Psychiatric Clinic Notes, nor were they discussed with the members of the IDT that attended the Psychiatric Clinics. The Facility's Self-Assessment also recognized these deficiencies, and a plan had been developed to address this issue. The rating of noncompliance for this provision is related to this deficiency in the dissemination of the information concerning the results of the Neurology Consultation. However, the considerable progress that the Facility had made in addressing the requirements of this provision were noted.	

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. These documents also should be updated on an annual basis. (Sections J.2 and J.6)
2. 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 also should include a thorough justification for the individual's primary psychiatric diagnosis. (Sections J.2, J.6, J.8, and J.9)
3. The documentation contained in the Chemical Restraint forms that involve the oral or 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. 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 appointments as a separate objective from more intrusive dental procedures, and/or procedures for which the general population typically would request sedation. (Section J.4)
5. 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)
6. The Facility should consider explicitly identifying the criteria that they utilize to identify the clinical parameters that warrant the administration of the Reiss Screening instrument for a change in an individual's status. (Section J.7)
7. The documentation for the individual ISP meetings, which are attended by the individuals' Attending Psychiatrist, should clearly delineate both the attendance of the Psychiatrist, as well as any contributions that the Psychiatrist made to the deliberations. (Section J.8)
8. The documentation for the individuals' ISP meetings should include a discussion of the individual's psychiatric status and Treatment Plan, and, as appropriate, integrate this treatment with other treatment, supports, and services. (Section J.8)
9. 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. (Sections J.8 and J.9)
10. The discussions of whether the prescribed psychotropic medication represents the least intrusive approach to the individual's problematic behavior should be included in the ISP and documented clearly, including the deliberations. (Section J.9)
11. The newly developed risk-versus-benefit discussion that appeared in the revised Quarterly Review documentation should be consistently carried over to the CPEs, the Human Rights review, and the Guardian Consent process. (Section J.10)
12. The risk-versus-benefit determination process should not only consider the potential side effects of the medication, but also those that have

actually been experienced. In a similar manner, the potential benefits of the medication in diminishing the morbidity related to the underlying psychiatric disorder should be augmented with a discussion of the benefits that already might have been observed. (Section J.10)

13. The Facility should improve the collection and presentation of the empirical data to document the efficacy of psychotropic medications they assert must be continued to maintain an individual's continued psychiatric stability. (Section J.11 and J.13)
14. 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.11 and J.13)
15. The Facility should develop and implement systems to ensure that the MOSES and DISCUS side effect assessments, which members of the nursing staff perform, are completed as specified. The prescribing provider also should review and sign these evaluations in a timely manner. (Section J.12)
16. The monitoring system for the MOSES and DISCUS of individuals receiving Reglan should be improved to increase completion rates. In addition, the prescribing provider should review the MOSES and DISCUS evaluations for individuals who are prescribed Reglan in a timely manner. (Section J.12)
17. 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.13)
18. The symptoms that support the individual's primary psychiatric diagnosis also should be listed in the Quarterly Psychiatric Review Notes. (Sections J.13)
19. The Quarterly 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 prescribed psychotropic medication. In those cases where this is not applicable (i.e., there is no overlap), this should be stated clearly. (Section J.13)
20. The discrepancy between the extensive psychotropic medication side effect information that the Facility maintains is provided to guardians as part of the consent process, and the corresponding information that is contained in the individuals' records should be resolved, either by providing a copy of the actual information, or a detailed description of that information. (Section J.14)
21. The Psychiatry Department should work with the Human Rights Committee to ensure that they fully understand the new risk-versus-benefit assessment process. (Section J.14)
22. The minutes from the Human Rights Committee Meetings should more fully reflect the thoroughness of the discussions that occur related to the psychiatric treatment of individuals who reside at ABSSLC. (Section J.14)
23. The Psychiatry Department should provide a more detailed synopsis of the results of the Neurology Clinic in the corresponding Quarterly Review for each individual reviewed in the Neurology Clinic during the prior three-month period. This also should serve as a prompt to discuss this information with the members of the IDT that attend those meetings. (Section J.15)

SECTION K: Psychological Care and Services	
Each Facility shall provide psychological care and services consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o Presentation for Section K at the entrance meeting, on 2/13/12; o Section K Presentation Book, including: Self-Assessment, updated 2/1/12; Settlement Agreement Cross Referenced with ICF-MR Standards; ABSSLC Provision Action Information, updated 1/30/12; Action Plan, K.13, updated 2/2/12; Action Plan, K.5, updated 2/2/12; Action Plan, K.4, updated 2/2/12; Psychology Procedure, Assuring Effectiveness of Positive Behavior Support Plans (Monthly Progress Review), revised 12/16/11; Monthly Progress Note template, revised 12/16/11, and samples; Action Plan K.6, updated 2/2/12; Psychology Procedures, Development of Behavior Supports; Abbreviated Functional Assessment template, revised 12/1/11; Behavior Support Plan template, revised 12/28/11; Behavior Support Committee Review and Revision templates; Requesting Counseling Protocol, dated 10/09; Counseling Referral Form, dated 9/26/01; Action Plan, K.9, updated 2/2/12; Functional Behavior Assessment Rating Scale; Action Plan, updated 2/2/12; Psychology Procedure, Assessing the Implementation of Positive Behavior Support Plans and Safety Plans, revised 7/21/11; Tracking of PBSP Monitoring, 7/11 to 12/11; Monthly Report of Engagement, Integrity and Reliability (I/R), 1/12; Instructions for PBSP I/R Monitoring, revised 7/29/11; ABSSLC PBSP Monitoring Form; Psychology Procedures, Behavior Services Team, dated 9/11; BSP/SPCI Skills Checklist, Individual #95; BSP Competency Checklist and Special Needs Training, Individual #505; and Action Plan, K.7, updated 2/2/12; o List of course work completed by Associate Psychologists, dated 12/7/11; o Section 2 Staff Services: Periodic Verification of Licensure and Registration, dated 7/6/11; o Narratives written by Associate Psychology staff regarding individual cases; o Psychology Department Meeting minutes: 8/19/11, 9/22/11, 10/20/11, 11/17/11, and 12/16/11; o Behavior Support Committee Meeting minutes: 8/3/11, 8/10/11, 8/17/11, 8/24/11, 8/31/11, 9/7/11, 9/14/11, 9/21/11, 9/28/11, 10/5/11, 10/12/11, 10/19/11, 10/26/11, 11/2/11, 11/9/11, 11/16/11, 11/23/11, 12/7/11, 12/14/11, 12/21/11, and 1/4/12; o External Peer Review reports: 8/8/11 to 8/12/11, 9/12/11 to 9/16/11, 11/14/11 to 11/18/11, and 12/19/11 to 12/23/11; o Psychology Monthly Progress Notes from 10/11 to 12/11 for: Individual #319, Individual #151, Individual #534, Individual #518, Individual #13, Individual #156, Individual #48, Individual #466, Individual #153, Individual #507, Individual #109, Individual #17, Individual #363, Individual #98, Individual #395, Individual #396, and Individual #504; o Psychology Monthly Progress Notes from 9/11 to 11/11 for: Individual #278, and Individual #384; o Data Sheets from 2/13/12 to 2/19/12 for: Individual #23, Individual #371, Individual #140, Individual #344, Individual #525, and Individual #245;

	○ Behavioral Assessments for: Individual #23, Individual #267, Individual #123, Individual #180 (Draft), Individual #43, Individual #151, Individual #74, Individual #95, Individual #390, Individual #351, Individual #196 (Draft), Individual #48, Individual #318, Individual #293, Individual #153, Individual #507, Individual #313 (Draft), Individual #332 (Draft), Individual #17, Individual #323, Individual #98, Individual #395, Individual #245, Individual #205, Individual #9, Individual #504, Individual #284, Individual #414, and Individual #11; ○ Brief Functional Analysis for: Individual #178, and Individual #332; ○ Abbreviated Functional Assessment (Draft) and Behavior Support Plan (Draft) for Individual #197; ○ Behavior Protocol for: Individual #137, Individual #197, and Individual #142; ○ Treatment Plan, Group Therapy – Anger Management for: Individual #156, Individual #374, and Individual #301; ○ Treatment Plan, Individual Therapy for Individual #324; ○ Individual Treatment Plans for: Individual #163, Individual #517, Individual #319, Individual #81, Individual #48, Individual #231, Individual #149, and Individual #396; ○ Psychotherapy Progress Note (Individual Therapy) for: Individual #534 (11/10/11 to 2/2/12), Individual #156 (11/2/11 to 2/1/12), Individual #430 (11/2/11 to 2/1/12), Individual #324 (11/17/11 to 2/2/12), and Individual #327 (11/9/11 to 2/6/12); ○ Psychotherapy Progress Note (Group Therapy) for: Individual #267 (11/10/11 to 2/2/12 and 1/9/12 to 2/6/12), Individual #95 (11/2/11 to 2/1/12), Individual #156 (11/7/11 to 1/30/12), Individual #99 (11/9/11 to 2/1/12), Individual #313 (11/22/11 to 2/2/12), Individual #323 (11/7/11 to 12/6/11), and Individual #160 (11/7/11 to 1/2/12); ○ Skill Acquisition Program Data form: Circles Social Skills – Part 1, Circles Social Skills – Part 2, Problem Solving, Stress Ball Counting, and Stop – Think – Relax; ○ Behavior Support Plans for: Individual #23, Individual #164, Individual #199, Individual #123, Individual #319, Individual #151, Individual #534, Individual #95, Individual #216, Individual #390, Individual #518, Individual #105, Individual #6, Individual #371, Individual #13, Individual #303, Individual #188, Individual #196 (Draft), Individual #505, Individual #48, Individual #104, Individual #466, Individual #318, Individual #507, Individual #313 (Draft), Individual #332, Individual #17, Individual #278, Individual #8, Individual #444, Individual #363, Individual #323, Individual #215, Individual #67, Individual #98, Individual #508, Individual #395, Individual #396, Individual #324, Individual #510, Individual #504, Individual #414, and Individual #11; ○ Human Rights Committee Meeting minutes: 8/2/11, 8/9/11, 8/16/11, 8/23/11, 8/30/11, 9/6/11, 9/13/11, 9/20/11, 9/27/11, 10/4/11, 10/11/11, 10/18/11, 11/8/11, 11/15/11, 11/29/11, 12/6/22, 12/12/11, and 12/20/11; ○ Tracking list of individuals, plans, and consents; ○ Consent/Approval Procedures, revised 2/12; and ○ Roster of Psychology Assistants and Behavioral Services Team members. ▪ **Interviews with**: ○ Ron Manns, Board Certified Behavior Analyst (BCBA), Director of Behavioral Services, on

	2/13/12; o Associate Psychology Staff, including Shana Huff-Carroll, Stacy Dow, Jenni Jamison, Kathryn Jones, Erin Lomasney, Adam St. Cyr, Sara St. Cyr, from 2/13/12 to 2/16/12; o Shae Butts, Human Rights Officer, on 2/14/12; and o Jerry Griffin, DDS, and Pam Acevedo, Dental Hygienist, on 2/16/12. ▪ **Observations of**: o Residence 5961, Residence 5962, Residence 5971, Residence 5972, Residence 6330, Residence 6350, Residence 6360, Residence 6370, Residence 6390, Residence 6400, Residence 6450, Residence 6480, Residence 6500, Residence 6510, Residence 6521, Residence 6690, Residence 6710, Residence 6720, Residence 6730, Residence 6740, Residence 6750, and Residence 6760; o Activity Center 5921, Activity Center 5922, Activity Center 5923, Activity Center 6340, and Activity Center 6700; o Senior Center; o Workshop 1, Workshop 2, and Workshop 3; o 5th Street Diner; o 7th Street Dental Clinic; o Center Incident Management Review Team (IMRT) Meeting, on 2/14/12 and 2/15/12; o Human Rights Committee Meeting, on 2/14/12; o Behavior Support Committee Meeting, on 2/15/12; o Community Discharge Living Plan Meeting for Individual #539, on 2/16/12; o Restraint Reduction Committee Meeting, on 2/16/12; and o Weekly IDT Meeting, Residence 6400, on 2/13/12.
	Facility Self-Assessment: The Facility's Self-Assessment provided a brief outline of several steps that had been taken to meet the requirements of the Settlement Agreement. 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. The Facility's Self-Assessment indicated substantial compliance with Section K.3 related to a peer-based system for review of behavior support plans. The Monitoring Team found the Facility to be out of compliance with this provision. This is explained in further detail below. The Facility's Self-Assessment also indicated substantial compliance with Section K.13 of the Settlement Agreement. Although the Facility does employ sufficient Associate Psychologists and Psychological Assistants to meet the identified ratios of staff to individuals, none of the Associate Psychologists were credentialed as Board Certified Behavior Analysts, and the quality of behavioral programming at the Facility was not of adequate quality to conclude that these staff had the necessary competencies. Therefore, the Monitoring Team found the Facility to be out of compliance with this provision.

	Progress towards compliance was noted in several areas. The following provide examples of information included in the Facility's Self-Assessment that was consistent with the Monitoring Team's findings: ▪ 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. However, consistent adherence to these guidelines was not always evident in the progress reports reviewed. ▪ Behavioral assessments were being completed in accordance with the outline developed by the Director of Behavioral Services. Assessment activities included indirect and descriptive measures. The completion of structured preference assessments had been introduced. A summary of setting events, antecedents, consequences, hypothesized behavioral function, and recommendations for programming were provided. ▪ Therapeutic support, in the form of on-campus counseling, had been expanded to include a greater number of individuals in person-specific therapy or group counseling activities. ▪ 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. ▪ Steps had been taken to gather measures of treatment integrity through staff interview and role-play. 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. Completed self-monitoring forms were provided. However, without accompanying documentation, it was difficult to assess the accuracy of the report and inter-rater reliability. Compliance scores provided in the Self-Assessment suggested an overall score, which did not assist in identifying specific areas that required additional attention and 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, one Associate Psychologist had taken the certification exam, and fourteen others continued to complete coursework in pursuit of certification. The Director of Behavioral Services met the requirements outlined in the Settlement Agreement, and continued to provide the required supervision to his staff. Both internal and external peer review continued. A review of minutes from the Behavior Support Committee and observation of this meeting during the Monitoring Team's onsite visit indicated that thoughtful feedback and recommendations were provided regarding the content of behavioral assessments and resulting behavior support plans. The Behavior Support Committee continued to provide internal peer

	review for plans developed or revised annually. There remained no mechanism for regular and timely internal peer review of particularly challenging cases. 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. As the Director of Behavioral Services reported, the role of these consultants was increasingly focused on staff training. Accommodations will be necessary to ensure regularly scheduled external peer review occurs. 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. Annual psychological assessments and functional behavior assessments had been combined to streamline the work of the psychology staff. While these assessments followed a similar format, the content of the assessment varied across individuals. Outdated measures of cognitive abilities and adaptive behavior were often reported, descriptive assessment of problem behavior was often limited, and recommended changes to the behavior support plan did not always reflect the information gained from the assessment. Behavior support plans were inconsistent in quality of services offered. Greater emphasis was needed on the teaching of functionally equivalent replacement behaviors; varied preventative strategies, including expanded opportunities for active treatment; enriched schedules of reinforcement for appropriate behavior; and individualized consequences that correspond to the hypothesized function. On-the-job competency-based training remained a challenge. As staff training improves, there should be a corresponding improvement in treatment integrity.

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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	Ron Manns, M.S., BCBA, continued to serve as 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. One Associate Psychologist had completed the course work and supervision requirements, and had taken the exam in January. Fourteen of the remaining 18 Associate Psychologists (78%) were listed as enrolled in the Spring 2012 semester, continuing to complete coursework offered through the University of North Texas. The four who were not enrolled included the Licensed Professional Counselor, a psychologist who was temporarily unenrolled, a newly hired psychologist who planned on enrolling in	Noncompliance

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	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.	the future, and one psychologist who was considering retirement. Of those enrolled, six were expected to take the exam in the Fall of this year, with five others expected to take the exam in the Spring of 2013. Mr. Manns continued to provide the required supervision to those enrolled. He also had obtained approval for four staff members to attend the Texas Applied Behavior Analysis (ABA) conference the Friday of the Monitoring Team's visit. The State and Facility are commended for their ongoing support of staff pursuing certification as behavior analysts. At the time of the visit, Mr. Manns remained the only Board Certified Behavior Analyst. This provision item was rated as being in noncompliance because the Associate Psychologists in the Department of Behavioral Services 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 quality of behavioral programming are discussed in further detail below with regard to Section K.9 of the Settlement Agreement.	
K2	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall maintain a qualified director of psychology who is responsible for maintaining a consistent level of psychological care throughout the Facility.	Ron Manns, M.S., BCBA, remained as the Director of Behavioral Services. As noted previously, Mr. Manns met the requirements outlined in the Settlement Agreement. He had a Master's Degree in psychology, was a Board Certified Behavior Analyst, and had experience in excess of five years working in the field of developmental disabilities. Throughout the week of the onsite review, the Monitoring Team spoke with a number of Associate Psychologists. Consistently, the feedback regarding Mr. Manns' supervisory skills was very positive. Staff described him as very helpful, thoughtful, and consistent in his approach to service delivery. Several stated that although the changes he had initiated had resulted in hard work, the outcome was better plans, resulting in better services to the individuals who reside at ABSSLC. The Facility maintained a policy to ensure periodic verification of all licenses and certifications. The Facility was found to be in substantial compliance with this provision.	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. Minutes from 21 meetings were reviewed. Membership included the Director of Behavioral Services, Associate Psychologists, and the Director of Speech and Language Services. Also present were the Clinical Pharmacist (five of 21 meetings) or a Registered Nurse (14 of 21 meetings). When individual behavioral assessments or behavior support plans were presented for review, written feedback was provided to the presenting psychologist. A review of 108 feedback documents was completed. Overall, comments were positive, with questions and suggestions presented clearly and thoughtfully. Examples include the following: ▪ The psychologist was asked to review the data to ensure that aggression Individual #43 displayed really was worse following a return from family visits. Included was a statement that this "campus myth" was often not supported by	Noncompliance

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		the data. ▪ For individual #207, staff were advised to check on whether a decrease in problem behaviors was an artifact of poor data collection from her recently introduced work site. ▪ Staff were cautioned about a phone restriction for Individual #267, based on concerns that this might not have the desired effect on her behavior. ▪ Contradictions in response to problem behaviors were noted in the behavior support plan for Individual #199. ▪ A preference assessment was recommended for Individual #363 to help expand her range of interests. ▪ The psychologist for Individual #323 was advised to include in his behavior support plan direct and clear instructions to staff. Advice was also given to describe the replacement behavior the individual will exhibit versus the behavior staff would exhibit. ▪ Staff were advised to increase teaching opportunities for Individual #388 to learn her replacement behavior. ▪ The psychologist for Individual #483 was advised to describe behavior in observable terms rather than using terms that implied mentalistic concepts. ▪ Staff were advised to provide a switch that could be activated by Individual #17 to gain the attention of staff, because raising her hand, the proposed replacement behavior, was not likely to be more effective than her problem behavior. ▪ The psychologist for Individual #463 was advised to describe what she observed when completing her functional behavioral assessment. In sum, the feedback provided to staff regarding behavioral assessments and behavior support plans was clear and comprehensive. When assessments and/or plans are approved with recommendations, it is important that a mechanism be in place to ensure that changes are made accordingly. At the time of the Monitoring Team's onsite review, this assurance was not clearly indicated. Observation of the meeting held during the week of the onsite review reflected committee members' active participation with discussion focused on improvements to the assessment process and resulting supports offered to the individual. However, presenting staff members should make every effort to be on time to these meetings. 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 August, September, November, and December 2011. Each report provided a summary of recommendations that addressed general home considerations and more individual-specific strategies. As noted previously, areas	

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		addressed included: reinforcement systems; active treatments strategies; plans for ensuring treatment integrity, including competency checklists; and staff training on skill acquisition procedures. The written feedback was comprehensive and clear. Specific concerns related to this feedback is provided below: ▪ In August, the consultants provided a description of a home-based reinforcement program for individuals living in Residence 6400. Guidelines were included to follow when one individual consumed an edible reinforcer given to another individual. Staff were advised that if this were to occur, both individuals would permanently lose edible reinforcer privileges. This was a very harsh response that could impede progress. ▪ In this same report, feedback was provided regarding Individual #425. Staff were advised to require this individual to exchange a token whenever he wanted to interact with someone other than his assigned staff member. Paying for social interactions with staff members should be considered a restriction of the individual's rights. ▪ The report from September noted that Individual #287 had a prescription for body wash and shampoo. However, home staff, including the manager, were unaware of this prescription. A follow-up visit in November revealed the individual's continued use of non-prescription personal hygiene products. Such poor implementation of prescribed treatments is a serious concern. The Director of Behavioral Services reported that he receives the feedback and then disseminates it to the Associate Psychologist assigned to the home and/or individual. When he was asked about some of these concerns, he indicated that he would need to approve any changes to the behavior support programs prior to implementation. To help ensure the implementation of only appropriate recommendations, the Director of Behavioral Services should delete unacceptable or concerning recommendations prior to dissemination, or specify that they were not to be implemented. The Facility clearly had established a peer-based review system for behavioral assessments and behavior support plans. The Behavior Support Committee, chaired by the Director of Behavioral Services, provided internal peer review. The participation of staff from other disciplines was commendable. It is recommended that Psychological Assistants, Behavior Services Team members (as appropriate), and direct support professionals be invited to participate. They likely would be able to provide valuable insight regarding the individual and feedback regarding the implementation of behavior change strategies. At the time of the Monitoring Team's visit, internal peer review was restricted to correspond to the individual's annual planning meeting. The planned addition of monthly case reviews had not yet been implemented. However, this was an important missing piece of internal peer review, and could assist the Facility	

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		in addressing the needs of individuals with particularly challenging behaviors that were not responding to current treatment. The Director of Behavioral Services explained that the external credentialed consultants were increasingly devoting their time to staff training. While this is likely a very useful service, this does not meet the requirements of external peer review. Plans were reported to introduce ongoing peer review with the Director of Behavioral Services at Corpus Christi State Supported Living Center. Regularly scheduled external peer review will be necessary to meet this provision of the Settlement Agreement. As noted previously, it will also be necessary to develop a Facility-specific policy outlining the internal and external peer review processes in place at ABSSLC. Due to these issues with internal and external peer review, the Facility remained out of compliance with this provision.	
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 57 progress notes representing 19 individuals were reviewed. These are identified in the section above listing documents reviewed. Three consecutive monthly reports were reviewed for each individual. Graphs depicting monthly occurrences of individual target behaviors were provided. Listed below each graph was the annual criterion for progress. For six individuals (i.e., Individual #156, Individual #153, Individual #278, Individual #363, Individual #384, and Individual #504), at least one monthly progress report reflected progress criterion that was out-of-date. A list of significant events in the reporting period was provided, followed by a summary of progress or lack thereof. The summaries did not always correspond to the information that was presented graphically. Examples included: ▪ Aggression displayed by Individual #151 was described as increased with a slightly decreasing trend. The graph indicated that the behavior had not occurred in November, down from four occurrences in October. ▪ Suicidal threats displayed by Individual #48 were noted to have decreased in October. However, the graph reflected an increase from zero occurrences the previous month to 11 occurrences in the current month. ▪ The October progress report for Individual #98 indicated a significant increase (zero to 30) in Emotional Outburst, but then concluded that this resulted in a stable trend. Medications were listed with notations of changes made following psychiatry clinic. Information regarding staff training, utilizing the Positive Behavior Support Monitoring Tool and Reliability Probe was reported, with retraining usually indicated when necessary. Lastly, recommendations were provided. Changes to the behavior support plan were recommended for Individual #396, and a new plan was identified as necessary for Individual #151. Otherwise, no recommended changes were made regarding the	Noncompliance

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		behavior support plans. Although the Associate Psychologist was identified in all of the reviewed documents, none of the progress reports were signed. Other concerns included the following: ▪ Individual #534 was reported to have earned one of four reinforcement trips in October, and zero of five in November. A note indicated that the criterion for earning the trip was increased on 10/24/11. When she earned only one trip in December, the plan was to monitor for one more month before revising the criterion. It would appear that three months of limited access to this presumed reinforcer would be sufficient for determining a need for revision. ▪ Information was presented for the target behavior, threatening retaliation, for Individual #156. This was referenced as "junk" behavior. Again, it is recommended that staff refrain from using this term. ▪ From October through December, recommendations for Individual #156 included writing the individual's 2011 behavior support plan following the behavior protocol that had been updated on 8/30/11. This delay in developing the plan was concerning. ▪ Included under the list of events for Individual #278 were descriptions of staff response to her agitation that might function as reinforcement. This matter was not addressed in the recommendation section. One promising change was the addition of a report of progress on dental desensitization plans as found in the December report for Individual #507, and the November report for Individual #384. As noted previously, staff should consider changes to the behavior support plan when improvement is not observed. At the September department meeting, the Director of Behavioral Services advised his staff that if there were three consecutive months without progress, the following actions should be taken: review for treatment integrity and data reliability, review the behavioral assessment, review the behavior support plan, and consider recommendations for interdisciplinary supports. These were appropriate guidelines, as long as they result in appropriate supports for positive behavior change. Staff also should provide graphic display of targeted behaviors in a manner that will allow analysis of the effects of planned (e.g., changes to the behavior support plan, changes in medication, etc.), and unplanned events (e.g., sudden move in residence, health problems, etc.). Although target behaviors were presented individually, display of monthly totals remained a concern. Graphs reflecting monthly totals of identified problem behavior were included in all but one of the progress notes provided to the Monitoring Team. The one exception was the 12/11 report for individual #507 that included two graphs reflecting ratings of bizarre behavior and mannerisms/posturing assessed on 1/3/12 and 1/9/12.	

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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 from the week of the visit were checked for six of these individuals, clear discrepancies existed between what was observed and what was recorded. The following describes concerns noted: ▪ On 2/13/12, Individual #140 was observed hitting his chin against his throat, and biting his hands between 3:00 p.m. and 3:30 p.m. No occurrences of self-injury were recorded on his data sheet. ▪ On 2/14/12 at 7:55 a.m., Individual #525 was observed banging his head against his wheelchair. No occurrences of self-injury were recorded on his data sheet. ▪ On 2/14/12 at 8:10 a.m., Individual #23 was observed engaged in self-injurious behavior. There was no record of this behavior on his data sheet. ▪ On 2/14/12 between 5:00 p.m. and 5:15 p.m., Individual #371 was observed repeatedly crying with several of her peers telling her to be quiet or move to her bedroom. There was no record of this behavior on her data sheet. ▪ At 3:20 p.m. on 2/15/12, Individual #344 was observed hitting the arm of his wheelchair. This behavior was not recorded. ▪ On 2/14/12 at 5:50 p.m. and again on 2/15/12 at 5:25 p.m., Individual #245 displayed aggressive behavior. These behaviors were not recorded on her data sheet. A review of data sheets during the Monitoring Team's onsite review also revealed inconsistencies. A visit to one residence at 4:20 p.m. revealed data sheets that had not been completed since 2:00 p.m. A visit to another residence revealed no data recorded since 2:00 p.m., although it was already 3:30 p.m. Even more concerning was a sheet used to record sweeps of the house to ensure it was safe for an individual who engaged in pica behavior. During a visit to the home at 3:30 p.m. on 2/15/12, sweeps were already recorded for the 2:00 p.m. to 10:00 p.m. shift on 2/16/12. A visit to another residence at 11:30 a.m. on 2/16/12 revealed data that was recorded through noon or 12:30 p.m. for that day. Such inaccuracies are very concerning, and potentially raise the issue of falsification of records. The Director of Behavioral Services reported his interest in reducing the use of Behavior Observation Notes in tracking problem behavior. This streamlining of data collection is positive as long as there remains a mechanism for staff to report particularly serious or unusual incidents. 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	

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		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. In addition, the monthly reviews psychology staff were completing were not yet adequate, and did not consistently result in changes being made to behavior support plans, as appropriate. 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.	The Facility continued to make improvements in standardizing the format for completion of Behavior Assessments. The following information was included: purpose of the assessment; functioning levels; diagnoses; date of last psychological evaluation; background information; a description of the individual's cognitive, adaptive, social, and affective profile; brief description of the current behavior support plan, including history of the targeted problems; assessment procedures; review of significant events over the past year; results of the assessment; conclusions regarding setting events, antecedent variables, consequences, and hypothesized behavioral function; and recommendations. While this information was included in all of the 29 reports reviewed, the quality of the assessments varied. The reports reviewed are identified in the section above listing documents reviewed. Specific comments related to Behavior Assessments are provided below: ▪ The assessments for two of the 29 individuals (7%) indicated that a full psychological evaluation was last completed less than five years previously. This results in concerns about the accuracy of the reported functioning levels noted in the reports. ▪ As noted previously, there were examples where very detailed history was provided. In the assessment for Individual #48, events dating back to 1990 were reviewed. Similarly, the assessment for Individual #293 included detailed information dating back to 2003. Much of this detailed information detracted from understanding the current variables that maintained the problem behaviors. While an individual's history is relevant, it could be briefly summarized to ensure a focus on the individual's current situation and needs. ▪ Every assessment (100%) identified both indirect and direct procedures for gathering information related to behavioral function. Rating scales (Questions About Behavioral Function and/or the Functional Assessment Screening Tool), interviews (the Functional Assessment Interview Form), and direct observation were identified as the methods employed. Notably, the information gained through descriptive assessment (i.e., direct observation) varied across reports. Examples where good detail was provided were the reports for Individual #74, Individual #95, and Individual #318. Examples where details from the observations were limited included the reports for Individual #351 and Individual #332. As indirect assessment relies on the perceptions of others, the accuracy of the information gained is questionable. Greater emphasis should be	Noncompliance

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		placed on the information gained through direct observation. It is notable that the Director of Behavioral Services had emphasized this point. ▪ Preference assessments were identified with the date of completion in only eight reports (28%). In the reports for Individual #196, Individual #332, and Individual #245, a preference assessment was indicated, yet the information was based on staff interview. Staff should provide a clear description of the methods employed to assess the individual's preferences. ▪ All of the reports included a summary of setting events, antecedents, consequences, and hypothesized behavioral function. Again, the quality and clarity of this information varied across reports. Twenty of 29 reports (69%) provided an adequate summary of this information. The report for Individual #74 included very specific and helpful information. ▪ While replacement behaviors were identified in all of the reports, the degree to which these were functionally equivalent to the problem behaviors varied. Ten of 29 reports (34%) provided suggestions for replacement behavior designed to result in the same outcome as the targeted problem behavior. An example of appropriate proposed replacement behaviors was found for Individual #390 who was going to learn to request items, and ask staff to stop when a non-preferred task was presented. An example where the proposed replacement behaviors did not appear to meet the same function as the target behavior was found in the report for Individual #23. He was going to learn to wait, although he reportedly engaged in his problem behavior to access food or to escape noise or pain. It was unclear how waiting would serve the same function. Staff should identify replacement behaviors that are more efficient in obtaining the same hypothesized outcome as the problem behavior. ▪ None (0%) of the assessments were signed. Other feedback related to individual-specific assessment reports is provided below: ▪ The report for Individual #95 indicated that the psychologist had probed different interventions during one observation. This effort to test the function of the behavior through manipulation of consequences was commendable. ▪ The report for Individual #313 included multiple repetitions of the same information following each review of targeted behaviors. This information could have been stated once, reducing the length and redundancy of the report. ▪ Individual #153 was noted to demonstrate "… several compliance activities, such as raising his hands when prompted, stick 'em up." Instructions such as this are inappropriate for use in the Facility. ▪ The report for Individual #507 referenced his autism diagnosis as a contributing factor. While this is most likely true, the general description of autism does not lend any valuable information to understanding the function of this individual's problem behaviors. The individual's observed behaviors are what are	

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		important. ▪ Individual #17 was going to learn to raise her hand to obtain attention or to indicate a request for something to do. In a crowded environment, it is unlikely that raising her hand will result in attention from staff more quickly than her current problem behaviors. ▪ Individual #9 was going to learn to sign "wait" to delay a non-preferred task. While this is an appropriate replacement behavior, the training indicated that he would need to sign a total of three times before staff would implement the delay. This required effort was not an efficient or less effortful way to request a delay. ▪ Continued reference to "junk" behavior is ill advised as observed behaviors serve some function for the individual. The Facility also provided evidence of completion of brief functional analyses completed for Individual #178 and Individual 332. The Director of Behavioral Services had conducted these structured analyses to better understand the function of self-injury and hostility, respectively. For both individuals four conditions were presented in randomized order. These conditions were as follows: the individual was observed while alone in a room, attention was provided contingent upon the target behavior, attention and access to preferred activities was provided non-contingently, and demands were withdrawn contingent upon the target behavior. Conclusions were based on comparisons of the rates of the target behavior in each condition. During the onsite review, the Monitoring Team observed an Associate Psychologist conducting a similar analysis in the workshop setting with Individual #99, who had been experiencing a sudden worsening of behavior. This thoughtful and carefully designed analysis of behavioral function is a commendable practice. 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. As noted with regard to Section K.6, in a sample of 29 individuals, the most recent full psychological evaluation was often quite dated. In only two of the 29 cases (7%) was the evaluation less than five years old. As has been recommended previously, more frequent assessment of an individual's cognitive abilities and adaptive behavior is necessary. The Facility remained out of compliance with this provision due to issues related to the quality of behavior assessments, as well as the timely completion of updated	

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>psychological evaluations.</td><td></td></tr>
<tr><td>K6</td><td>Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall ensure that psychological assessments are based on current, accurate, and complete clinical and behavioral data.</td><td>Information regarding the date of an individual's most recent full psychological evaluation was found in the Behavioral assessments. The information provided is summarized below:

<table>
<tr><th>Individual</th><th>Date of Evaluation</th><th>Individual</th><th>Date of Evaluation</th></tr>
<tr><td>Individual #23*</td><td>7/24/90</td><td>Individual #507</td><td>7/13/93</td></tr>
<tr><td>Individual #267</td><td>1/23/02</td><td>Individual #313</td><td>5/17/96</td></tr>
<tr><td>Individual #123</td><td>10/11/88</td><td>Individual #332</td><td>9/1/95</td></tr>
<tr><td>Individual #180*</td><td>10/4/02</td><td>Individual #17</td><td>3/30/89</td></tr>
<tr><td>Individual #43</td><td>5/17/89</td><td>Individual #323</td><td>2/6/02</td></tr>
<tr><td>Individual #151*</td><td>2/21/90</td><td>Individual #98</td><td>3/12/90</td></tr>
<tr><td>Individual #74</td><td>9/17/95</td><td>Individual #395*</td><td>5/25/88</td></tr>
<tr><td>Individual #95</td><td>3/22/11</td><td>Individual #245</td><td>4/25/88</td></tr>
<tr><td>Individual #390*</td><td>2/9/10</td><td>Individual #205</td><td>9/18/89</td></tr>
<tr><td>Individual #351*</td><td>6/17/89</td><td>Individual #9</td><td>8/20/95</td></tr>
<tr><td>Individual #196</td><td>4/4/89</td><td>Individual #504</td><td>1/24/05</td></tr>
<tr><td>Individual #48</td><td>8/8/98</td><td>Individual #284*</td><td>4/27/93</td></tr>
<tr><td>Individual #318</td><td>4/6/00</td><td>Individual #414*</td><td>1/10/86</td></tr>
<tr><td>Individual #293</td><td>2/12/88</td><td>Individual #11*</td><td>5/23/94</td></tr>
<tr><td>Individual #153</td><td>8/12/95</td><td></td><td></td></tr>
</table>

The following statement or something similar was included in the report for nine (noted by asterisk) of these 29 individuals (31%): "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, this statement suggested that training and habilitation had been ineffective for a time period of one to 25 years. For the remaining 20 individuals, evaluations were between several months to 23 years old. In only two of the 29 cases (7%) was the evaluation less than five years old.

On average for this sample of individuals, full psychological evaluations had been completed 16.52 years before the date of the behavior assessment. This did not provide current information regarding the individual's cognitive abilities or adaptive behavior. Psychological evaluations should be updated on a regular basis. Problems with data collection are reviewed in detail with regard to Section K.4.

Based on the inadequate clinical and behavioral data available and/or incorporated into psychological assessments, the Facility remained out of compliance with this provision.</td><td>Noncompliance</td></tr>
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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.	Three individuals were admitted to the Facility in the last six months (i.e., Individual #197, Individual #137, and Individual #142). A request was made for the initial psychological assessment completed for each of these individuals. The Behavior Protocols were provided for the three individuals, as well as the draft of the Abbreviated Functional Assessment for Individual #197 and her resulting draft Behavior Support Plan. No other documentation related to psychological assessment was provided. While the Abbreviated Functional Assessment for Individual #197 provided information related to her health, diagnosis, identified problem behaviors, and observed skills in some areas, missing was information regarding standardized assessment of cognitive abilities or adaptive behavior. A comprehensive assessment of adaptive behavior was also not provided. The Behavior Protocols for Individual #137 and Individual #142 provided information regarding problem behaviors, but gave no other information about the person's cognitive abilities and adaptive behavior skills. The Facility was out of compliance with the provision of the Settlement Agreement that requires psychological assessment of newly admitted individuals within 30 days. As noted with regard to Section K.6, in a sample of 29 individuals, the most recent full psychological evaluation was often quite dated. In only two of the 29 cases (7%) was the evaluation less than five 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.	Noncompliance
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 list the Facility provided of individuals receiving counseling, 27 individuals were receiving individual counseling from providers not employed by the Facility. An additional 30 individuals were identified as receiving individual and/or group counseling services from the Licensed Professional Counselor employed within the Psychology Department. Groups included topics such as anger management (total of nine participants), adolescent social skills group (two individuals), adult social skills groups (total of seven individuals), community readiness (four individuals), and anxiety management group (three individuals). It was unclear whether all treatment strategies were evidence-based, because no supporting documentation was provided. For those receiving services from the staff member the Facility employed, the following documents were reviewed: treatment plans for four individuals, psychotherapy notes for seven individuals participating in group sessions, and psychotherapy progress notes for five individuals receiving individual services. Additionally, a review was completed of treatment plans for eight individuals receiving counseling services from two independent providers. The specific documents reviewed are detailed above in the	Noncompliance

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		documents reviewed section. The following summarizes the results of this review: ▪ Goals were included in every document, but one. The anger management progress note for Individual #267 did not include a goal. However, as noted previously, none of the goals (0%) were described in observable and measurable terms with clearly established criteria for determining progress or the lack thereof. Also missing were the conditions under which the behavior was to occur. ▪ None of the documentation (0%) included failure criteria that would trigger a review or revision. ▪ Further, there were no measurable goals to ensure generalization of the skills learned in therapy to other environments (0%). ▪ It was also difficult to determine whether counseling services had been introduced in a timely manner, because dates of referral and initiation of services were not identified. ▪ None of the treatment plans or progress notes were signed (0%). 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. When resistance to counseling is evidenced through refusal to participate, it would be advisable to meet with members of the ISP team, including the individual, to develop strategies to improve attendance. Consideration should be given to behavioral contracting with the individual. All actions taken should be identified and recorded. The Facility also provided copies of five Skill Acquisition Program Data forms addressing the following activities: Circles Social Skills, parts 1 and 2; problem solving; stress ball counting; and stop-think-relax training. Teaching strategies were identified as one of four types of chaining methods, and prompting was identified as either least-to-most or most-to-least. Steps were then outlined. It appeared that these were a very rudimentary beginning to developing a data-based system to track an individual's progress. As the Facility moves forward with this system, staff should review the components of a behavioral objective to ensure that all necessary information is identified. Given the concerns related to counseling, and the other alternative treatments that the Facility offered individuals through skill acquisition programs, the Facility remained out of compliance with this provision.	

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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 43 individuals were reviewed. These individuals are identified above in the documents reviewed section. The format was consistent across all plans and remained as described in the Monitoring Team's last report. Review of these plans resulted in similar findings as reported previously. Therefore comments from the last report that remained relevant are repeated below: ▪ Dates of implementation were provided in 37 of the 43 plans (86%). The date of the ISP was identified in two draft plans (i.e., Individual #196 and Individual #313), and the completed plans for Individual #215 and Individual #414. The date the staff were trained was provided in the plan for Individual #67. No date was included on the plan for Individual #323. As suggested previously, 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. ▪ Target behaviors were listed in the first section of the plan. However, the operational definition of the target behavior and method of measurement or data collection system was present in this section in only two of 43 plans (5%). It should be noted that this information was provided later in the existing plans. 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. Notably, the two draft plans provided the definition of the targeted behaviors in this introductory section. A description of data collection was provided later in these plans. ▪ It was clear that changes were being introduced with regard to the inclusion of psychotropic medication in the behavior support plans. Twenty-one of the 43 plans (49%) included a brief statement regarding the individual's current medication regimen. ▪ The "Revision and Review" section indicated that the plan was being revised in conjunction with the annual PSP/ISP, in response to an updated behavior assessment, due to a change in data collection, or with specific changes to the content of the plan. A broad rationale for a behavior support plan was provided in table format in 37 (86%) 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 their effectiveness. ▪ The next section of the plans included a description of activities and outcomes from recent Behavior Assessments and a list of identified reinforcers. The date of completion of the functional behavior assessment or specific assessment activities was provided in only 13 of the plans reviewed (30%). In the plans for Individual #196, Individual #313, and Individual #414, there was no reference to a completed assessment, nor was there an identification of behavioral function in these first two plans. Staff should briefly review the assessment activities (e.g., staff interview and direct observation), indicate the date of	Noncompliance

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		completion, and summarize the information gleaned. Hypotheses should be clearly stated with review of the conditions in which the behavior is most likely and least likely to occur. The primary purpose of describing the potential function of the targeted problem behavior(s) 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. ▪ 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 (not staff interview) and resulting information are reported in the behavior support plan. ▪ Baseline or comparison data was clearly reported in 41 or 43 plans (95%). No comparison data was provided in the plan for Individual #414, and the data included in the plan for Individual #11 was unclear. Psychotic behavior was noted as occurring less than one percent and sleep disturbance was listed as three. It remained unclear what the measure referenced. ▪ Data collection was described in all of the plans (100%). However, the plan for Individual #23 noted the use of a partial interval recording system, but later in the plan staff were advised to record frequency. Although self-injury was the target behavior identified for Individual #414, staff were directed to document injuries in an incident report. There were no measures of the self-injurious behavior. The BSP for Individual #414 identified the PSP date of 12/5/11. ▪ All of the plans reviewed included definitions of identified problem behaviors. The majority of the plans provided observable descriptions of targeted problem behavior. One example where the target behavior was less clear was provided in the plan for Individual #319. His disruptive behavior was defined as "any behavior that interferes with his or his peers' schedule to a significant degree…" Although examples of observable behaviors were provided, this definition was very subjective. Staff should make every effort to describe target behaviors in observable and measurable terms to ensure accuracy in data collection and program implementation. ▪ 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 17 (40%) of the plans. Staff should identify clear 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	

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		that these behaviors are observable and measurable. ▪ 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. For example, Individual #216 was to learn to use his communication book to make choices, but his book was kept on the back of his chair. Individual #123 and Individual #6 were learning to request food or drink, yet teaching opportunities were dependent upon staff instruction. Individuals should learn to display functional communication skills without reliance on a question posed by another. The plan for Individual #414 referenced sensory items and techniques outlined in a report from the occupational therapist. Teaching strategies to develop replacement behaviors should be clearly outlined in the behavior support plan and ISP. Directing staff to review other documents only increases concerns regarding treatment integrity. ▪ 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. As staff continue to make observations as part of their ongoing functional assessment efforts, specific preventative strategies should be expanded and added to the behavior support plans. Some concerns were noted. For example, in an effort to prevent pica, Individual #151 was to be given candy spray or Listerine strips prior to going outside. Concerns were raised regarding the possibly aversive quality of Listerine strips, unless this was a specific preference of the individual. On a positive note, the plan for Individual #395 appropriately advised staff to spend time introducing themselves before providing medical care. ▪ Schedules of reinforcement sufficient to promote positive behavior change were present in few of the plans reviewed, specifically, 17 of the 43 (40%). Reinforcement that is available once per shift or once per week will not be sufficient to result in improved behavior. Examples included Individual #123, Individual #319, Individual #13, Individual #332, Individual #278, Individual #8, Individual #363, Individual #508, and Individual #324. 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. As noted with regard to Section K.5, staff also should conduct frequent preference assessments. ▪ Treatment procedures were described in clear terms. 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 23, or	

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		53%, 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. At least two plans (i.e., Individual #151 and Individual #95) advised staff to ask, but not require the individual to clean up following targeted behavior. The individual might simply learn not to listen to instructions. Staff should provide instruction only when follow through is expected. Other plans included consequences that clearly could produce a strengthening of the identified problem behavior. For example, although the hypothesized function of this behavior was escape, Individual #518 was to be offered a break if she displayed aggression. In the plan for Individual #23 staff were advised to physically prompt him to sign, yet his assessment report indicated that it was not physically possible to shape his hand to produce a sign. Individual #371 tore clothing, yet contingent upon this behavior, she was to be encouraged to shred cloth that was provided to her. This was a fine discrimination that could be very difficult to learn. Numerous examples of this have been provided in the Monitoring Team's previous reports. ▪ The author of the plan was identified in 36 of the 43 plans (84%). None of the plans were signed. It is strongly recommended that all plans be signed, indicating the author and any supervisory staff who provided review. The Human Rights Committee maintained a regular schedule of weekly meetings. Minutes of 20 meetings held between 8/2/11 and 12/20/11 were reviewed. Two of these 20 scheduled meetings were cancelled due to the absence of either a parent or non-affiliated member. The meeting held on 11/8/11 was noted as cancelled for the same reason indicated above, yet minutes were provided. Of the remaining 17 meetings, members present included the Human Rights Officer or her designee, a parent or non-affiliated member, and a psychologist. Medical personnel and an individual residing at the Facility were present in 16 (94%) and eight (47%) of these meetings, respectively. The responsible Associate Psychologist continued to present individual behavior support plans. As discussed with the Human Rights Officer, changes to the meeting minutes are recommended. Individuals' names and the related topic were recorded, but the content of the discussion was absent. Further, there was no mechanism to ensure that concerns raised or recommendations provided were addressed. This feedback loop is essential to ensure that the Human Rights Committee functions as intended. It also would be helpful to have a legend explaining the disposition codes. For this review, the timeliness of consent for behavior support plans was very difficult to determine. A document was provided to the Monitoring Team that indicated the date of the Behavior Support Plan, the date it was presented to the Behavior Support Committee, and the date approval was obtained from the Human Rights Committee. Information was missing for many individuals. For 55 individuals, the date of the plan and the date the	

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		plan was presented to the Behavior Support Committee were provided. For only nine individuals was the date of Behavior Support Committee presentation after the date of the plan development. For 29 individuals, the date of the plan and the date of approval by the HRC were provided. In only two cases was the approval date after the date of the plan development. Given that in most cases, review and approval dates were prior to plan development dates, it was very difficult to interpret this data. It is essential to ensure timely review, consent, and training for all Behavior Support Plans. The Facility should develop a system that allows for accurate tracking of this information. Comments made in the last report are repeated here due to concerns raised during an observation of the Community Living Discharge Planning Meeting for Individual #539. Specifically, a date for his transition had been determined with training on his behavior support plan provided two days before his move. This short time frame does not allow the receiving staff to familiarize themselves with the plan, or to engage in thoughtful dialogue regarding the same. 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. This includes behavior support and habilitation plans. 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. Staff are encouraged to follow this recommendation particularly for individuals who present with complex needs and/or significant challenging behaviors. The Facility remained out of compliance with this provision due to ongoing concerns related to behavior support plans, inadequate documentation to confirm that consent and HRC approval had been obtained, as well as inadequate follow-up documentation related to HRC recommendations.	
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.	Graphs continued to display monthly occurrences of targeted behaviors. Axes were labeled, and data points and paths were displayed. Condition change lines and/or arrows were included depicting changes in medication, changes in residence, increased level of supervision, hospitalization, new behavior support plan, or specific daily events. Given that each graph depicted total frequency of the target behavior per month, it was difficult to ascertain the individual's response to these identified changes. Measures of inter-observer agreement or treatment integrity also were not depicted on any of the graphs. Monthly data display can mask critical changes in behavior that result from changes in intervention, changes in medication, including subtle changes to dosing, and	Noncompliance

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	Documentation shall be maintained to permit clinical review of medical conditions, psychiatric treatment, and use and impact of psychotropic medications.	changes related to health issues. As recommended previously, as appropriate, graphing of daily measures of performance will allow for better analysis of treatment efficacy. Although the Facility had begun collecting inter-observer agreement measures for behavior support plans, observations and review of documentation indicated that the accuracy of the data could not be assured as described with regard to Section K.4 of this report. Further, as described by the Director of Behavioral Services, simultaneous observation and recording of problem behavior by two independent observers was not yet an established practice at the Facility. As described in previous reports, the availability of data that Individual Support Plan Teams can have confidence in is essential to ensure that teams are making effective data-based decisions. 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.	Direct support professionals who were interviewed during the tour reported that behavior support plans were clearly written. When there were questions, staff reported that members of the Psychology Department were responsive in addressing these. However, while visiting the Facility, there was limited evidence of the use of strategies outlined in the behavior support plans that were reviewed. This included augmentative communication systems, active treatment, or response to problem behavior other than telling the person to stop or asking what was the matter. Even when observing individuals who were provided enhanced supervision, there was little evidence of efforts made to involve these individuals in interesting and functional activities. Greater emphasis should be placed on preventative and antecedent strategies to help reduce the occurrence problem behavior.	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.	Psychology Monthly Progress Notes reviewed for Section K.4 included statements regarding treatment integrity checks with staff. There was not sufficient information provided to clearly understand the process employed to check for treatment integrity and staff competency in implementing the plans. Some reports indicated the a check was completed with a particular staff member, others indicated the core competencies were reviewed, and others suggested that the Positive Behavior Support Monitoring tool had been completed with an identified staff member. In most instances, checks of less than 100% competency resulted in retraining. Several concerns remain. When the staff member providing the training was identified, it was often the Psychological Assistant. As Associate Psychologists write the plans and	Noncompliance

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		have completed at least some training in Applied Behavior Analysis, it is suggested that these are the individuals who should be taking the lead in providing training. Further, the information provided suggested that this training consisted of interviews with direct support professionals. As such, it appeared that most checks of treatment integrity occurred when staff were not working with the individuals served. Competency-based training requires that staff receive training, and, in part, their competence is measured as they carry out their job responsibilities. While these initial efforts to enhance staff training are commendable, the Facility will remain out of compliance with this provision of the Settlement Agreement until adequate competency-based training, including but not limited to an on-the-job component becomes the standard for ensuring competent performance. Tracking of didactic and competency-based training for all staff who provide support in residences, activity centers, workshops, and other environments is strongly advised.	
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, a total of 19 Associate Psychologists were 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 to identified individuals. With a census of 428, this resulted in a 1:24 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. Additionally, there were 19 direct support personnel who served as Behavior Services Team members. These staff were assigned to work in specific residences and/or with specific individuals based upon identified need. A rating of noncompliance has been made 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 of the Associate Psychology staff members (79%) were actively 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, including membership information, guidelines for annual review and ongoing presentation of individual cases, the role of external review, and review and dissemination of external peer review

recommendations. (Section K.3)

3. The Facility should encourage and support the inclusion and participation of Psychological Assistants, Behavior Services Team members, and direct support professionals in the Behavior Support Committee. (Section K.3)
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. If Behavior Observation Notes are limited or eliminated to streamline data collection systems, the Facility should ensure some mechanism exists for staff to report unusual or significant incidents. (Section K.4)
7. 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)
8. 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)
9. As recommended previously, one suggested format for behavior assessments 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. Particular emphasis should be placed on identifying functionally equivalent replacement behavior and preventative strategies. (Section K.5).
10. All documents should be revised to ensure that the term "junk" behavior is eliminated. (Section K.5)
11. The State and the Facility should develop and implement 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. For individuals newly admitted to the Facility, it is essential that a psychological evaluation be completed within the first 30 days. This evaluation can consist of a review of previous standardized assessments, but should include a timeframe for completion of assessment of cognitive abilities and adaptive behavior skills once the individual has acclimated to his/her new environment. If problem behaviors are evident, a functional behavior assessment also should be completed. (Section K.7)
13. 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. Additionally, ISP teams should meet to review and address repeated resistance to participation. (Section K.8).
14. The Facility should ensure that information regarding the functional behavior assessment is provided in the behavior support plan. The date of completion of the functional assessment along with a brief description of assessment activities should be identified, followed by statements identifying hypothesized behavioral function. (Section K.9)
15. Behavior Support Plans should be developed with greater emphasis placed on:
    a. Teaching of functionally equivalent 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;
    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; and

e. All plans should be signed, indicating the author and any supervisory staff who provided review. (Section K.9).

16. The minutes recorded during Human Rights Committee meetings should include clear descriptions of matters discussed. Further, the HRC should develop a mechanism to ensure that all recommendations and revisions are addressed prior to plan implementation. (Section K.9)
17. It would be helpful to have a psychiatrist or other identified professional periodically attend the Human Rights Committee meetings. (Section K.9)
18. 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)
19. 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)
20. 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)
21. 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).
22. The Facility should develop a master staff list with dates of training on behavior support plans and other critical supports. Training should be identified as general in-service training on behavior supports, individual-specific training via interview or role-play, and on-the-job competency-based training and assessment. (Section K.12)
23. 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. (Facility Self-Assessment)

SECTION L: Medical Care	
	Steps Taken to Assess Compliance: The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o List of all staff who work in the Medical Department, including names and titles; o Name and CV of Medical Director, if new since the last visit; o Name and degrees of all primary care providers that are new to Facility since the Monitoring Team's last visit; o Number of individuals on each physician's caseload; o Employees listed under Medical Department completing Cardiopulmonary Resuscitation (CPR) training certification with dates of completion, and dates of expiration; o Copy of any in-service for PCP training on ICD and DSM diagnostic criteria in last six months; o Since last on site Monitoring Team visit, copy of continuing medical education (CME) for each primary care provider, list CME credits according to topics reviewed, list per PCP of total CME credits during this time period; o Copy of any clinical guidelines developed and implemented since the Monitoring Team's last visit; o Minutes of infection control committee meetings during the prior six months; o Minutes of skin integrity committee meetings during the prior six months; o Most recent results/report of the medical quality improvement program, including identification of trends and descriptions of improvement actions taken; o For any medical staff meetings (morning medical meetings, etc.), copy of all minutes, handouts, logs from Infirmary, hospitalizations, and 24-hour reports discussed for 15 days prior to the Monitoring Team's visit; o Most recent/results report of the Facility-wide medical review system, including copy of any non-Facility physician review reports or data since last monitoring visit; o List of individuals who died since Monitoring Team's last visit. For each individual, provide date of death, death certificate, whether autopsy was done (and if so, copy of the 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 for: Individual #60, Individual #85, Individual #459, Individual #128, and Individual #131; o Mortality Reviews (clinical, administrative and nursing reports) since Monitoring Team's last visit; o Corrective actions related to Mortality Reviews, including status reports on previous recommendations; o Notes and orders for any Do Not Resuscitate Orders (DNRs) and rescinding of DNRs; o Current DNR list with reason/criteria for DNR; o List of death reports (clinical/ administrative) that remain incomplete/outstanding; o Most recent annual medical assessments and physical examinations and prior annual assessment and examination for following individuals: Individual #163 annual medical

	assessment 12/13/11, prior annual medical assessment 12/10/10; Individual #19 annual medical assessment 12/14/11, prior annual medical assessment 11/16/10; Individual #180 annual medical assessment 12/20/11, prior annual medical assessment 10/27/10; Individual #220 annual medical assessment 12/22/11, prior annual medical assessment 11/22/10; Individual #478 annual medical assessment 12/19/11, prior annual medical assessment 2/1/11; Individual #228 annual medical assessment 12/7/11, prior annual medical assessment 12/15/10; Individual #351 annual medical assessment 11/8/11, prior annual medical assessment 11/15/10; Individual #265 annual medical assessment 12/13/11, prior annual medical assessment 11/19/10; Individual #89 annual medical assessment 12/16/11, prior annual medical assessment 12/3/10; Individual #168 annual medical assessment 12/22/11, prior annual medical assessment 12/8/10; Individual #24 annual medical assessment 11/2/11, prior annual medical assessment 11/17/10; Individual #320 annual medical assessment 12/20/11, prior annual medical assessment 12/14/10; Individual #215 annual medical assessment 11/7/11 (submitted physical exam form was not completed), prior annual medical assessment 11/8/10; Individual #71 annual medical assessment 12/1/11, prior annual medical assessment 11/12/10; Individual #456 annual medical assessment 12/1/11, prior annual medical assessment 11/4/10; Individual #34 annual medical assessment 12/6/11, prior annual medical assessment 11/16/10; Individual #214 annual medical assessment 12/5/11, prior annual medical assessment 11/16/10; Individual #536 annual medical assessment 11/4/11, prior annual medical assessment 10/14/10; and Individual #70 annual medical assessment 12/2/11, prior annual medical assessment 12/1/10; o Specialty clinic schedule per month for past six months; o List of all outside consultations for medical purposes for the past six months, categorized by specialty; o For one individual from each residence for the past month, copies of all consultant reports (medicine and surgery inclusive of subspecialties) since Monitoring Team's last visit, and all integrated progress notes commenting on consultant reports (medicine and surgery inclusive of subspecialties) (agreeing or reason not agreeing) and any ISP addendum related to the consultant report; o List of individuals with: ▪ Tracheostomies; ▪ With Vagus Nerve Stimulator (VNS) and date of VNS placement (if applicable, replacement date); ▪ With fractures, date of fracture, type of fracture (compound, simple, stress, etc.), and bone fractured (location); ▪ With injuries requiring visit to ER or hospitalization since the last onsite review; and ▪ With pica or ingesting inedible object, date of ingestion, object ingested, whether taken to the ER or hospitalized, since the last onsite review; o Policies or procedures for medical screening and routine evaluations; o 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; o For those women over 40, date of last mammogram, and reason, if not up-to-date (guardian refusal, etc.); o Current list of all those with diagnosis of osteopenia/osteoporosis with medications and dosage per person (including calcium, Vitamin D, IV bisphosphonate, etc.), date of last DEXA scan or state none completed, copy of most recent DEXA scan reports for each individual with diagnosis of osteopenia or osteoporosis; o For individuals with Down syndrome, date of last thyroid test; 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 ER, and ER report for: Individual #371, Individual #75, Individual #452, Individual #187, Individual #157, Individual #94, Individual #50, Individual #468, Individual #414, and Individual #70; o For those going to ER and not hospitalized, copy of discharge orders from ER and copy of Facility orders, integrated progress notes/Infirmary progress notes, follow-up to any recommendations, for 10 most recent ER visits at least 30 days prior to the Monitoring Team's visit for the following individuals: Individual #296, Individual #371, Individual #75, Individual #201, Individual #187, Individual #157, Individual #94, Individual #447, Individual #468, and Individual #414; o For those admitted to hospital, copy of admission history and physical, discharge summary, copy of discharge orders/recommendations from hospital, and copy of Facility orders, integrated progress notes/Infirmary progress notes, and follow-up for any hospital discharge orders and recommendations, 10 most recent hospitalizations that have returned for at least 30 days for the following individuals: Individual #178, Individual #60, Individual #19, Individual #378, Individual #346, Individual #350, Individual #253, Individual #128, Individual #167, and Individual #103; o For 10 most recent hospitalizations that have been completed, copy of hospital liaison nurse documentation; o Length of stay for Infirmary admissions for past six months; o Infectious disease data per quarter by category of infection last two quarters; o Any summary report or trend analysis of infectious disease/communicable disease last two quarters; o Avatar pneumonia tracking forms for past six months; o For those 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, and last swallow study; o Absolute numbers of new cases (prior year, by month) for the following: pneumonia, decubitus ulcers, urinary tract infections (UTIs), and bowel obstructions; o Individuals' names, dates of diagnosis, specific diagnoses for past year for individuals who have been newly diagnosed with: malignancy, cardiovascular disease, diabetes mellitus, sepsis, bowel obstruction or bowel perforation, pneumonia; o List of individuals who have diagnosis of constipation or are receiving anti-constipation medication at least weekly;

	o All policies and procedures related to seizure management; o A list of all individuals being treated for seizure disorders, including name of individual, residence, diagnosis (type of seizure), and medication regimen; o For past six months, for five individuals, documentation of seizure management (neurologist's notes) for: Individual #543, Individual #275, Individual #498, Individual #193, and Individual #304; o List of individuals seen by neurologist with dates seen and reason, since Monitoring Team's last visit; o List of all those with status epilepticus, since the Monitoring Team's last visit; o List of seizure medications per individual for diagnosis of seizure disorder; o List of those going to ER for uncontrolled/prolonged/new onset seizure, since the Monitoring Team's last visit; o List of individuals with refractory seizure disorder; o List of individuals with refractory seizure disorder who are being evaluated for VNS placement and the stage of evaluation; o Percentage of individuals on one, two, three, four, and five antiepileptic drugs; o Percentage of persons on older antiepileptic drugs (Phenobarbital, Dilantin, Moline); o Any tracking of data for individuals who have transitioned to community in past one year, including hospitalizations, ER visits, and 911 calls. Any Facility review of adverse outcomes, communication with provider agency, and description of technical assistance provided. Information provided for the following individuals: Individual #402, Individual #438, Individual #188, Individual #243, Individual #58, Individual #251, Individual #130, individual #102, Individual #258, Individual #106, Individual #132, Individual #12, and Individual #357; o A list or lists currently available at the Facility identifying each individual who is identified to be "at risk" utilizing the State's risk categories, including, but not limited to the following categories, identifying for each individual: the applicable risk(s), the level of risk, the date the risk was identified, and whether an action plan is currently in place to address the risk(s): aspiration, aspiration pneumonia/non-aspiration pneumonia, chronic respiratory infections, contractures, gastroesophageal reflux disease, choking, dysphagia, falls, weight loss or gain, skin breakdown/decubitus ulcer, causing harm to self or others, impaction bowel obstruction/constipation, dehydration, pica, metabolic syndrome, seizures, osteopenia/osteoporosis, non-ambulatory or assisted ambulation, requiring mealtime assistance, poor oral dental status, receiving enteral feeding by type of tube (including individual's name, living unit, type of feeding, the date that the tube was placed, and if the individual is receiving pleasure foods), and/or chronic/acute pain; o For the last year, lists of individuals who have been identified with a diagnosis of pica, or who have had an incident of swallowing an inedible object, including the date of the incident and the object ingested; o For the last year, lists of individuals who have been seen in the Emergency Room, including the date seen at the ER, and reason for visit; admitted to the hospital, including date of admission, reason for admission, and discharge diagnoses, and date of discharge

	from hospital; admitted/transferred to the Facility's Infirmary, including date of admission/transfer, reason for admission transfer, and date transferred back to residence; been diagnosed with pneumonia, including date of diagnosis and type of pneumonia; and/or have had a swallowing incident (defined as an event during eating that required an emergency intervention), including the date of incident, item that caused the swallowing incident, and the interventions following the incident; o Presentation Book for Section L; o The following components of the active medical record: DG-1, most current annual medical assessment and physical exam, preventive care flow sheet, most current nursing assessment, past one year of PCP IPNs, labs, x-ray reports, scans, magnetic resonance imaging (MRIs), ultrasound reports, hospital discharge summaries for past one year, ER reports for past one year, consults and procedure reports for past one year, DNR forms if applicable, physician orders for past one year, most recent PSP/ISP and subsequent addendums, most recent BSP for following individuals: Individual #23, Individual #263, Individual #151, Individual #26, Individual #417, Individual #530, Individual #110, Individual #283, Individual #48, Individual #168, Individual #274, Individual #486, Individual #8, Individual #323, Individual #349, Individual #294, Individual #542, and Individual #246; o Autopsy report for Individual #85; o Timeline of Mortality Reviews as of 2/9/12; o Community hospital census by month, and Infirmary daily census; o Number/percentage of individuals on Dilantin, Primidone, Phenobarbital, Felbamate; o List of individuals with gastrostomy feeding tubes (G-tubes)/Jejunostomy feeding tube (J-tubes), updated 2/6/12; o Infirmary rounds minutes, dated 2/13/12 to 2/21/12; o Minutes and attendance roster for meeting of the Ethics Committee, on 1/12/12; o DADS Preventive Health Care Guidelines: SSLCs, dated 8/30/11; o ABSSLC: New Cases of AbSSLC Decubitus Ulcers, since last onsite visit; o Presentation on Sections G, H, and L for 2/13/12; o Section L: Provision Action Information, updated 1/30/12; and o Section L: Self-Assessment, updated 2/1/12. ▪ **Interviews with**: o Richard Chengson, MD, Medical Director; o Edward Craig, MD, Staff Physician; o Stephen Pritchard, MD, Staff Physician; o Mary Pat Arth, RN, NP-C, Nurse Practitioner; o Laura Wilford, Admissions Placement Coordinator (APC); o Kerry Loveland, Post-Move Monitor (PMM); o Michael Murray, MD, Chief Psychiatrist; o Pat Smith, QA Director; and o Mary White, QA nurse.

	▪ **Observations of**: o The following individuals: Individual #119, Individual #429, Individual #122, Individual #162, Individual #7, Individual #361, Individual #75, Individual #452, Individual #91, Individual #53, Individual #457, Individual #492, Individual #253, Individual #359, Individual #270, Individual #497, Individual #385, Individual #353, Individual #186, Individual #54, Individual #148, Individual #468, and Individual #409 o Morning medical meeting, on 2/16/12, 2/17/12, and 2/21/12;
	Facility Self-Assessment: Since the Monitoring Team's previous review, the Facility had made changes to the way it presented its self-assessment information. Using a new format from State Office, the Facility had identified activities engaged in to conduct the self-assessment, the results of the self-assessment, and a self-rating summary. Additionally, the "Provision Action Information" with recent updates, provided an outline of compliance steps taken per subsection. Although a number of concerns continued to exist with the Facility's Self-Assessment process, over time, this format should be helpful in substantiating the Facility's findings with regard to compliance. According to the Self-Assessment, the Facility had made progress in providing medical care to meet the needs of the individuals. The external and internal audit process indicated that annual medical assessments were completed in a timely manner. Quarterly medical assessments had begun and were ongoing. However, for both the annual medical assessments and the quarterly medical reviews, the Monitoring Team's findings were not consistent with the Facility Self- Assessment. Likewise, although the Medical Department's initial presentation to the Monitoring Team on 2/13/12 indicated that the clinical death reviews were now including recommendations for improving some aspect of the individuals' medical care, this was not consistent with the findings of the Monitoring Team. On a positive note, the Facility was able to use data from these external/internal audit tools to provide guidance to the Medical Department with regard to corrective actions to be undertaken. Areas needing improvement included updating the active problem list and preventive screening, although there was progress demonstrated over time in improvement in these areas. Although the Medical Department had created a number of databases from which trends could be identified related to documentation of care as well as quality of care, this information was not incorporated into the self-assessment process. For example, the preventive tests that were tracked for mammograms and colonoscopies were not included in the self-assessment. Information concerning osteoporosis identification and treatment was not included in the self-assessment. Information appeared to be incomplete and might not have reflected the treatment at ABSSLC. It appeared the Facility was not using this information, because the submitted format had many omissions of information that should have been identified had the Facility been using the data regularly. The decubitus ulcer database indicated many cases Stage II to IV decubiti, but there had been no analysis or committee input to address systemic issues. The quality of the data remained questionable, because a later roster of decubiti documented significantly different numbers. This was problematic for the Medical Department. At this time, it did not know the baseline or the quality and completeness of the database(s). Without this foundation, the Department will

	not have a strong QI program to be able to identify risks and trends needing improvement. In its Self-Assessment, the Facility cited some limited data from the external monthly audits, and none from the internal audits. Over time, more of this information should be used in the self-assessment process. The internal and external reviews identified global trends and also areas needing improvement for each PCP. Improvement was noted in several areas. However, as mentioned above, the Monitoring Team could not confirm some of these improvements. At the time of the Monitoring Team's visit, the Medical Department had not developed a comprehensive, strong clinical QI review process. The State Office had developed a number of clinical algorithms and guidelines. However, the Facility had not reviewed or implemented them into the practice patterns of the PCPs, or used them for self-improvement by developing QI measurement tools and clinical indicators. The morning medical meeting had significant potential for clinical oversight, but no data was tracked that focused on changes in health status. There was no tracking of information from the morning medical meeting to the IDT, through the ISPA development process, and back to the morning medical meeting. In its Self-Assessment, the Facility indicated that it was not compliant with Section L. This was consistent with the Monitoring Team's findings.
	Summary of Monitor's Assessment: The Medical Department had continued to make progress toward compliance. The morning medical meeting now encompassed health status changes of the individuals for which the Medical Department was involved, including individuals in the Infirmary, those hospitalized, as well as those for whom the on-call physician was contacted during after hours. Detailed minutes were taken of the meetings. External peer review results indicated progress in the nonessential components of their review, and indicated the PCPs maintained compliance in essential areas. A total of 34 DNRs were rescinded. However, a number of weaknesses and challenges remained in the Medical Department. The quarterly medical reviews could not be found in the sample of records reviewed. In November 2011, the internal medical review process appeared to have halted, and was expected to resume in February 2012. Routine communication with the QA Department was needed to ensure corrective action plans were completed in a timely manner. At the morning medical meeting, there remained a lack of critical thinking for acute care issues. Although cases of aspiration pneumonia were intensively followed and critically reviewed for opportunities of improvement, that same critical review was not occurring with other types of diagnoses. Annual medical assessments were generally not completed in a timely manner. The Medical Department's databases appeared to be maintained for the Monitoring Team's visit, rather than as working tools that the Medical Department used to improve care at ABSSLC. The Facility did not appear to have a follow-up communication pathway for recommendations made at the morning medical meeting to the QDDP and IDT, and then back to the morning medical meeting. Lastly, the number of decubiti appeared to troublingly high, and the Facility needed to create and sustain a close monitoring system to review all cases.

#	Provision	Assessment of Status	Compliance
L1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall ensure that the individuals it serves receive routine, preventive, and emergency medical care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	Given that this paragraph of the Settlement Agreement includes a number of requirements, this section of the report includes a number of different 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 and preventative care, medical management of acute and chronic conditions, and Do Not Resuscitate (DNR) Orders. <u>Staffing and Administration</u> Four PCP staff positions were filled. One was vacant, with a locum tenens physician in place. The caseload for the Medical Director was 73. This caseload was similar in size to the caseloads of the other PCPs, and did not allow the Medical Director ample time to address the many needs of medical administration. For the other PCPs, the caseloads varied from 80 to 107 for each PCP. This was based on a census of 430 individuals as of January 2012. Additionally, there was a medical secretary assigned to the Medical Department. A list was submitted indicating those members of the Medical Department that remained current in CPR certification. The list was dated January 2012. Of the primary care providers in the department, information for four out of five (80%) was provided concerning current CPR status. No information was provided concerning the locum tenens PCP. The four PCPs listed all were current in CPR. Additionally, the three staff psychiatrists also had current CPR certification. Of the five PCPs in the Medical Department, a list of CME credits was submitted for four of these PCPs. One PCP was a locum tenens, and no information was submitted concerning CME completion. For the four PCPs for which CME information was provided, the CME completed varied from 5.25 hours to 31.25 hours for the prior six months. A sampling of the topics that were covered included: osteoporosis update, new standards for concussion and head injuries, hospice transition, end-of-life care, low back pain, communicating in a multi-cultural environment, heart failure, diabetic wound prevention, prostate cancer, cellulitis, fibromyalgia, pneumococcal infection risk reduction in cancer patients, dementia, compassionate care, new medication for benign prostatic hyperplasia, atypical fractures with bisphosphonates, weight gain in mid-life, sepsis, recognition and evaluation of child abuse, acute stroke care, polypharmacy, prescribing for older adults, medical treatment of hypertension, probiotics, fracture prevention treatments for postmenopausal women, allergic rhinitis, treatment of insulin dependent diabetes mellitus, hyponatremia in heart failure, dyspnea on exertion, exercise induced syncope, chronic pain treatment, rotavirus, asthma treatment, and herpes zoster. The diverse list of topics was considered appropriate in treating the individuals at ABSSLC.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Physician Participation In Team Process Morning medical meetings were completed each business day at which the group discussed Infirmary admissions (24-hour shift report), hospital admissions (hospital liaison nurse), and on-call physician calls. The on-call PCPs provided a detailed review of all important phone calls and visits, which allowed for good communication with the attending PCPs for those individuals, and provided information for any further follow-up needed that day. Attendance included all PCPs, and several other departments were represented at the meetings, including pharmacy, psychiatry, dental, PNMT nursing, and other nursing representatives. Although some improvements were seen in the meetings, such as clinical discussions of individuals in the Infirmary, critical clinical discussion often was still lacking. For example, at one of the meetings the Monitoring Team attended, one individual had been hospitalized twice for respiratory distress, once for aspiration pneumonia, and once for an undetermined etiology that might have included aspiration pneumonia, as well as a mucus plug. It appeared once the determination was made that it was not a case of aspiration pneumonia, the group engaged in no further critical clinical discussion concerning preventive measures or other diagnostic tests that would have the potential to assist in determining a cause for the recurrence of the individual's respiratory distress. A number of concerns derived from a review of the minutes and observations of the morning meetings on 2/16/12, 2/17/12, and 2/21/12. For example: ▪ Individual #409 was sent to the ER in respiratory distress. Later information indicated that she might have had vomitus in her oral cavity. A notation in the minutes stated: "hypoxia related to positioning," but there was no further documentation of discussion, next steps, or involvement of the PNMT. Considering her respiratory status was dependent on consistent correct positioning, this appeared to be an urgent problem. However, no indication was provided that any follow-up would occur in relation to this concern. ▪ There were follow-ups attached to the minutes of 2/14/12. Individual #94 had a follow-up due to ataxia. He subsequently underwent a spinal tap, and the documentation did not indicate if there would be further follow-up of results once available, with a closure note. Individual #304 was unable to cooperate at a VNS clinic, and bit a nurse during interrogation of the VNS. Pre-sedation history was reviewed. Psychiatry recommended a different sedation. The PCP was to discuss desensitization with the case manager. It was not clear if this was considered closure. Closure requires tracking to the clinical conclusion. Important information to document would be when the PCP discussed desensitization with the case manager, and the final outcome of the concern. If desensitization was considered, the date the IDT met and the date psychology was consulted would also be important to track to closure. The information	

#	Provision	Assessment of Status	Compliance
		provided included a start point, but did not indicate closure. ▪ Individual #209 received four medications intended for a peer. The medication variance resulted in an overnight observation in the Infirmary. However, closure would include preventive steps to ensure recurrence did not occur in the residence. A discussion of the details of the incident would allow the members of the morning medical meeting to discuss corrective actions. ▪ Individual #492 developed dyspnea and hypoxia following a Computed Tomography (CT) scan. There was the potential concern that the positioning for the CT or during transport might have provided the opportunity for reflux. A new guideline had been developed for positioning to prevent aspiration pneumonia (as discussed with regard to Section L.4). When the radiology technicians were questioned about the use of wedge pillows for transport or information concerning positioning during the CT, the response did not suggest that this guideline had been followed. However, there was no discussion or documentation of the need for further training of the guideline, deployment of staff familiar with positioning needs, and monitoring to ensure it was being followed. ▪ Individual #27 developed hypothermia, and the PCP noted this was temporally associated with constipation. There was no discussion of follow-up concerning the current constipation preventive medication regimen, or nursing monitoring to reduce the frequency of constipation. ▪ There was mention of an individual with continued *H pylori* infection despite treatment. Several peers in the residence tested positive. There was documentation that the PCP would refer this to the infection control nurse. However, no information was provided indicating when this would occur and when the morning medical meeting would expect a response from the infection control nurse. Clinical areas needing follow-up should be assigned a date by which the assigned person reports back to the committee/meeting. These dates then should be tracked to ensure follow-through. ▪ One individual, Individual #91, returned from the hospital with bacterial pneumonia. The hospitalist had discussed with the Medical Director the need to consider hospice care, as he had been in the ER with two prior bouts of respiratory failure. He had a prior full cardiac arrest with subsequent hypoxic brain injury. Family members appeared to be unable to be involved in his health care decisions, and an ethics committee meeting was suggested. With two prior episodes of respiratory failure, and declining health, along with lack of a health care decision-maker, it was not clear why the ethics committee was not called at the time of the earlier ER visit, and/or why the process to obtain a guardian was not initiated. ▪ Individual #125 had a history of pica, was taken off one-to–one staffing, and was subsequently found to have metallic foreign bodies in his abdomen during an x-	

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		ray evaluation. The morning medical meeting minutes indicated he was placed on enhanced level of supervision. The morning medical meeting minutes did not indicate any further discussion of adequacy of this level of supervision, if one-to-one supervision was needed, or whether the psychologist and/or QDDP were asked to provide information regarding the rationale for reducing the level of supervision, given pica is often a life-long habit until a severe functional decline occurs (such as from a stroke). A review of the last IDT meeting also would provide the group with information regarding the discussion with the PCP concerning pica. Closure also might have included a recommendation for a staff training component. ▪ Individual #141 had emesis with a history of eating excrement, but the minutes did not indicate steps to be taken to prevent a recurrence (e.g., change in level of supervision, consultation by psychology, quality of active programming, reduction in opportunities for pica, etc.). ▪ Individual #125 developed two Stage 2 decubiti, reported at the 2/21/12 morning medical meeting. However, the group did not discuss PNMT involvement or other background information. The attending PCP was to review the case, but given the number of decubiti on campus, a rigorous interdisciplinary response should be created to ensure decubiti are prevented or minimized in those with ongoing or prior decubiti. There were some good integrated clinical discussions, including for Individual #80. The minutes of 2/15/12 documented that the psychological and eating evaluations had been completed, gastroenterology completed a consultation, and the Pharmacy Department made a recommendation to taper Protonix rather than abruptly stopping it. There was discussion of potential surgical options. There also was good integrated clinical discussion concerning Individual #268, who developed hypotension and dizziness. Side effects of Clozaril were discussed, as well as the use of diuretics for heart failure. The Clinical Pharmacist also observed that the ataxia coincided with the start of Topamax, and the individual was to have a titration upward the next day. The integrated discussion provided important information for the PCP to review the complexities of the case. The dentist attending the morning medical meeting discussed a dental emergency with discussion of examination results. Areas needing closure reportedly were discussed, tracked, and followed on Tuesdays of each week, with documentation in the minutes. During the Monitoring Team's visit, this could not be confirmed, because the Tuesday meeting that the Monitoring Team observed was following a long holiday weekend. The group's time was used to complete	

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		the necessary review of the three-day weekend. However, review of the morning medical meeting minutes indicated follow-up was difficult to find. The format was narrative, and it would be easy to miss areas that had outstanding follow-up issues. The Facility should create a record clearly identifying the follow-up issues/areas needing closure, person responsible, date follow-up is requested/due, along with a brief closure entry, including the date of closure when it occurs. This information should be organized in a one-page format to allow Medical Administration to see what is outstanding. Additionally, there should be data to reflect closure. Tracking indicators such as the number of areas requiring closure per week, and the number of closures per month would provide an indicator that the process is being implemented. <u>Routine Care</u> As part of the monitoring review process, the Monitoring Team selected the medical records of 12 individuals to determine compliance with several requirements of Section L.1. These individuals are listed in the documents reviewed section. Every 43rd name listed on the "ABSSLC List of Individuals February 2012" was selected, after the first name was chosen by random selection. Documents reviewed included the preventive care flow sheet, physician orders for the past year, integrated progress notes for the past year, most recent BSP, last annual ISP and subsequent addendums, labs, x-rays, consult forms from the past year, 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. Of these 12, it was determined that one individual expired early in the time period reviewed, and was not included in the sample results. Additionally, the same information was requested for six individuals considered at high risk for one or more medical conditions. The combined sample resulted in 17 (11 plus 6) active record reviews for medical care. Based on the information submitted for the above requested documents, each aspect of the Monitoring Team's review is discussed as the relevant preventive or routine care topic is discussed below. From 17 medical records reviewed: ▪ 15 (88%) annual medical assessments had been completed in a timely manner. For one individual (Individual #110), the history and conclusions were current, but there was no physical exam recorded. ▪ Active problem lists appeared to be thorough in 14 (82%). ▪ 16 (94%) had information about smoking history. ▪ 16 (94%) had information about family history. ▪ 10 (59%) had information discussing requirements for transition. ▪ The DG-1 forms were reviewed. Of the 17 DG-1s reviewed, six (35%) had updated diagnoses.	

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		▪ 12 (71%) had an updated preventive care flow sheet. ▪ Six (35%) had been admitted to the hospital in the prior year. ▪ All individuals (100%) were listed as "full code." ▪ Three (18%) had pica incidences. In addition to the sample of 17 individuals, for 19 other 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. These are listed above in the documents reviewed section. 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 19 individuals, compliance was three out of 19 for completion of the annual medical assessment (16%). Compliance for completion of the annual physical examination was two out of 19 (11%). The 17 medical records in the sample also were reviewed to determine whether the physician IPN note used the SOAP format. In 17 (100%), the SOAP format was used, and included date and time on the IPN in each record reviewed. Consistent with the Health Care Guidelines, the PCPs had started to complete quarterly medical reviews. A template was developed dated 8/2011. A laminated card was given to each PCP for dictation of the quarterly medical review according to the outline on the template. Included were the following areas: date of last annual medical summary, current medications and allergies, active problem list, changes to active problem list, ER visits, Infirmary admissions or over-night stays, and hospital admissions. This was followed by common problems of the IDD population according to organ system: neurology (date of last seizure, number of seizures past three months), respiratory (pneumonia, upper respiratory symptoms), number of UTIs, endocrine diagnoses that need monitoring and the indices that were monitored (for diabetes mellitus, hypothyroidism), current weight with changes in last three months, consults in last three months with consults still pending, diagnostic, therapeutic or screening procedures completed since the last quarterly, and a brief summary of any acute care concerns. However, none of the medical records reviewed (0%) included a PCP quarterly review of medical progress during any quarter in the prior year. The Medical Department indicated it had completed quarterly medical reviews in 19.5% of the active records, but the sample did not include these. <u>Access to Specialists</u> The following numbers of off–site visits for consultation or procedures were documented for the time period from 7/1/11 through 12/31/11: two allergy consultations, one	

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		audiology consultation, 42 cardiology consultations, one dermatology consultation, one endocrinology consultation, 46 gastroenterology consultations, one genetics consultation, 33 hematology/oncology consultations, three brace and foot orthotics consultations, four nephrology consultations, three neurology consultations, nine neurosurgery consultations, 14 optometry consultations, 140 ophthalmology consultations, 29 orthopedic consultations, seven otolaryngology consultations, three pain management consultations, one podiatry consultation, four pulmonary medicine consultations, five rheumatology consultations, six sleep study consultations, six surgery consultations, four urology consultations, and 25 wound care specialist consultations. On site, several specialty clinics were held to meet the needs of the individuals. These included the following clinics with dates held: Dental Surgery on 7/15/11, 8/19/11, 9/23/11, 11/18/11, and 12/16/11; Dermatology on 7/20/11, 8/24/11, 9/21/11, 10/19/11, and 12/14/11; Endocrine on 7/6/11, 7/28/11, 8/11/11, 8/25/11, 9/29/11, 11/10/11, and 12/15/11; ENT on 7/12/11, /8/9/11, and 11/8/11; gynecology on, 9/14/11, 10/27/11, and 12/14/11; Neurology on 7/11/11, 7/25/11, 8/8/11, 8/22/11, 9/12/11, 9/26/11, 10/10/11, 10/24/11, 11/14/11, 11/28/11, and 12/12/11; Podiatry on 7/19/11, 8/16/11, 9/20/11, 10/18/11, 11/15/11, and 12/20/11; Surgery on 7/28/11 and 8/25/11; Urology on 7/1/11, 8/5/11, 9/2/11, and 10/7/11; and Visual acuity on 7/7/11 and 8/31/11. The Facility appeared to provide the needed spectrum of specialists through both on-site and off –site appointments. In addition, the Monitoring Team's findings with regard to the follow-up on consultations are discussed with regard to Section G.2. <u>Preventive Care</u> Current vision screening was documented in 14 out of 16 of the records reviewed for which vision screening was indicated (88%). One individual was blind and a vision screen was not indicated. Audiological screening was current in 16 out of 17 records reviewed (94%). The influenza vaccination had been given to 15 out of 16 eligible individuals (94%) in a timely manner during 2011. For one individual, the guardian had refused permission. 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 14 of the 17 active records reviewed (82%). Immunity to hepatitis B was recorded in 16 of 17 records (94%). A list dated 1/13/12 was submitted indicating women residing at ABSSLC who were	

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		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 167 women were identified, but of these, two were under the age of 40, one had an undetermined age, and 23 were over the age of 70. The eligible population between the age of 40 and 70 was 141 women. The State Office provided a document entitled: Preventive Health Care Guidelines: SSLCs 8/30/11. In reviewing the submitted information, the recommendations in this document for annual screening mammography for women ages 40 to 70 were followed. Of these 141 women ages 40 to 70, eight had reasons not to have a mammogram (guardian refusal, inability to physically provide proper positioning for the test, etc.). Of the remaining 133 women, 108 had mammograms within the prior year. This was a compliance rate of 108 out of 133 (81%). From the sample of 17 medical records reviews, there were five females over the age of 40. Of these, four (80%) were up-to-date on mammogram testing. From the sample of 17 medical records reviewed, there were six females for which a pap would be recommended. Of these, all had reasons for not having a pap completed (e.g., gynecologist unable to complete, refused, hysterectomy). For two, the adequacy of the documentation to provide the reasoning was not complete. From the sample of 17 medical records reviewed, there were three males age 50 or greater. Of these, three (100%) had a PSA test in a timely manner. 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 216 names were submitted. Nine of these were under the age of 50, 13 had no information concerning birthdate or age or had typographical errors, and 14 were over the age of 75. This left 180 eligible individuals. For these individuals, the document Preventive Health Care Guidelines SSLCs August 30, 2011 was followed in reviewing the information. Of these, 19 had reasons not to order a colonoscopy. Therefore, the eligible population was 161 individuals. Of these, 124 completed a colonoscopy or an acceptable alternative, for a compliance rate of 124 out of 161 (77%). From the sample of 17 medical records reviewed, six individuals were over the age 50. Of these, for one individual, the gastroenterologist did not recommend preventive screening with a colonoscopy due to medical risks. Of the remaining five individuals, four (80%) had colonoscopies completed within the past 10 years. 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	

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		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. Additionally, based on the T score, treatment would be ordered to optimally treat the individual. A total of 71 individuals with a diagnosis of osteopenia and 154 individuals with a diagnosis of osteoporosis were reviewed. Of these, all had a DEXA scan submitted. There were three DEXAs that were considered overdue (i.e., Individual #164 with last scan on 5/13/04, Individual #110 on 1/3/05, and Individual #467 on 2/28/06). For the 71 with a diagnosis of osteopenia, there were 13 for which no information was submitted concerning treatment. For the 58 individuals for whom treatment was provided, 62% were on a bisphosphonate or other medication in dosages recommended for osteopenia. Of the 58 individuals reviewed with osteopenia, the submitted information indicated 26 (45%) were receiving calcium supplementation, and 23 (40%) were receiving vitamin D supplementation. For the 154 individuals with a diagnosis of osteoporosis, there were 17 for whom treatment information was not submitted. For the remaining 137 individuals for which treatment information was provided, 66 (48%) were on calcium supplementation, 52 (38%) were on vitamin D supplementation, and 120 (88%) were on an additional medication for osteoporosis such as a bisphosphonate or Miacalcin. The lack of data for some individuals (one had no diagnosis listed of osteopenia or osteoporosis) and the 30 individuals for whom treatment was not recorded in the data submitted suggested that the Medical Department had not begun to utilize this information for internal tracking and monitoring of osteopenia/osteoporosis treatment. The low rates of vitamin D and calcium supplementation might indicate need for improved database management, because the 17 medical records reviewed indicated adequate treatment of those with osteopenia and osteoporosis. From the sample of 17 medical records reviewed, six had a diagnosis of osteoporosis or osteopenia. Of these, six (100%) had completed a DEXA scan within the recommended time intervals. Of these, treatment was considered adequate in six (100%) of the reviews. 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. All 18 (100%) had a current thyroid test. <u>Acute and Emergency Care</u> The Facility had an Infirmary for which individuals needing more intensive nursing and medical care were admitted until resolution or stabilization of their acute condition. For the time period from 7/2/11 through 12/30/11, 66 individuals were admitted to the	

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		Infirmary. Length of stay varied from one day to 72 days. A total of 26 individuals stayed in the Infirmary from one to five days. Twenty-three individuals remained in the Infirmary from six to 10 days. Six individuals remained in the Infirmary for 11 to 15 days, and six individuals remained in the Infirmary from 16 to 30 days. Four individuals remained in the Infirmary for 31 or more days. There was one individual for whom a length of stay was not submitted, the last individual admitted in 12/11. Separately, an Infirmary daily census was submitted. This included medical admissions for acute problems, overnight admissions for procedures or brief observations, and administratively assigned admissions. Per month, the census was reported as follows: August 2011 - 181 total for daily census, September 2011 - 208 total for daily census, October 2011 - 256 total for daily census, November 2011 - 221 total for daily census, December 2011 - 187 total for daily census, and January 2012 - 95 total for daily census. The Facility also submitted a community hospital census by month. The following monthly census was provided: August 2011 - four admissions, September 2011 – eight admissions, October 2011 - 15 admissions, November 2011 – 18 admissions, December 2011 - 10 admissions, and January 2012 - seven admissions. Each of the permanent PCP staff was interviewed. All noted the decreased admissions to the hospital and to the Infirmary. During the Monitoring Team's visit, there was only one admission at the hospital. Reasons for the decrease were not clear. The PCPs suggested some potential reasons or insights. However, no information was provided indicating that the Facility had conducted a review of the data trends, and/or a methodical analysis to determine potential reasons for the decreased acute census at both the Infirmary and hospital. The Medical Department is encouraged to track the data for further trends, and if an improvement is noted that extends through a few quarters, the Facility should analyze the data to determine the causes of the trend. If contributing causes can be determined, an improved health care delivery system could be achieved by incorporating these practices into ongoing care of individuals and monitoring to ensure they are implemented. It was noted the hospital census was low in August and September, which might reflect a normal periodicity to acute illness, because the census increased in October and November 2011. The January 2012 Infirmary census was the lowest for any of the most recent six months. The active record was reviewed for 10 individuals who had most recently gone to the Emergency Room (ER) for 11 ER visits and returned. These individuals are listed in the documents reviewed section. All (100%) of the individuals had gone to the ER from their residence. None had gone from the Infirmary to the ER, although one was originally routed to the Infirmary, and subsequently transferred directly to the ER. The following summarizes the results of this review:	

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		▪ Information was submitted indicating that the ER was verbally notified of the arrival of the individual with appropriate medical background information provided for nine of the 11 (82%). ▪ Prior to the transfer to the ER, a PCP was on site for four of these transfers. Of these, in four (100%) records, the PCP had written an IPN that included the date and time. ▪ Of these four pre-ER PCP IPNs, the IPNs included vital signs in three of four (75%). ▪ Of these four pre-ER PCP IPNs, the IPNs included the reason for the transfer in four of four (100%). ▪ Of these four pre-ER PCP IPNs, three of the four (75%) used the SOAP format. ▪ Treatment was considered timely in 100% of the transfers. The active record was reviewed for 10 individuals who had most recently gone to the Emergency Room and returned. These 10 individuals made eleven visits to the Emergency Room. The focus of this record review was post ER care at the Facility. These individuals are listed in the documents reviewed section. ▪ When the individual returned to the Facility after evaluation at the ER, all eleven (100%) of the visits had an IPN. One of the PCP IPNs was not completed the next business day (i.e., five days after the ER visit). ▪ For these 11 ER visits, all 11 (100%) post-ER IPNs utilized a SOAP format. ▪ For these 11 ER visits, time was recorded in all 11 (100%) post-ER IPNs. ▪ For these 11 ER visits, six (55%) post-ER IPNs recorded the vital signs or documented an attempt at obtaining vital signs. ▪ For these 11 ER visits, eight (73%) post-ER IPNs included a summary of the ER visit. ▪ For these 11 ER visits, when the individual returned to the Facility, nine were admitted to the Facility Infirmary, and two returned to their residence. ▪ For these 11 ER visits, all records (100%) included one or more additional PCP notes as follow-up to the original concern. The reasons for transfer were as follows: five had respiratory concerns, one had a cardiac concern, one had a gastrointestinal concern, one had potential pain, one had an orthopedic emergency, and two had neurological conditions, ▪ For all (100%), treatment was considered timely. There were no perceived delays in care. Additionally, 10 active records were reviewed for those individuals admitted to the hospital. These individuals also are listed in the documents reviewed section. The following provide the results of this review. These 10 individuals had 11 hospitalizations. ▪ Nine individuals returned to the Facility. One died while in the hospital. Of the	

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		nine individuals that returned to the Facility from 10 hospitalizations, nine out of ten (90%) had IPNs post hospitalization. For one individual, post hospital documentation was not submitted ▪ Of the nine post-hospital IPNs submitted, eight (89%) included vital signs or attempts were made at taking vital signs. ▪ Five of nine (56%) included time. It was noted that completion of a form progress record note or a dictated admission Infirmary note did not include the time. It is recommended that such forms and dictations include time of completion. ▪ Eight of nine (89%) included an adequate summary of hospital events and findings. It was noted one IPN readmission note was incompletely submitted, and adequacy of documentation could not be determined. ▪ Seven of nine (78%) active records used the SOAP format. The IPNs were incompletely submitted for two documents to determine compliance with this measurement. ▪ For nine of 11 (82%) hospitalizations, active records included a copy of the hospital admission history and physical. ▪ For seven of the 11 (64%) hospitalizations, active records included a copy of the hospital discharge summary. ▪ For 10 of the 11 (91%) included a copy of either the hospital admission history or physical, or a copy of the hospital discharge summary. ▪ For three of the 11 (27%) hospitalizations, the active records included a copy of the hospital liaison nurse notes for the individuals. Under a separate submitted file for hospital liaison notes, six of these 11 hospital admissions had hospital liaison nurse notes. This might indicate these notes were not located in the IPN section of the active medical record, but were filed separately, not filed, or filed correctly but not copied as part of the requested information for Section IX.32. ▪ For eight of the 10 (80%) hospitalizations for the nine individuals that returned to the Facility, adequate PCP notes were included as part of the follow-up. For two of the records, submitted information appeared incomplete. ▪ Four of the 11 hospitalizations occurred after the individual was admitted to the Infirmary. One hospitalization occurred directly from the residence. For six hospitalizations, insufficient information was provided to determine whether the individual was transferred from the Infirmary or the residence to the hospital. ▪ Eight of the 10 individuals who returned to the Facility were admitted initially to the Facility Infirmary. For two, insufficient information was submitted to make a determination. ▪ Of the 11 hospitalizations, reasons included: seven were for respiratory concerns (pneumonia or aspiration pneumonia), one was for a fracture needing surgical repair, one was for an acute abdomen requiring surgery, one was for a	

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		neurological concern, and one included diagnoses of urosepsis and seizures. A copy of documents from the AVATAR software program was submitted for review of pneumonia tracking. From 7/1/11 through 12/26/11, the system reported 27 pneumonias. There were 14 categorized as aspiration pneumonia, 12 categorized as pneumonia, and one was unknown. Fifteen of these individuals had G-tubes, and feedings varied from bolus, to intermittent, to continuous. Of these pneumonias, off-campus physicians categorized 15, and staff physicians at ABSSLC categorized 12. For those fed by mouth, only one was on a regular diet, the others had a therapeutic textured diet and/or thickened liquids. For each of those with aspiration pneumonia and receiving tube feedings, consideration should be given to reviewing the rate of the feeding to ensure it is not aggravating reflux. Additional medical/surgical options might be considered if recurrent aspiration pneumonia occurs in these individuals. For those fed by mouth, an aspiration pneumonia diagnosis should be followed by a review of contributing/causative conditions, such as dysphagia. The Medical Department had several guidelines in draft form that will be helpful in optimal treatment of pneumonias in this population. It also was noted that four pneumonias listed in the AVATAR system (i.e., Individual #23 on 10/27/11, Individual #378 on 11/20/11, Individual #60 on 11/29/11, and Individual #128 on 12/10/11) not listed in a separate document entitled: Communicable Disease Report. Likewise, two cases of pneumonia listed in the Communicable Disease Report were not listed in the AVATAR system (i.e., Individual #253 11/3/11, and Individual #297 12/30/11). A third report entitled "Summary Report (Overall)" agreed with the total number of pneumonias per month listed in the AVATAR system for July 2011 – three, August 2011 – two, and September 2011 – one. However, for October 2011, it listed eight pneumonias, and AVATAR listed seven. For November 2011, it listed five pneumonias, and AVATAR listed six. The two agreed for December 2011 - eight cases. However, the Communicable Disease report listed an additional one for November and December. Either one database should be used or ongoing efforts should be made to reconcile the different reporting systems using different software to ensure each is accurate, complete, and in agreement with other databases recording pneumonia information. The most recent data from the 2/15/11 Pharmacy and Therapeutics (P&T) Committee meeting provided an update for pneumonia. For the last quarter of the calendar year 2011, the Communicable Disease Report listed 10 aspiration pneumonias and 11 pneumonias. <u>Chronic Conditions and Specific Diagnostic Categories</u> Chronic constipation had been diagnosed and treated in 337 of the individuals residing at	

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		ABSSLC. From July 1, 2011 through December 31, 2011, there were two new cases of bowel obstruction. A separate list indicated that during the same time period an individual also developed abdominal ileus and another developed obstipation. As is discussed in further detail below, the Facility had not yet begun to implement the State Office clinical guidelines that would assist in ensuring that individuals were being provided with adequate treatment for constipation. Information was requested concerning new diagnoses of chronic conditions that occurred over the past year. No information was submitted either through hard copy or electronically (TX-AB-1202-IX.40.c) which would have provided the number of individuals newly diagnosed with diabetes mellitus type II. From a separate document, there was at least one individual with diabetes mellitus type II diagnosed in the prior six months. It was reported that there was one new diagnosis of malignancy from July 1, 2011 through December 31, 2011, but this did not include the death of Individual #128, who had been recently diagnosed with colon cancer. A list was provided of individuals newly diagnosed with cardiovascular disease (e.g., hypertension, congestive heart failure, cardiac arrhythmia, etc.), but it was not clear the time period involved. A total of 14 individuals were named. For three individuals, there were no diagnoses to indicate the reason the individual was listed as new onset cardiovascular disease (e.g., one listed a normal ejection fraction). There were three cases of sepsis reported in the prior six months. As part of the review of 17 medical records, GERD was reviewed. Of the 17 individuals, nine were diagnosed with GERD. Of these nine, eight had appropriate (medical/surgical) treatment (89%). As of 1/10/12, 11 individuals residing at ABSSLC had tracheostomies. Since the Monitoring Team's last visit, the Skin Integrity Committee did not meet. A record was submitted (TX-AB-1202-IX.39b) documenting the "absolute numbers of decubitus ulcers" over the 2011 calendar year, broken down by month. Additionally, the stage of the ulcer and the setting of origin were recorded. For the six months from July 1 through December 31, 2011, 47 individuals were listed with new decubiti (counted only once even if present in more than one month). Of the decubiti existing in this time period (these were absolute numbers and might not necessarily have been only new decubiti present during this time, as decubitus care will often extend from month to month), 52 were acquired at ABSSLC, and 11 were acquired outside the Facility. Fourteen were considered Stage 1, 27 were considered Stage 2, four were considered Stage 3, and five were considered Stage 4. There were five unstageable ulcers. The interpretation of the	

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		data was difficult, because only the first line listing 47 decubiti was specifically noted to be unduplicated across the months. However, the number of ulcers, especially Stage 3 and 4, suggested the need to review skin assessment and monitoring frequency of skin breakdown. This should be followed by the development of a rigorous policy that is trained, implemented, and tracked for compliance. Separately, a document was submitted, entitled: "New Cases of ABSSLC Decubitus Ulcers since last onsite visit." This listed 18 ulcers, most of which were Stage 1 or 2. The discrepancy between the two sets of information was concerning, and suggested the need for QA oversight of the database system for this issue. However, both listed significant numbers of decubiti, and the need to focus on this clinical concern remained. The reason was unclear for the large variation in the information reported. When such variation exists, adequate information is not being provided to the clinical departments responsible for skin integrity (i.e., Medical Department, Nursing Department, PNMT). The Facility submitted information concerning antiepileptic medication usage. There were 30 individuals with a seizure disorder or history of seizures for which no antiepileptic medication was prescribed. As of data submitted in January 2011, 220 individuals were prescribed antiepileptic medication. Of these, 47% were prescribed one antiepileptic medication, 36% were prescribed two antiepileptic medications, 15% were prescribed three antiepileptic medications, 2% were prescribed four antiepileptic medications, and 0% was prescribed five antiepileptic medications. Six individuals were considered to have a refractory seizure disorder, defined as 36 or more seizures in the last three months or placement of a vagal nerve stimulator. Five of the six (83%) with 36 or more seizures in the prior three months had a VNS implant. One of the six had a prior VNS placement, but it was removed due to development of a foreign body reaction. In the prior six months, two individuals with refractory seizures were referred for evaluation of a vagal nerve stimulator implant. The dates of the referrals were not submitted, but from the statistics it appeared one of them had a VNS placed in the prior three months. Four individuals in the last six months developed status epilepticus. Two individuals were sent to the ER for an uncontrolled/prolonged/new onset seizure. A list was submitted indicating the percentage of individuals that were prescribed older antiepileptic medications. Most recently, as of 2/20/12, a total of 220 individuals were prescribed antiepileptic medication. A total of 130 individuals were prescribed Dilantin, Primidone, Phenobarbital or Felbamate. Forty-five individuals (20%) with seizures were prescribed Dilantin, 11 individuals (5%) were prescribed Primidone, 68 individuals (31%) were prescribed Phenobarbital, and six individuals (3%) were prescribed Felbamate. Information was requested listing individuals with a vagal nerve stimulator and date of placement, with replacement date, if applicable (TX-QB-1202-IX.24.b). This was not provided through hard copy or electronic copy. However, from the list of those	

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		with intractable seizures, 26 were listed as having a vagal nerve stimulator. The Facility submitted neurology consultation notes documenting seizure management for five individuals. These individuals are listed in the documents reviewed section. The following provides a summary of the review of these records: ▪ Three of the five individuals (60%) had notes submitted documenting that they had been seen at least twice over the past year. ▪ For five individuals (100%), the notes submitted indicated a description of the seizures. ▪ For five (100%), records included a review of current medications for seizures and dosages. ▪ For five (100%), records included recent blood levels of antiepileptic medications. ▪ For five (100%), there were ongoing plans and recommendations. ▪ There was one record in which further clarification was needed. On 8/22/11, Individual #543 saw the neurologist. Her last seizure was recorded as 11/19/02, and the plan was to reduce her Lamictal slowly. She was seen 10/10/11, and it was documented her seizures recurred on the lower dose of Lamictal. Her Lamictal was increased to the former dosage. On 11/28/11, the neurologist saw her. Notation was that the last seizure was on 10/30/11. The objective notation from neurology indicated: "has had no seizure in the last three months." When discrepancies in documentation occur, the PCP should seek clarification before accepting and filing the report. ▪ Specific notation of presence of absence of side effects (somnolence, etc.) was not specifically addressed. The PCP should ensure such information is recorded in an IPN or quarterly medical review. A roster of those attending neurology clinics on site was submitted. A total of 203 individuals were seen for 254 appointments in neurology clinic from August 2011 through December 2011. A roster of individuals on enteral feeding as of 2/6/12 was submitted. There were 92 individuals with a gastrostomy tube, and four with a jejunostomy tube. Original placement date ranged from 5/16/77 to 9/27/11. A list of those with pica incidents was submitted. Seven individuals had been observed to ingest inedible objects or attempt to ingest these objects. In the prior six months, the number of pica events per person ranged from one to 57. No one was taken to the ER or hospitalized for a pica event. Two individuals (i.e., Individual #440 and Individual #105) were responsible for most of the pica incidents.	

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		A fracture roster from 2011 was submitted. Since August 1, 2011, eight fractures occurred at ABSSLC. These included three hip/femur fractures, a fractured pelvis, a fractured rib, an upper arm fracture, a toe fracture, and a thumb fracture. Since August 1, 2011, seven injuries required ER visits/hospitalization. Four of these were due to fractures. <u>Do Not Resuscitate Orders</u> A total of 23 individuals at the Facility had DNR orders in place. The initial DNR orders were implemented from 7/12/01 to 12/6/11. For 19 (83%), a medical reason was listed (i.e., cancer – one, osteoporosis – 11, scoliosis/kyphoscoliosis two, cardiac condition - three, morbid obesity - one, respiratory distress/hospice - one). Four DNR orders did not have a medical reason listed. Since the Monitoring Team's last visit, 34 DNRs were rescinded. IPNs documented communication with IDTs, family, and guardians, as appropriate. Due to the diagnosis of osteoporosis and severe scoliosis, for 16 individuals, there was the request for "no chest compressions," but otherwise all treatment should be considered. It was believed that the chest compressions would only cause injury and produce a flail chest, but that all other measures should be considered and offered as appropriate. For one individual, restrictions included "no chest compressions" and "no AED." For the past six months, minutes of ethics committee minutes, along with attendance rosters, were requested. One set of ethics committee meeting minutes with attendance roster was submitted from 1/12/12. Participants included a community physician as chair, a parent representative, chaplain, attorney, a human rights officer, and several staff at ABSSLC (i.e., Medical Director, QDDP, RN case manager, direct support professional, and staff physician). Three cases were discussed: ▪ The first case discussed was an individual with DNR status from 2002, although there was no qualifying condition. An ethics committee note was entered into the IPN section of the record, indicating the guardians wished the DNR order to remain. The conclusion of the ethics committee was that there was agreement with the guardians' decision. It was unclear if this was consistent with the direction given in the State Office guidance. This is discussed in greater detail below. ▪ Minutes of an ethics committee meeting from the same date 1/12/12, included a discussion of whether to put a DNR Order in place for Individual #350 due to deterioration in health from repeated aspiration pneumonias. The individual recently had been hospitalized, and DNR/Hospice had been initiated during that time. Options were discussed, including: DNR with hospice initiation, DNR with palliative care, or further medical intervention. An attempt was made by phone to contact the guardian, without success. The committee could not make a	

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		decision, and instructed the Medical Director to discuss this issue with the guardian. There was no information as to when the committee expected a resolution/response back to committee members. ▪ The third case was an individual with DNR status per guardian, but with no qualifying medical condition, according to current state supportive living center guidelines. The guardian had expressed in the past to continue the DNR status. An attempt was made to contact the guardian by telephone, but the guardian could not be reached. The decision was deferred for further discussion at the next meeting. A few comments on the ethics committee and documentation follow: ▪ The brief summary of the discussion of ethical issues should be included in the report, because it would provide guidance to all interested parties. These summaries might best be distilled to bullet entries when possible. ▪ It is imperative that the committee has current information as to family/guardian wishes/decisions. Naming the family member or guardian responsible for the decision-making would provide important details, along with relationship (i.e., parent, sibling, guardian, co-guardian, etc.), especially if one or more are not specifically listed on the attendance roster. ▪ The decision should include a response/interpretation of agreement or not with the State Office guidelines in place at the time. When the committee is making a decision or recommendation that is inconsistent with State Office guidelines, clear justification should be provided. ▪ When the committee assigns tasks, timelines should be documented as guidance, especially for decisions that need urgent finalization. ▪ When the committee defers a decision until the next meeting, there should be a determination of the time and date of the next meeting before adjournment, unless the committee meets regularly at a pre-set time and date each month or each quarter. In the current situation, given that the committee did not appear to meet frequently (only one set of meeting minutes was submitted for the prior six months), deferring to the next meeting did not provide adequate guidance to the PCP and IDT in a timely manner. ▪ Documents reviewed at the meeting should be listed, with the date of the document for reference. For instance, the in-hospital DNR/hospice status with date would have been an important reference in the meeting discussed above. Likewise, the documents listing the guardian and dates of guardianship would provide needed evidence the committee was having discussions with the appropriate person with authority and responsibility in the decision-making process. A current active problem list/hospital discharge summary, including the diagnoses used to justify/verify a terminal condition also would be essential. ▪ Minutes of the ethics committee, like any other committee, should include the	

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		typed minutes, along with the references/attachments used in the decision process. Although IPN entries might provide the immediate information the IDT needs in the record, a formal set of minutes should be maintained. The Facility would need to determine the department responsible for generation and maintenance of these minutes. <u>Transitions to Community Settings</u> The Facility submitted post–move monitoring checklist documents on several individuals that had transitioned to the community in the prior year. A total of 13 names were submitted. In the prior six months, eight individuals had transitioned to the community. During the immediate 90-day post-move period, seven of the 13 (54%)had completed appointments with physicians, dietitians, psychologists, and a variety of other specialists beyond the initial agreed upon time period in the transition plan (i.e., late appointments). For the eight individuals that had been transitioned in the more recent six month time period, four (50%) were overdue in completing initial clinical appointments. For the 13 individuals, two had police encounters (one had police encounters three times). One underwent a psychiatric hospitalization. Three had psychotropic medications started or increased. A few comments are offered based on review of the records of these 13 transitioned individuals: ▪ Obtaining a government ID appeared to delay employment opportunities, and it is recommended that this process be completed or nearly completed by the time the transition occurs. ▪ A number of required appointments could not be immediately scheduled because of a lack of Medicaid card or a lack of clinicians accepting Medicaid. For the latter, it would be important to identify the needed resources in the community before transitioning the individual. Determining that there were few to no local resources once the individual moved did not assist in providing a smooth transition. For some, appointments not dependent on obtaining a Medicaid card could be scheduled before the transition, especially for specialties for which there is a several month waiting period for accepting new patients. ▪ Additionally, one individual moved once after transitioning to the original home in the community, and for one other individual, plans for moving to a second home were considered and later dropped. Agencies should be challenged to minimize movement in the immediate post transition period. This places additional stress on the individual, and could disrupt continuity of care. Finding a good accommodation to meet the individual's needs the first time would be an expected goal. ▪ Provider agencies appeared to experience challenges when utilizing the services of local schools for class enrollment, counseling services, as well as specialty	

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		services such as OT, and PT. These concerns should be resolved before transitions are completed. One individual appeared to miss several months of schooling, and early communication with the school system might have provided opportunities for classroom work and activities, or at least realistic expectations of what could be offered by the local school system. The Facility submitted individual monitoring reports, but no data tracking had occurred to determine areas of strength and areas of weakness. Several areas would be of value to track, including individuals with police encounters, individuals with increased psychotropic medication use, number of overdue initial visits to clinicians listed in the transition plan, etc. <u>Mock Code Drills and Emergency Response Systems</u> 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.	<u>Non-facility Physician Case Reviews</u> During the prior six months, the Facility completed one non-facility physician case review. This occurred from January 11 to 13, 2012. Only one external medical reviewer completed the audit. The prior external peer review occurred in July 2011. The Facility had determined the compliance threshold as 70%, which was low. No essential or non-essential areas scored below this threshold. The Stat Office defined the compliance threshold as 80% for all internal and external medical audits. The following represents a synopsis of the information: ▪ For the January 2012 external peer review, PCP compliance in essential areas ranged from 93% to 100%. For areas considered non-essential, compliance ranged from 89% to 100%. ▪ Areas that appeared to need improvement included: updating the active problem list with each new problem or when problems were resolved, and providing the appropriate preventive screening services. An additional essential area of compliance needing improvement was ensuring the annual physical exam and summary were current. ▪ A follow-up system was implemented to ensure compliance/completion of corrective action plans for each PCP's areas of noncompliance. The external audit of January 2012 generated 21 action plans for completion by the Medical Department. The QA nurse/QA Department was to start reviewing compliance and completion of these action plans beginning within three weeks of the external audit. ▪ According to a Q1FY12 QA/QI data report, action plans were followed from the prior external audit performed in July 2011. This generated 161 action plans, all of which QA staff followed to determine resolution. It was noted that several of	Noncompliance

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		the action plans required serial reviews to track compliance to completion. As of the writing of that report on 12/15/11, two action plans remained without evidence of closure. The QA nurse attempted to meet with the PCPs in 2011, but no meetings were held. On 1/5/12, a meeting was held with the Medical Director, and on 1/18/12, one was held with the PCPs. This was the first official meeting ever concerning QA peer review. The Medical Department is encouraged to have monthly meetings with the QA nurse/QA Department to review progress and new initiatives. <u>Mortality Reviews</u> At the time of the review, the Facility had two outstanding clinical death reviews (for Individual #128 and Individual #350). One had expired in 12/11, and one in 1/12. Since the start of the Monitoring Team's last visit, five deaths had occurred from 8/1/11 through 12/31/11. Information concerning the most recent mortality of 1/12 is not included in this report: ▪ The average age was 70 (varied from 60 to 81). ▪ The causes of death were: sudden cardiac death due to arrhythmia, myocardial infarction with heart failure, aspiration of gastric contents, complications of end stage dementia (respiratory failure with bilateral pneumonia), and post operative complications (aspiration pneumonia). ▪ An autopsy was performed in three of the five (60%). ▪ DNR status was ordered for three of the five individuals (it had been rescinded for one individual on 5/13/11.) ▪ Two were under hospice care. ▪ One died in a hospital setting, one died in the Infirmary, and three died in the residence. ▪ One had multiple or prolonged hospitalizations prior to death. ▪ One had a G-tube. ▪ From the submitted information covering seven days prior to death, there appeared to be appropriate medical treatment in each case. Since the Monitoring Team's last visit, six death review investigations were completed. Of these, one had a follow-up recommendation. Although the initial presentation for Section L on 2/13/12 indicated that: "most clinical summaries are now including a recommendation on some aspect of the deceased's recent medical care that may have been improved upon," the only recommendation dealt with communication between the hospital liaison nurse and Nursing Administration concerning the need for hospice training of staff when the individual returned to the Facility. There were no other recommendations from the other five death reviews. Considering the many departments involved in the care of each individual, it is recommended the Facility focus not only on	

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		recommendations involving the time period surrounding death, but on more general quality of life concerns and systemic issues across the lifespan of the individual (e.g., meaningful day, communication with family, documentation by clinical and nonclinical departments, review of adaptive equipment and repairs, more detailed family history at time of admission, etc.). The Facility submitted follow-up documentation for the one recommendation as an email communication. There were no other recommendations that would have required follow up.	
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.	<u>Medical Department Internal Reviews</u> Information concerning monthly audits was provided from May through November 2011. The audit process appeared to have stopped at that time. A new internal peer review with clinical components was to be initiated in February 2012. From a Q1FY12 QA/QI report, the process for the internal audit included completion of a 5% sample per quarter, divided into a smaller monthly sample size of eight active records. The audit tool was the same as the external audit tool, and divided into essential and non-essential components. Components were not weighted. One PCP completed half the reviews, and each of the other PCPs completed one active record review per month. The reviews were completed on a provider other than themselves. Inter rater reliability had not been established. As the problems identified in the internal audits were similar to that of the external review, the information was considered helpful. It was noted that the external audits from July 2011 and January 2012 were completed at different times than the internal audits. To provide validation of inter-rater reliability, the new external/internal review process was to begin in February 2012. The external audits were to occur every six months, and the Facility would simultaneously complete an internal audit of the same sample within 24 hours. This had not occurred at ABSSLC at the time of the Monitoring Team's visit. Additionally, the Facility had plans for an additional internal audit review. It would include a review of three active records for three specific diseases/diagnoses to be audited each quarter. For September to November 2011, during an internal audit, 22 active records were reviewed. The overall compliance score was obtained by averaging the positive responses recorded for each of the indicators in the audit. Overall compliance ranged from 82 to 95% per month, and was considered similar to the previous quarter range of 82.5 to 87.9%. The seven essential components averaged 90.6%, identical to the average score of the prior quarter. There was improvement in the non-essential components.	Noncompliance

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		The prior quarter had an overall score of 77%, and the current quarter had an overall score of 88% in the non-essential areas. Areas with lowest scores were identified. The active problem list was not updated with new or resolved problems. The IPN did not document if preventive services were not provided. Current and historical information was not included in all consult referrals (this area had the lowest percentage compliance). All diagnostic tests were not initialed. The internal review for the 1st Q 2012 generated 68 action plans. As of 12/15/11, 58 had been reviewed. Ten remained to be reviewed. Of the 68 action plans, 51 had evidence of closure. The QA Department continued to track 17 of the plans. The QA Department submitted a number of documents, but information appeared to be missing, or interpretive information would have been helpful. There were detailed graphs per month (May through November 2011) for each of the 30 indicators utilized in the internal review. However, the title of the graph indicated it was cumulative data when the graph appeared to include data broken down per month. Documents entitled: "Action plans follow up by QA" provided evidence of QA monitoring of progress on the completion of action plans. However, no dates were included on these documents, so the month or quarter to which the results applied could not be determined. Documents entitled: "Questions with multiple no answers" were submitted, and the identified date was at the bottom, but the month or quarter to which these totals referred was unclear. For the document dated December 15, 2011, it was not clear if this included the September 15, 2011 totals as an ongoing cumulative total or referenced responses from that date to December 15, 2011. There were extensive graphs labeled "Medical Provider Quality Assurance Audit: Compliance by question category." However, each of the graphs was labeled "Audits for Round 2," when the contents were different, indicating different timeframes, but these were not identified in the documents. The term "Round 2" was not defined. The only month clearly identified in the internal audit process was August 2011, and this was handwritten on several documents. Longitudinally, an untitled table provided information of overall compliance per month from May 2011 through November 2011. The overall compliance was at 83% in May 2011, and was at 95% in November 2011. Each of the 30 tools was listed with individual results. It is recommended that the QA Department review the final graphs, charts, and reports to include background information concerning dates, etc. to ensure appropriate interpretation of findings.	

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		<u>Medical Department Initiatives and Improvement Projects</u> Current initiatives included focus on continued improvement with the external and internal audit results. Additionally, the completion of the quarterly medical reviews was to be a new initiative, which would continue to be a challenge based on lack of a full complement of State-employed PCPs. However, the Facility had not appeared to focus much on data collection and database management to assist with departmental improvement. The information submitted from the databases appeared to be developed to address the Monitoring Team's questions or requests for information. However, in order to meet the requirements of Section L.3, the Facility's development of databases or other information management systems should be useful to the department. The Medical Department should use information generated to determine strengths and weaknesses, and to begin to act on areas of weakness. However, there was no internal analysis of clinical information that would then lead to quality improvement initiatives in the Medical Department. Additionally, the State Office clinical guidelines had not been reviewed and adapted for use at ABSSLC. Clinical indicators from these guidelines had not been used for data collection to determine quality of care for a number of clinical issues. However, the internal peer audit should begin to look at clinical aspects of care, and the first round of this should be completed prior to the Monitoring Team's next visit.	
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.	A number of policies for ABSSLC were in draft phase, and were based on a number of clinical guidelines developed recently by the State Office. The following drafts were submitted: "Identifying Risk, Treatment, and Prevention of Aspiration Pneumonia" (a clinical outline with the goal of enhancing the management of aspiration pneumonia.) This included two flow diagrams: Evaluation of Suspected Aspiration Pneumonia, and Adult Aspiration Pneumonia Prevention Algorithm, along with identification of risks/causes with preventive steps: tube feeding, pharyngeal dysphagia, reduced activity/bedbound status, xerostomia, poor oral hygiene, gastroesophageal reflux, multiple comorbidities, and dependence for oral feedings, and a Swallowing Precautions form/signage/notification completed by the speech pathologist. Other drafts were submitted, including: SSLCs Policy: Constipation prevention and management protocol; Clostridium difficile Management Pathway; Flow chart to seizure management; SSLCs Policy: Screening and Treatment of reduced bone density, including possible algorithm for screening and management; Anticoagulation protocol; and management of hyperlipidemia. These appeared to be in the initial stages of draft review. One guideline was submitted that was developed 1/12, entitled: Guidelines for Ensuring	Noncompliance

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		Proper Positioning during Procedures for People Identified at Medium to High Risk of Aspiration Pneumonia. This document provided detailed step-by-step guidance for individuals requiring test procedures in which their ideal positioning could be compromised. It included guidance concerning orders to be written by the PCP, the steps to be taken by the clerk in ensuring the consultant addressed the positioning concern, as well as consideration of the use of adaptive equipment or alternative procedures/tests that could be completed with less compromise of the individual's position, communication to the IDT and the LAR, documentation by the IDT and the PCP, and those assigned to accompany the individual to the procedure. This procedure provided much needed guidance for procedures in the community that might contribute to increased risk for the individual. The procedure provided clear detailed guidance for each department involved in the procedure.	

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. At the morning medical meeting, clinical areas needing follow-up should be assigned, including a date by which the responsible person reports back to the committee/meeting. These dates then should be tracked to ensure follow-through. (Section L.1)
3. As recommended previously, the morning medical meeting should be used as a forum to encourage critical thinking about next steps to potentially prevent Infirmary stays, ER visits, and hospitalizations. (Section L.1)
4. A rigorous interdisciplinary response to decubiti should occur, as well as routine Facility oversight. Given the number of decubiti, the skin integrity committee should take a more active role, the PNMT should increase its involvement, and more intensive monitoring should occur overall. (Section L.1)
5. Morning medical meeting concerns should be tracked in a non-narrative form, such as a chart in which the follow-up concern, the person assigned responsibility for closure, and date follow-up is requested/due are standard entries, along with a brief closure entry, including data supporting the closure, and the date of closure. (Section L.1)
6. Closure data from the morning medical meeting should be tracked, including the number of requests for closure per week, the number of concerns with closure per month, and the number remaining open. (Section L.1)
7. Databases should not be created for the purpose of the Monitoring Team's review, but the Facility should use them at periodic intervals, to interpret results and to complete an analysis of the information. Such databases should include a quarterly analysis of the results. Any gaps in data should be corrected before data is analyzed. (Section L.1 and Section L.3)
8. Improved database management is needed for tracking osteopenia and osteoporosis, and ensuring individuals are receiving adequate treatment. (Section L.1)
9. For the dictated post hospital IPNs, the time of the dictation should be recorded to establish chronology of the IPNs. (Section L.1)
10. For those individuals diagnosed with aspiration pneumonia and receiving tube feedings, consideration should be given to review of the rate of the feeding to ensure it is not aggravating reflux. (Section L.1)
11. Ongoing efforts should be made to reconcile the different reporting systems to ensure that each is accurate, complete, and in agreement with other databases. The QA Department should provide oversight, as necessary. At a minimum, review should be completed of the information systems for:
    a. Pneumonia; and

b. Decubitus ulcers. (Section L.1)

12. When discrepancies are noted in consultant reports, the PCP should seek clarification before accepting and filing the report. (Section L.1)
13. PCPs should ensure that side effects or lack of side effects are recorded for those individuals prescribed antiepileptic medication. This might be recorded in an IPN or quarterly medical review, or other agreed upon document in the active record. It is important for IDT members to be aware of side effects from medication or whether individuals are free of side effects. (Section L. 1)
14. The ethics committee minutes should be formalized. Minutes should include brief summaries, stating succinctly the reasons leading to the conclusion of the committee. Naming the responsible decision maker, and relationship/role (parent/guardian, etc.), and recording current information concerning their wishes or decisions would provide important details. The decision of the committee should include a response/interpretation of agreement or not with current State Office guidelines in place at that time. If the decision is inconsistent with State Office guidelines, clear justification should be provided. A list of documents, including the date of the document, the committee reviewed should be part of the minutes. When the committee assigns tasks, a timeline should be established for task completion, and this should be recorded in the minutes. When a decision is deferred, the time and date of the next meeting should be documented before adjournment. Like any other committee, minutes should be typed and a designated department should maintain them. Although a brief IPN should continue to be entered to give immediate feedback to the team, minutes should officially record many of the important details of the deliberations of the committee. (Section L.1)
15. For those individuals undergoing a transition to the community, the Facility should review processes that would potentiate/ensure a smooth transition. Examples include: obtaining initial medical and clinical appointments while the individual is still at ABSSLC, especially with consultant offices with long waiting lists (unless the Medicaid card is required for actually making an appointment); ensuring resources are available in the community to meet the individual's needs before choosing that location, as opposed to discovering the lack of resources once the individual has moved; working with the local school systems to resolve enrollment problems or use of services at schools, such as counseling or OT/PT before the individual transitions; and minimizing additional moves once the individual is in the community. Appropriate pre-planning, including the involvement of ABSSLC Medical Department staff, should minimize challenges of finding needed resources after the individual moves to the community. (Section L.1)
16. For those who have transitioned, the Facility should track and analyze events such as police encounters, hospitalizations (both for medical and psychiatric reasons), 911 calls, initiation or increase use of psychotropic medications, number of overdue initial office visits by PCP/psychiatry/consultations listed in transition plan, etc. (Section L.1)
17. The QA Department should review the final graphs, charts, and reports to ensure they include background information concerning dates, etc. to ensure appropriate interpretation of findings. (Section L.3)
18. As recommended previously, the Medical Director should begin to analyze the current information available in the Medical Department database. Clinical indicators need to be determined to begin to monitor quality care from a variety of perspectives (e.g., timeliness of treatment, lab tests completed, medications chosen, documentation, consents, outcomes for individuals, etc.). One source of potential indicators should be the State Office clinical guidelines. Priority should be on those clinical issues that lead to ER visits, hospitalizations, and poor quality of life. (Section L.3)

SECTION M: Nursing Care	
Each Facility shall ensure that individuals receive nursing care consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o ABSSLC's Self-Assessment; o ABSSLC's Provision Action Information; o ABSSLC At-Risk Individuals list; o ABSSLC training rosters; o ABSSLC's Nursing Department Presentation Book; o ABSSLC's Monitoring Tools for Nursing; o ABSSLC's minimum staffing numbers for nursing; o ABSSLC's Infection Control Monitoring Tool data; o ABSSLC's Corrective Action Plans for Nursing; o Program Compliance Nurse's monitoring data; o ABSSLC's lists of individuals who were seen in the emergency room, and hospital; o Infection Control Summary Report; o Resumes for the Chief Nurse Executive, Infection Control Nurse, and Nurse Educator; o Medication Variances per Month Summary data; o Medical records for the following individuals: Individual #119, Individual #25, Individual #199, Individual #126, Individual #163, Individual #87, Individual #95, Individual #393, Individual #184, Individual #147, Individual #235, Individual #511, Individual #447, Individual #538, Individual #139, Individual #35, Individual #397, Individual #57, Individual #31, Individual #465, Individual #414, Individual #293, Individual #413, Individual #513, Individual #172, Individual #159, Individual #442, Individual #393, Individual #87, Individual #59, Individual #115, Individual #534, Individual #22, Individual #247, Individual #323, Individual #517, Individual #302, Individual #444, Individual #461, Individual #6, Individual #201, Individual #138, Individual #368, Individual #350, Individual #123, Individual #202, Individual #312, Individual #454, Individual #100, Individual #504, Individual #313, Individual #2, Individual #42, Individual #545, Individual #201, Individual #444, Individual #287, Individual #101, Individual #351, Individual #524, Individual #,206 Individual #327, Individual #192, Individual #376, Individual #203, Individual #272, Individual #502, Individual #212, Individual #361, Individual #128, Individual #483, Individual #107, Individual #70, Individual #257, Individual #439, Individual #394, Individual #452, Individual #297, Individual #285, Individual #253, Individual #468, Individual #23, Individual #162, Individual #187, Individual #60, Individual #178, Individual #94, and Individual #70; o Facility list of individuals with Methicillin-resistant Staphylococcus aureus (MRSA); Hepatitis A, B, and C; human immunodeficiency virus (HIV); positive Purified Protein Derivative (PPD); converters; Clostridium difficile (C-Diff); H1N1; and sexually transmitted diseases (STDs); o SSLC Skills Checklists curriculum; o Real Time Audit tool for Infection Control;

	○ Resident Immunizations, revised 9/11; ○ Gastrointestinal Outbreak timeline; ○ Emergency Drill Checklist, revised 9/11; ○ Nurse Manager/Quality Enhancement Nurse (QEN) Meeting minutes, dated 8/9/11, 10/11, 12/11, 1/9/12, and 2/8/12; ○ Care Plan Development curriculum and test; ○ QA/QI Data, Section M: Nursing Services Quarterly summary for September through November 2011; ○ Infection Control Committee meeting minutes, dated 7/28/11, and 12/22/11; ○ Infection Control Rounds audit data; ○ Medication Variance Committee meetings minutes, dated 7/27/11, 8/24/11, 9/28/11, 10/26/11, 11/30/11, and 1/5/12; ○ Medical Emergency Response Drill meeting minutes, dated 8/9/11, 8/17/11, 8/29/11, 9/20/11, 9/22/11, and 10/18/11; ○ ABSSLC Medication Variance Graphs; ○ ABSSLC's Infection Control overall summary report list; ○ ABSSLC's lists of individuals who were seen in the emergency room, hospital, and Infirmary; ○ ABSSLC's Immunization Database; ○ Drug Utilization Discrepancy Reports; ○ Training curriculum for the Care Plan/Summary Class for Case Managers, Medication Administration using the Physical Nutritional Management Plan; ○ Medication Administration Observations raw data; ○ Nurse Educator Medication Observation form for onsite medication observation; ○ Medication Variance forms for the review period; ○ Prescriber Medication Variances data; ○ Pharmacy Technician Medication Variances data; ○ Emails from Nursing to Pharmacy, dated 8/25/11, and 9/1/11; ○ ABSSLC Corrective Action Plans for Nursing; ○ Pharmacy and Therapeutics Committee meeting minutes, dated 7/27/11, and 10/26/11; ○ Medication Administration Observation raw audit data; ○ Medication Administration Observation audit, dated 2/15/12; ○ Incident Management Review Team meetings from September 14, 2011 through January 11, 2012; ○ Medication Variances policy, dated 9/23/11; and ○ Emergency Medical Drills and tracking sheets. ▪ **Interviews with**: ○ Cathy Northrup, RN, MSN, CPN, Chief Nurse Executive; ○ Terri Massengill, RN, Nurse Manager; ○ Debra Schroeder, RN, Nurse Manager; ○ Tracey Cunningham, RN, Nurse Manager; ○ Teresa Lowry, RN, Nurse Manager;

	○ Kathy Brannon, RN, Nurse Manager; ○ Amy Jo Bramlett, LVN, At-Risk Coordinator; ○ Krista Hamilton, RN, Infection Control Manager; ○ Mary Willingham, RN, Program Compliance Nurse; ○ Carole Ivy, RN, Nurse Operations Officer; ○ Judy Henry, RN, Quality Assurance; ○ Mary White, RN, MSN, Quality Assurance; ○ Connie Horton, Consultant, Family Nurse Practitioner; ○ Hae Sean Kim, RN, BSN, Nurse Educator; ○ Jennifer Huffaker, RN, Infection Control Nurse; ○ Charlotte Myers, Respiratory Care Practitioner; ○ Vicki Williams, LVN, Nurse Educator; ○ Misty Fry, Campus RN; ○ Teresa Mitchell, Campus RN; and ○ Richard C. Martinez, Risk Manager. ▪ **Participants of the live record review included:** ○ Cathy Northrup, RN, MSN, CPN, Chief Nurse Executive; ○ Mary Willingham, RN, Program Compliance Nurse; ○ Mary White, RN, MSN, Quality Assurance; ○ Wyester Sincere, QDDP; ○ Kelli Geil, LVN; ○ Teresa Lowry, RN, Nurse Manager; ○ Angela Reiman, RN, Case Manager; ○ Megan Cheek, Physical Therapist; ○ Nicole Spalding, Registered Dietitian; ○ Tricia Reyes, Registered Dietitian; ○ Debra Schroeder, RN, Nurse Manager; ○ David Feenster, MA, CCC/SLP Speech-Language; ○ Elizabeth Seballos, BSN, RN III; ○ Debralea Sessions, MS CCC/SLP, Physical Nutritional Management Team; ○ Tammy Bayer, RN, Physical Nutritional Management Team; ○ Mary Gonzales, RN, II; ○ Pam Lantrip, RN, Case Manager; and ○ Charlotte Myers, Respiratory Care Practitioner. ▪ **Observations of**: ○ Medication Administration in the Infirmary; ○ Pharmacy and Therapeutics Committee meeting, on 2/15/12; and ○ Use of emergency equipment at the Infirmary, Activity Center, 6521, and 6480.
	Facility Self-Assessment: Based on a review of the Facility's Self-Assessment, 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.

	Although the Facility self-assessment of noncompliance was in alignment with the findings of the Monitoring Team, the Facility's Self-Assessment contained information and observations that were difficult or impossible to interpret, especially the findings from auditing data on which the Facility had based its findings. Due to a number of problematic issues related to the Facility's monitoring process, including the lack of clear and specific instructions for the Health Monitoring Tools for Nursing, no validation of the clinical competence of the auditors scoring the Health Monitoring tools, the lack of a procedure for establishing inter-rater reliability for each of the Nursing Health Monitoring tools, and no standardization regarding the presentation of the monitoring results, the reliability of the data presented was questionable. In addition, many of the training activities that were cited in the Self-Assessment did not have the associated training rosters indicating how many staff were required to attend, and how many of those staff actually attended the training. Also, for most of the trainings, the Presentation Book for Section M did not contain a description, and/or curriculum for the training. Consequently, without this information, the Monitoring Team could not verify the quality of many of the training sessions. Also, as had been noted in past reports, in several areas for Section M, the documentation in the Self-Assessment reported a single compliance score for months of data. This did not accurately reflect the areas of strength, weakness, and the quality of the areas being reviewed. Also, for many of the subsections in Section M, the Facility Self-Assessment did not address all of the requirements of the Settlement Agreement. For example, very little information was included in the Facility's Self-Assessment regarding the Emergency Medical Systems, and Mock Codes. In addition, no indication was included regarding what actions and interventions the Facility planned to implement and accomplish by the next review. The Action Plans for each Section of M, with the exception of Infection Control, were generic, and did not clearly indicate how problematic areas would be addressed. Overall, in the Facility's Self-Assessment, and the Provision Action Information, little information was provided regarding the Facility's positive steps forward. Rather, the Monitoring Team had to extract this information from the documentation found in the minutes of meetings, or from the interviews conducted on site.
	Summary of Monitor's Assessment: Since the last review, ABSSLC had some changes in its Nursing Department and nursing positions, which included the retirement of the Chief Nurse Executive, the Infection Control Manager, and one of the Registered Nurse Educators. However, at the time of the Monitoring Team's most recent review, all these positions had been filled. In addition, the Nursing Department had a total of 76 allotted positions for RNs and 99.5 for Licensed Vocational Nurses (LVNs). Nursing vacancies included one RN position, and eight LVN positions. Although the Nursing Department had experienced a high degree of nursing turnover, and a change in some of the leadership and management positions related to retirements, the Chief Nurse Executive reported that the Facility had continued to not use the services of any agencies to cover nursing positions. Some of the Facility's positive steps forward included: ▪ In October 2011, the QA Nurse and the Program Compliance Monitor for nursing had begun

	meeting monthly to discuss auditing findings, and discrepancies regarding compliance scores in an attempt to assess inter-rater reliability; ▪ The QA/QI Data, Section M: Nursing Services Quarterly summary for September through November 2011 contained a very promising summary of the selection process for the samples for a number of the nursing monitoring tools, and a summary of the data; ▪ The QA Department focused on the data for the areas of most concern, including acute injury/illness, hospitalization/Emergency Room visits, and Annual/Quarterly Nursing Assessments. This was a positive step for the Facility, since these particular areas have significant clinical ramifications regarding the individuals' health issues; ▪ The Infection Control (IC) monitoring audit results had been integrated into the minutes of the IC Committee; ▪ A number of appropriate and timely in-service training sessions were provided to staff in response to acute infectious illnesses; ▪ Additional emergency scenarios had been added to the emergency drills, and were documented on the Emergency Drill Checklists; ▪ The Pharmacist reviewed the medications for buildings 6730 and 6740, and made recommendations for changes in the medication administration times, amounts, and routes to decrease the potential for medication errors; and ▪ Medication variances regarding pharmacy technician variances and prescriber variances had begun to be tracked by the pharmacy, and were being reported in the Medication Variance Committee meetings. Although the Facility had made some positive steps in the areas noted above, of most concern was the lack of overall progress made in the critical areas addressing nursing Health Management Plans, nursing assessment and documentation in response to changes in status, and the quality and timeliness of the quarterly and annual nursing assessments. These troubling findings were consistent with the findings from the past four reviews, and no concrete plan appeared to be in place to address these findings.

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M1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, nurses shall document nursing assessments, identify health care problems, notify physicians of health care problems, monitor, intervene, and keep appropriate records of the individuals' health care status sufficient to readily identify	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, 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 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 above with regard to Section C.	Noncompliance

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	changes in status.	Based on a review of the Facility's Self-Assessment and the Presentation Book, the Monitoring Team found the following: ▪ The Facility reported that the Quality Assurance nurse and the Nurse Managers reviewed Health Monitoring tools (HMTs) for Acute Illness and Injuries to determine if the nursing care was provided according to policy. The Facility indicated that the data for 32 HMT audits conducted, nursing care was provided from 42% to 98% according to policy. However, the Self-Assessment did not describe how the samples were selected, what the established inter-rater reliability percentages were for the audit tool, what specifically the compliance percentages (42%-98%) reflected, and how they were determined. In addition, as had been noted in past reports, reporting single compliance scores for months of data for monitoring tools is meaningless, and does not accurately reflect the areas of strength, weakness, and the quality of the areas being reviewed. Consequently, the Facility's data could not be accurately interpreted or considered reliable. ▪ The Nurse Operations Officer reviewed the list of nurses to determine if all nurses attended required training for nursing protocols, and found that 151 out of 168 nurses received trained on nursing protocols that were implemented in November 2011. However, no training rosters specifically for the nursing protocols or description of the training were provided in the Presentation Book for Section M.1. The training rosters that were included in the Presentation were entitled "Nursing Meeting," and were dated November 15th and 16th, 2011, but did not include an associated outline or curriculum. ▪ The Infection Control Nurse (ICN) reviewed the Pharmacy database to determine if all antibiotic usage was being captured on the Infection Control Report according to policy, and found that this data was being appropriately reported. ▪ The Infection Control Nurse and Program Compliance Monitor reviewed the Resident Immunization database, implemented in September 2011, to determine if individual immunizations were current related to immunization guidelines. The review noted that the Resident Immunization database was 80% complete. Due to the age of some individuals and nonexistent records, titers were being sought to complete the immunization records, and provide preventative care. ▪ The Infection Control Nurse reviewed the revised Infection Control Outbreak template following an actual infectious outbreak, and found that it provided an improved format to conduct root cause analyses of the situation, and develop needed action plans. ▪ IC was not able to review the effectiveness of the new Real Time Infection audit form implemented in December 2011, because only one reportable infection had occurred after it was implemented.	

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		▪ The Nurse Operations Officer examined the results of distribution of Nursing Protocol cards given to all nurses on campus by 11/30/2011, and found that 100% of the nurses received Nurse Protocol card key rings for ready reference. These also were being included for all future nurse orientation. The Facility indicated that data was not available to analyze the efficacy of this action. ▪ The Facility indicated that the statewide standardized Emergency Response Policy and forms were implemented this quarter, along with the oversight process by Nurse Managers. Although the Facility indicated that the Emergency Response Policy and forms had been fully implemented with training provided to all staff, no training rosters or description of the training was provided in the Presentation Book for Section M.1. Regarding compliance, the Facility indicated that "based on the findings from this self-assessment, this provision is not in total compliance due to the results of the monitoring tools that show that nursing is not addressing all areas of nursing care; furthermore staff have been trained on the nursing protocols except one on health leave since October. Discrepancy reports indicate a downward trend in discrepancies related to the documentation of antibiotic usage. Infection Control reports are capturing the antibiotic usage. The new Immunization database is enabling us to target needed preventative immunizations, but is not totally complete. IC Outbreak template shows promise to expand on use of root cause analysis and to help generate interventions in alignment with the process." The overall impact that these activities had on progress, and outcomes are addressed in the associated subsections below. <u>Staffing</u> At the time of the review, ABSSLC had a census of 428 individuals. Since the last review, ABSSLC had some changes regarding its Nursing Department and nursing positions, including: ▪ The Chief Nurse Executive retired in September 2011; ▪ The Infection Control Manager retired in September 2011; ▪ One of the Registered Nurse Educators retired in September 2011; ▪ In October 2011, a new Chief Nurse Executive was hired; ▪ In December 2011, a full-time Registered Nurse was hired as the Assistant Infection Control Nurse; ▪ In September 2011, a full-time Registered Nurse was hired for Nursing Education; and ▪ The existing Assistant Infection Control Nurse was promoted to the IC Manager position.	

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		At the time of the review, the Nursing Department had a total of 76 allotted positions for RNs and 99.5 for Licensed Vocational Nurses. Nursing vacancies included one RN position, and eight LVN positions. Although the Nursing Department had experienced a high degree of nursing turnover, and a change in some of the leadership and management positions related to retirements, the Chief Nurse Executive reported that the Facility had continued to not use the services of any agencies to cover nursing positions. From a review of the Facility's nursing staffing data and discussions with the Chief Nurse Executive, ABSSLC continued to maintain an adequate nursing staff. As recommended previously, although there had been staffing changes and nursing turnover, which had stabilized at the time of the review, ABSSLC should continue its efforts in recruiting, maintaining, and evaluating reallocations of nursing positions to meet the requirements of the Settlement Agreement. Also, as previously recommended, as ABSSLC policies are reviewed and/or revised, the Facility should ensure that policies, procedures, or protocols address the integration of any new positions. <u>Quality Enhancement Efforts</u> From discussions with the Quality Assurance Nurse, since the last review, the following activities had been initiated: ▪ Although the Facility did not have an established procedure addressing inter-rater reliability, the QA Nurse and the Program Compliance Monitor for nursing had begun meeting monthly in October 2011 to discuss auditing findings, and discrepancies regarding compliance scores in an attempt to assess inter-rater reliability. No information was provided addressing how the discrepancies were reconciled. At the time of the review, no minutes were recorded of these meetings. However, these efforts were a very positive step forward to ensure consistency between the auditors. ▪ In August 2011, the QA Nurse began meeting with the Nurse Managers monthly regarding the findings of audits addressing nursing issues. A review of the minutes of the meetings found this to be a very positive step forward in communicating some of the problematic issues found from the audits. ▪ The QA/QI Data, Section M: Nursing Services Quarterly summary for September through November 2011 contained a very promising summary of the selection process for the samples for a number of the nursing monitoring tools, and a summary of the data. Although this report had significant potential, the problematic issues noted below need to be addressed in order for the data, and presentation of the data to be reliable and valid. ▪ Although most of the areas regarding nursing were audited, the QA Department focused on the data for the areas of most concern, including acute injury/illness, hospitalization/Emergency Room visits, and Annual/Quarterly Nursing Assessments. Again, this was a positive step for the Facility, since these	

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		particular areas have significant clinical ramifications regarding the individuals' health issues. ▪ The Facility had significantly decreased the number of nurses conducting the audits in an attempt to generate more reliable data. Ultimately, the decrease in the number of auditors should facilitate the establishment of inter-rater reliability. ▪ Although the Presentation Book for Nursing included graphs addressing data collected regarding the various areas for nursing, they could not be accurately interpreted due to the data being combined for three months (October through December 2011), and not reflective of progress or lack of progress by month. Thus, it was impossible to accurately interpret the Facility's data. However, on a positive note, the QA/QI Data, Section M: Nursing Services Quarterly summary for September through November 2011 included a good explanation of why an overall single compliance score could be misleading, and inaccurately reflect improvement. Regarding the Facility's data, and presentation of data, in order for the Facility to move into a position of sustainable substantial compliance, a number of foundational systems should be constructed first before additional systems are implemented. The integrity of this foundational framework will affect the determination of substantial compliance in most, if not all, clinical and non-clinical areas. To adequately and consistently monitor Section M of the Settlement Agreement, the Facility should ensure the following systems are adequately implemented: ▪ Although the Facility had developed, and modified some of the instructions for the Nursing Health Monitoring tools, overall, the instructions were not clear and specific. For example, the current instructions did not consistently outline exactly where the required documentation should be found, and specifically what 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. Without clear and specific instructions for the monitoring tools, compliance would be determined according to each auditor's judgment, which produces unreliable data. The Facility and the State should collaborate on developing specific instructions for the Health Monitoring tools. ▪ 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. ▪ Inter-rater reliability should 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, as was already	

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		reported by the QA Nurse, and the PCM. 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. ▪ Regarding the presentation of auditing data, as noted in previous reports, it should include a description of the total population being reviewed (N), and a description of the sample of that population that was audited (n) to yield a percent sample, indicating the relevance of the compliance scores. Also, data presented by item by month rather than by one single compliance score per tool for a quarter provides essential information regarding the progress for specific areas being reviewed. A review of the QA Nurse and Nursing/PCM's raw audit data found that the problematic issues listed above rendered the data unreliable. However, implementing the structures listed above should facilitate the accuracy and reliability of the Facility's data. The Facility should implement the remaining essential pieces of the monitoring system to generate credible data going forward, and continue to give thoughtful consideration when prioritizing the implementation of the Health Monitoring audit tools based on the areas that affect the health and safely of the individuals at ABSSLC. The overall actions that were implemented since the last review demonstrated that the QA Nurse and the PCM had a good understanding of the purpose of the monitoring system. <u>Assessment and Documentation of Individuals with Acute Changes in Status</u> Since the last review, the Facility indicated that the following steps had been implemented to address the nursing assessment and documentation of individuals with acute changes in health status: ▪ In November 2011, the Facility implemented the State Office Nursing Care Protocols. Although the Facility reported that 151 out of 168 nurses received training regarding these nursing protocols, no description of the training was provided in the Presentation Book for Nursing. In addition, based on the findings of the Monitoring Team noted below, there was essentially no consistent improvement seen in the nursing assessments, and documentation in the IPNs. A review of 12 individuals' medical records (i.e., Individual #452, Individual #297, Individual #285, Individual #253, Individual #468, Individual #23, Individual #162, Individual #187, Individual #60, Individual #178, Individual #94, and Individual #70) who had been transferred to a community hospital, emergency room, or the Infirmary found: ▪ Nurses promptly and consistently performed a physical assessment on any individual displaying signs/symptoms of potential or actual acute illness in none (0%).	

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		▪ Licensed nursing staff timely and consistently informed the PCP of symptoms that required medical evaluation or intervention in none (0%) of the cases. ▪ Appropriate information was communicated to the PCP in none (0%) of the cases. ▪ The nurse consistently performed appropriate and complete assessments as dictated by the symptoms in none (0%) of the cases. ▪ The nurse conducted frequent assessments of the individual's clinical condition in none (0%) of the cases. ▪ An adequate plan of care was developed including instructions for implementation and follow-up assessments in none (0%) of the cases. ▪ The documentation indicated that acute illness/injuries were followed through to resolution in none (0%) of the cases. A review of these 12 individuals found essentially the same significant problematic clinical issues regarding nursing assessments and documentation that the Monitoring Team identified during the past four reviews. The overall problematic issues that were found in all 12 records included specifically: ▪ 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; ▪ A consistent lack of complete and appropriate nursing assessments was noted in response to status changes in vital signs, and oxygen saturations; ▪ The lack of consistent nursing documentation made it impossible to accurately determine when changes in status were initially occurring; ▪ There was a consistent lack of follow-up for health issues noted in previous nurses' progress notes; ▪ There was consistent inadequate documentation and nursing assessments addressing the administration and follow-up of the effectiveness of pro re nata medications (PRN, or as needed medications); ▪ There was consistent inadequate assessments and follow-up addressing indications and/or complaints of pain; ▪ The nursing notes lacked specific description, size, and location of skin issues, such as reddened area, injuries, or bruises; ▪ There was a lack of documentation of individuals' activities and tolerance for activities during the day, evening, and night to indicate any associated changes in mental status from physical changes in status; ▪ There were few mental status assessments documented during status changes; ▪ There was a consistent lack of documentation indicating that lung sounds were regularly assessed and documented for significant respiratory issues; ▪ There was a consistent lack of assessment of bowel sounds, and abdomen exams documented for individuals with constipation or receiving PRN laxatives;	

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		▪ There were gaps in nursing documentation, when the nurses' notes indicated that they were "monitoring" the individual's status; ▪ Physicians/Practitioners were consistently not timely notified of changes in status, due to nurses' inadequate follow-up; ▪ There was consistently no documentation that nursing communicated with the PNMT regarding changes in status for individuals at risk of aspiration/choking; ▪ 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; ▪ Many inappropriate abbreviations were used that could not be interpreted; ▪ A consistent lack of communication was noted between shifts regarding status changes, and the need for regular assessments and follow-up; ▪ There was inadequate documentation noted regarding the individual's status and assessment at the time of transfer to the hospital or Infirmary, or emergency room; ▪ In the progress notes, there was inconsistent documentation of the time, date, and/or method of transfer to the receiving facility; ▪ There was inconsistent documentation that the nurse or physician notified the receiving facility of the individual's transfer; ▪ In the nursing notes, there was a consistent lack of analysis of contributing problematic issues affecting changes in status documented; ▪ There was inadequate documentation of a complete nursing assessment upon return to the Facility, especially addressing the same symptoms that precipitated the transfer to a community hospital; ▪ There was a consistent lack of regular follow-up days after the transfer occurred for symptoms related to the initial reason for the hospitalization; ▪ Heath Management Plans addressing health issues were consistently inadequate with regard to the goals and nursing interventions, and were not effectively modified after hospitalizations; ▪ Dates and times were not consistently documented for progress notes; ▪ A significant number of nursing progress notes and signatures were illegible; and ▪ There was inconsistent documentation addressing the care of healthcare equipment individuals required, such as catheters, tracheotomies, and G-tubes. Although some Integrated Progress Notes contained an adequate nursing assessment, and associated findings, because of the inconsistency of these notes, it was clear that these were not the result of a structured system. Although the Facility reported that Nursing Protocols had been implemented, there was no indication that they were being used to guide nursing assessments and documentation. The Facility should continue to implement and expand the use of nursing protocols (as is discussed in further detail with	

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		regard to Section M.4) to guide nursing practices, in conjunction with the adequate competency-based nursing skills training being provided by the State Office Nurse Practitioner Group. As noted in previous reports, due to the number of individuals with medical complexities at ABSSLC, this area should be considered a priority for Facility review, and the development and implementation of action plans addressing the significant deficits that exist in the nursing care. The Facility's Self-Assessment indicated that it was not in compliance with the elements of this requirement, which was consistent with the Monitoring Team's findings. <u>Availability of Pertinent Medical Records</u> From a limited review of records while on site, it was noted that few documents were missing from the active records. The Facility should continue to ensure that documents are available, and filed in a timely manner in the individuals' records, so that pertinent clinical information is readily available to clinicians needing this information when making decisions regarding treatments and health care services. <u>Infection Control</u> At the time of the review, the Facility recently had hired a full-time RN in the position of the Assistant Infection Control Nurse. This staff member had no previous experience in Infection Control. In addition, the previous Assistant Infection Control Nurse was promoted to the Infection Control Manager position. From discussions with the IC Manager, and review of the documentation contained in the Presentation Book for Infection Control, the new Assistant Infection Control Nurse had received some initial competency-based training regarding infection control principles, which should be continued From a review of the Facility's Self-Assessment, ABSSLC's Action Provision Information report, the documentation contained in the Presentation Book addressing Infection Control, as well as interviews with the IC Nurse Manager, and information gathered during the review, some very positive progress had been made in building systems to meet the requirements of the Settlement Agreement. Some of the progress noted included: ▪ The Presentation Book addressing Infection Control was very organized and clearly reflected the activities and progress made by the IC Nurses since the last review; ▪ The minutes of the Infection Control Committee meetings provided clear and specific information regarding issues discussed, actions implemented, and the effectiveness of the actions on outcomes. An increase was noted in the analysis of the IC data, comparing quarterly data for 2011 to the same quarter in 2010,	

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		and noting an overall decrease in infections. In addition, specific actions implemented, such as the addition of Dispatch bleach wipes, and disposable shoe covers were included in the analysis as measures contributing to a positive outcome. However, more clinical analysis was needed regarding current data, such as urinary tract infections, including any associated trends identified regarding the organisms found from the urine cultures, and the units that experienced the most frequent occurrences; ▪ A Root Cause Analysis section was added to the Outbreak Investigation form to provide the committee with a consistent and thorough process for evaluating the actions initiated during an infectious outbreak; ▪ An immunization database was developed and implemented. At the time of the review, Facility staff were in the process of completing collection and entry of data to ensure that all individuals' immunizations were current, and being tracked. Although data was still being entered into the database at the time of the review, the Facility could not generate a list of all the individuals whose immunizations had been researched, and were updated; ▪ The IC monitoring audit results had been integrated into the minutes of the IC Committee. A very positive step was the Committee's use of the IC data to develop action plans addressing problematic areas found regarding: the need for appropriate follow-up and documentation regarding the administration of an antibiotic for an acute infection, and the implementation of care plans for acute infectious processes; ▪ In December 2011, the IC Nurses began reviewing the nursing care plans regarding chronic infections. The information contained in the Presentation Book indicated that several recommendations for modifications were made in relation to a number of care plans. However, from discussions with the IC Nurse Manager, there had been an on-going lack of cooperation from nursing regarding making the necessary changes. As noted with regard to Section M.3, there continued to be a significant lack of clinically appropriate nursing care plans addressing both acute and chronic infectious illnesses; ▪ In January 2012, the Facility implemented a new form for Infection Control Rounds. Although the form was newly implemented, some problematic issues already were being identified and addressed, such as hand washing hygiene issues, and the disposal of soiled linens. ▪ The IC Nurse Manager provided training to the Foster Grandparents regarding proper hand washing, proper cough etiquette, the use of hand sanitizer, immunization information, the Facility's protocol for illnesses for employees, and common IC signs the Facility used to indicate the need for specific precautions. This was an exceptional idea since employees, visitors, and family members can bring many of the infectious processes into the Facility. In addition, providing this basic training to the Forster Grandparents should assist	

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		in the prevention of the spread of the infectious illness; and ▪ A number of appropriate and timely in-service training sessions were provided to staff in response to acute infectious illnesses. Although the IC Nurses had made several positive steps forward, a number of systems addressing clinical issues and outcomes needed further attention, including; ▪ As noted above, an immunization database was developed and implemented, and was in the process of completion. However, at the time of the review, the IC Nurse Manager indicated that only about 80% of the individuals had had their immunization status researched, and entered into the database. Thus, the Facility could not generate a list of all the individuals whose immunizations had been researched, and were updated. A formalized immunization schedule and system to track immunization information should be implemented to ensure all individuals have received all the required immunizations as outlined in the Health Care Guidelines; ▪ Although the Facility's implemented the Infection Control Round form, the results of these audits should be included in the minutes of the Infection Control Committee meeting minutes; ▪ The Facility should expand its pool of staff that conducts environmental monitoring auditing. Including different staff members, such as residential and programmatic staff, would prevent auditors from becoming desensitized, and not accurately and adequately assessing the environment; ▪ Regarding Nursing Care Plans, essentially the same problematic issues were found during this review as were found during the previous reviews. Specifically, a review of 28 individuals (i.e., Individual #100, Individual #504, Individual #313, Individual #2, Individual #42, Individual #545, Individual #201, Individual #444, Individual #287, Individual #101, Individual #351, Individual #524, Individual #206, Individual #327, Individual #192, Individual #376, Individual #203, Individual #272, Individual #502, Individual #212, Individual #361, Individual #128, Individual #483, Individual #107, Individual #70, Individual #257, Individual #439, and Individual #394), who had a variety of infectious illness, were reviewed to determine if the individuals had appropriate care plans to address their needs. Of the 28 individuals, 20 (71%) were found to have HMPs addressing the infectious issue. Of the 20 Nursing Care Plans reviewed addressing infectious diseases, none (0%) were found to be adequate. However, there was an increase noted in attempts to individualize some of the HMPs with the assistance of the Infection Control Nurse. From the review, the HMP for Individual #272 was noted to be the most promising attempt at individualizing, and including specific clinical information addressing an infectious illness. ▪ In addition, the Facility's Gastrointestinal (GI) Outbreak list indicated 28	

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		individuals were affected by the outbreak (i.e., Individual #414, Individual #293, Individual #413, Individual #513, Individual #172, Individual #159, Individual #442, Individual #393, Individual #87, Individual #59, Individual #115, Individual #534, Individual #22, Individual #247, Individual #323, Individual #517, Individual #302, Individual #444, Individual #461, Individual #6, Individual #201, Individual #138, Individual #368, Individual #350, Individual #123, Individual #202, Individual #312, and Individual #454). Of the 28 individuals, only 14 (50%) were found to have HMPs addressing the infectious issue. Of the 14 Nursing Care Plans reviewed addressing the infectious illness, none (0%) were found to be adequate. This is discussed in more detail 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 and consistently implemented; ▪ At the time of the review, since the tool had only been recently implemented, only one IC audit had been conducted addressing IC clinical practices regarding infectious illnesses. The Facility should continue to focus its efforts on the implementation of the clinical Real Time auditing tool to assess the clinical practices and treatments of infectious and communicable diseases. In addition, 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 needs to be conducted while the acute infection is active; ▪ Although from review of the Infection Control Committee meeting minutes, the Committee had increased its analysis of the Facility's IC surveillance data, the Facility should continue to conduct analyses of the IC data, implement plans of action addressing problematic issues, document the interventions implemented, and the resulting outcomes. Since the last review, the Facility had made a number of impressive steps forward with regard to Infection Control. However, a significant amount of work was yet to be done regarding Infection Control in meeting the requirements of the Settlement Agreement. Consideration should be given to having additional expertise in Infection Control provided to the Facility to assist in effectively operationalizing the Infection Control systems in alignment with IC standards of practice, as well as providing professional feedback regarding the quality and completeness of the Infection Control Program. <u>Mock Code Drills and Emergency Response Systems</u> Although the Facility's Self-Assessment did not include information regarding this area, from interviews and review of the Medical Emergency Response Drill Workgroup	

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		meeting minutes, some progress had been made including the following: ▪ Additional emergency scenarios had been added to the emergency drills, and were documented on the Emergency Drill Checklists; ▪ Reference Cards were updated reflecting the changes made in the CPR process; ▪ Information cards were developed addressing the correct oxygen flow rates, and the amount of suction to be used; ▪ Minutes of the Medical Emergency Response Drill Workgroup meetings indicated that the criteria for failed drills was being reviewed and clarified; ▪ New emergency equipment bags were obtained for all the residences at the Facility; ▪ In December 2011, Risk Management began monthly checks of the Emergency Equipment in alignment with the State Office policy; and ▪ The committee approved the addition of bringing emergency equipment to all emergency drills to the job skills checklist. Although the Facility implemented some positive steps addressing the Emergency Response System, a number of problematic issues were found that should be addressed in order for additional progress to be made: ▪ The Facility did not have a system in place to track the completion of the Refresher Course for staff required to take the training; ▪ The PCMs and Nursing QA staff had implemented a system to establish inter-rater reliability for the Mock Drills. However, no documentation was available addressing this process or the percentages established; ▪ Although the minutes of the Incident Management Review Team meetings listed the Mock Drills that had been conducted and failed, no discussion or analysis was found regarding this information; ▪ Although the Facility reported some improvement, there continued to be staff refusals regarding participation in the Mock Drills. In addition, it was noted the physicians continued to participate infrequently in the drills; ▪ No discussion or analysis was found regarding the actual medical emergencies (4444 calls), and there had been no form documenting the actual medical emergencies developed; ▪ From a review of the documentation the Facility provided addressing Emergency Drill Checklists, the Monitoring Team was unable to accurately determine how many drills had been conducted each month, and how many had passed. The tracking sheet was a handwritten log that was difficult to read, and this data had only been reported once in the Minutes of the Medical Emergency Response Drill Workgroup meeting; ▪ Minutes of the Medical Emergency Response Drill Workgroup meetings, dated 9/20/11, indicated that when an actual medical emergency (4444 call) occurred, no nasal canula was in the emergency bag for Residence 6500, causing a delay in	

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		providing oxygen to an individual whose oxygen saturations were dropping. This indicated that the equipment had not been checked every shift as required, or if it had, adequate corrective action had not been taken to address this serious issue; ▪ From a review of the Minutes of the Medical Emergency Response Drill Workgroup meetings, no meetings were held after October 2011 addressing the medical emergency systems; and ▪ Although the Monitoring Team's observations of nurses demonstrating the emergency equipment at the Activity Center, and Residences 6521, and 6480 indicated significant improvement in the staff knowledge and ability to demonstrate the use of the emergency equipment, the nurse observed at the Infirmary was not very familiar with the use of the all the emergency equipment. Although the Facility had made some positive steps forward regarding ABSSLC's Emergency Response System, the Facility needed to address the number of problematic issues noted above. The Facility should review all data related to its emergency systems, and analyze the findings from the Mock Drills to ensure that any training provided translates into improved practices in the residences. In addition, trends from the actual medical emergencies (4444 calls) should be identified and analyzed, so that appropriate corrective actions can be timely implemented.	
M2	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall update nursing assessments of the nursing care needs of each individual on a quarterly basis and more often as indicated by the individual's health status.	In assessing its progress, ABSSLC indicated in the Facility's Self-Assessment that since the last review, the following steps were initiated regarding this requirement of the Settlement Agreement: "Activities engaged in to conduct the self-assessment: 1. Nurse Educator (NE) reviewed nursing training records to determine what nurses have completed Physical Assessment competency training according to the settlement agreement. 2. PCM began reviewing Annual Nursing Physical Assessment to determine if individuals' preferences, strengths, skills, needs and barriers to community integration were included. 3. Hospital Liaison (HL) began reviewing current discharge summaries to ensure all information is captured for a smooth transition to the community and/or another facility according to policy. 4. PCM {sic} reviewed Quarterly and annual Nursing assessments to determine completion within 30 days of PSP or per facility policy. 5. NE reviewed nursing competency based training for implementation. 6. HL began reviewing statewide community discharge form which will maintain continuity of care in the community. 7. CNE reviewed ability of Case Managers to analyze and synthesize clinical	Noncompliance

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		indicators and document a clinical analysis regarding health and behavioral status of individuals. The results of the self-assessment: 1. As of 09/27/2011, 37% of nurses have completed training on Physical Assessment. 2. The new Annual Nursing Physical Assessment is in use however; no data is available at this time. 3. New Discharge summary form was developed and implemented in November, 2011, therefore no data is available. 4. Review of Annual Nursing Assessments tool (question 2) to determine if they were completed on time and per policy was 41% for the latest quarter based on sample size of 60 from the average population of 438. December was 64% and discussion with QDDP Director indicated big changes in scheduling affected these numbers. 5. Nursing Education Handbook with the nursing competency based training was partially implemented September, 2011. Educator retired during time with new Nurse Educator hired and trained in October. Competencies are being scheduled presently. 6. Form has been implemented and used by case managers; however insufficient data is available for analysis at this time. 7. Meetings with Case Managers as a group completed with information and activities to assess ability to summarize (synthesize and analyze) and individualize clinical information. Result noted was the need for practice and instruction to enable individualization and good analysis. Individual meetings to come. Self-rating: Based on findings of self-assessment, this provision is not in compliance due to the need for more audits to monitor for competency. Also, the training of nurses on Physical Assessment is continuing, but has not been completed. Annual Nursing Assessments show improvement, however the numbers may be misleading. Monitoring tool now must be reevaluated with a more narrow focus. Nursing Education Handbook is being more fully implemented, especially Preceptorship section. Data will be obtained when totally functional." A review of the Presentation Book for Section M found that no training rosters were included to verify how many nurses had completed the Physical Assessment Competency training. In addition, it was unclear why the Facility's Self Assessment contained a percentage of nurses (37%) that completed the training as of September 2011, rather than as of the current month of February 2012. In addition, although the Presentation Book for Section M included graphs addressing data collected regarding Annual Nursing Care Plans, and Medical Administration and	

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		Documentation, they could not be accurately interpreted due to the data being combined for four months (September through December 2011), and not reflective of progress or lack of progress by month. The data also could not be considered valid due to the lack of clear and specific instructions for the monitoring tools, unestablished clinical competence of the auditors in the areas they were reviewing, and the lack of inter-rater reliability established for the monitoring tools. Also, data regarding Annual Nursing Care Plans did not address the provisions for this requirement of the Settlement Agreement, and in the documentation provided, no monitoring tool was found addressing Medical Administration and Documentation. In addition, the data that was addressed in the Self-Assessment regarding the timeliness of Annual Nursing Assessments was not included in the Presentation Book for Section M.2. Moreover, the data was only presented as one quarterly compliance percentage that, again, the Monitoring Team could not accurately interpret. Although the CNE indicated that she had begun working with the Case Mangers regarding the quality of the documentation for the nursing assessments, which was a positive step forward, no explanation was found in the Presentation Book in Section M.2 addressing what specific method was used to assess the Case Managers' ability to synthesize, and analyze clinical information in order to adequately complete a nursing summary for the Comprehensive Nursing Assessments. The Presentation Book also did not include a plan addressing how the determined need for further practice and instruction would be addressed. Although the Facility had conducted some audits on the Comprehensive Nursing Assessments, from discussions with the Nursing Department and the QE Nurse, and review of the Annual Nursing Assessment monitoring tool, no specific criteria had been developed to ensure consistency when auditing the quality of the documentation. The Facility had appropriately decreased the number of nurses auditing the various areas of nursing practices, and was clearly making earnest attempts to monitor the Comprehensive Nursing Assessments. The Facility also was reviewing the findings monthly with Nursing management, and at the monthly meetings with the Case Managers. However, accurate and reliable data is essential in order to effectively address problematic areas. It is anticipated that with the assistance of the State Office Data Consultants, many of the problematic issues regarding the Facility's data, and the presentation of the data should be addressed by the next review. Based on the findings of the Monitoring Team regarding this requirement, since the last review, little improvement had been made regarding the quality of the documentation contained in the Comprehensive Nursing Assessments, specifically in the Summary Section where an analysis should be conducted regarding the individuals' health/mental health issues. From discussions with the CNE, since the last review, some state-wide modifications had been made to the Quarterly/Annual Comprehensive Nursing Assessment form that included the addition of the Braden Scale regarding skin integrity, categories for	

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		discussion in the Summary Section, and statements regarding the supports and services provided by nursing and community integration. Although these were positive steps forward, the Monitoring Team found that there had been little to no progress made regarding the quality of the quarterly/annual nursing assessments. The Quarterly/Annual Nursing Assessments for 20 individuals who the Facility identified as being at risk for specific health indicators were reviewed, including those for: Individual #119 for respiratory distress; Individual #25, Individual #199, and Individual #126 for weight issues; Individual #163, Individual #87, and Individual #95 for challenging behavior; Individual #393, and Individual #184 for falls; Individual #147 for osteoporosis; Individual #139, Individual #35, and Individual #397 for dental; Individual #57, Individual #31, and Individual #465 for fractures; and Individual #235, Individual #511, Individual #447, and Individual #538 for urinary tract infections. ▪ Of the 20 individuals' nursing quarterly assessments reviewed, 18 (90%) were timely completed. Assessments that were not timely completed included Individual #447, the last Quarterly Assessment was completed 9/16/11; and for Individual #31, no Quarterly Assessment was found between 6/11 and 11/11. ▪ 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. ▪ There was an adequate assessment of the high and medium risk health indicators included in none (0%) of the Comprehensive Nursing Assessments. ▪ Nursing assessments were updated as indicated by the individual's health status in none (0%) of the Comprehensive Nursing Assessments reviewed. As noted from previous reviews, variations continued to be seen in the Summary Sections as nurses attempted to write an analysis. However, in most of the Comprehensive Nursing Assessments reviewed, the summaries contained a list of the health issues, some of the interventions from the HMPs, and in some cases, a list of the changes in the physician/practitioner orders since the last quarter. In addition, some of the Summary Sections actually contained the template instructions under several categories rather than information regarding the individual. Consistent with the findings from the previous reviews, none of the Comprehensive Nursing Assessment summaries included an appropriate analysis of the individuals' health/mental health issues between quarters. Irrespective of the changes made in the format of the Summary Section, the summaries were essentially a listing of sequential data, and dates of events, such as hospital admissions, with no associated analysis of the data indicating if the health issue was improving or getting worse. The consistent lack of progress regarding the Comprehensive Nursing Assessments was	

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		very troubling, and suggested that nursing at all levels within ABSSLC lacked the ability and understanding of how to analyze, summarize, and document health/mental health issues to determine whether or not progress was being made regarding individuals' health and behavioral issues. The Facility should provide appropriate competency-based training regarding the Quarterly/Annual Comprehensive Nursing Assessments from a competent source to ensure that the nursing assessments include an adequate clinical analysis of the individuals' progress. Without adequate and appropriate competency-based training regarding the documentation of a clinical analysis, changes in the Comprehensive Nursing Assessment form, and variations in the summary format will not result in improving the quality of the Comprehensive Nursing Assessments as required by the Settlement Agreement. Regarding the nursing documentation for discharges/individuals transitioning to the community, from discussions with the CNE, the Facility had implemented the new Nursing Discharge Summary form in November 2011, and at the time of the review, had used the new state-wide form for two individuals (i.e., Individual #149, and Individual #532). A review of the Nursing Discharge Summaries for 13 individuals including: Individual #387, Individual #402, Individual #188, Individual #149, Individual #243, Individual #121, Individual #398, Individual #532, Individual #160, Individual #102, Individual #258, Individual #106, and Individual #132 found the following: ▪ None (0%) of the Nursing Discharge Summaries adequately addressed the health/mental issues of the individuals. ▪ There was adequate information contained in none (0%) of the Nursing Discharge Summaries that would guide the community staff in providing the needed nursing care to the individual. ▪ A current nursing assessment was conducted for none (0%) of the individuals prior to discharge/transferring to the community. ▪ There was adequate documentation identifying specific nursing interventions needed for all health/mental issues in none (0%) of the cases reviewed. Nursing should provide a clear and comprehensive analysis summarizing the individual's health/mental health issues since they have been at the Facility, as well as their current status. This should be available from the summaries from the Quarterly/Annual Comprehensive Nursing Assessments. In addition, Nursing Care plans addressing all health issues, including individual-specific nursing interventions the individual needs should be provided to the receiving staff. Also, a summary of the goals and progress of any nursing programs should be included in the documentation for transition/discharge. Clearly, the problematic issues regarding nursing assessments for discharges/transitions to the community were not resolved by the implementation of a new form. In addition, the consistently inadequate Health Management Plans (as discussed with regard to	

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		Section M.3) would not have provided any specific guidance regarding the type and frequency of nursing care, and interventions that the individuals required. It is imperative that ABSSLC review and revise its current nursing discharge procedures and documentation requirements to ensure that upon an individuals' discharge from the Facility, the nursing documentation is specific and detailed enough to maintain continuity of care. Again, the problematic issues found by the Monitoring Team during this review were consistent with the findings from previous reviews with no progress noted. Overall, the same problematic issues were found in all the Comprehensive Nursing Assessments reviewed as noted from the previous reviews. These problematic issues included: ▪ A significant lack of clinical assessments for clinical health indicators; ▪ A lack of an analysis of the individuals' health/mental health issues; ▪ A lack of critical thinking when completing the Comprehensive Nursing Assessments; and ▪ A lack of a comprehensive and specific nursing assessment for individuals being discharged/transitioned to the community. The Facility's Self Assessment 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 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.	Based on a review of the Facility's Self-Assessment and the Presentation Book, the Monitoring Team found the following: ▪ Nurse Managers and QA staff reviewed audits addressing Acute Care Plans (ACPs) completed between September 2011 and November 2011 to determine if they had been developed and implemented according to Facility policy. The Facility's Self-Assessment indicated that 24 samples were reviewed for the current quarter, and found that 58% were developed and implemented. In addition the Facility reported that for the last quarter, 47% were developed and implemented. However, the Facility provided no information regarding what specifically a single percent compliance score for two quarters reflected, such as what the compliance scores were by month for the timely development of Acute Care Plans, or the implementation of those Acute Care Plans. In addition, no explanation was provided as to how compliance with implementation was determined and measured. Also, the Facility provided no information regarding how samples were chosen for auditing. Thus, the Facility's data could not be accurately interpreted. ▪ Regarding the development and modification of Acute Care Plans addressing changes in conditions, based on auditing data from a sample size of 24, the Facility reported a compliance score of 52% this quarter, as compared to	Noncompliance

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		46% from the previous quarter. As noted above, the Monitoring Team found that the Facility's data provided in the Self-Assessment could not be accurately interpreted. ▪ The Facility's Self-Assessment noted that the At-Risk Coordinator reviewed audits addressing the implementation of the Integrated Risk Rating forms related to nursing. Reportedly, no data was available for the Risk Action Plans, because it was being updated for nursing at the time of the review. However, Integrated Risk Rating forms and Risk Action Plans are two different processes, so it was unclear as what exactly the At-Risk Coordinator reviewed regarding Integrated Risk Rating forms, what criteria was used to measure compliance, how samples were selected, and why unavailable data regarding a different process, the Risk Action Plans, would be a factor in determining compliance regarding the implementation of the Integrated Risk Rating forms. In addition, the Facility's Self-Assessment indicated that Infection Control reviewed the effectiveness of the new Real Time Infection audit form that was implemented in December 2011. However, no data was available, because there had been no "qualified" infections to audit since it was implemented. Thus, since no data had been available to review, there actually was no review of the effectiveness of the Real Time Infection audit as reported in the Facility's Self Assessment. Overall, the Facility's Self-Assessment did not provide a clear and specific description of the activities that were conducted, and the associated results. In addition, some of the activities listed in the Facility's Self-Assessment did not address the requirements for this provision. Also, although the Facility's data regarding the Acute Care Plans could not be accurately interpreted regarding the completion of care plans, there was no indication that the quality of the care plans was being assessed. Regarding the Facility's self-rating, the information contained in the Self-Assessment indicated that "*Based on the findings of the self-assessment, this provision is not in compliance as Acute Care Plans completed according to policy fall below the 70% minimal goal. Also, ACPs do not meet policy requirements addressing changes in condition. Attention to monitoring tools must be accomplished to specify areas to observe."* In addition, the Monitoring Team's review of the Facility's Provision Action Information for Section M.3 indicated that: ▪ The Facility reported that the development of adequate Health Management Plans was included in the competency-based education taught by the Education Nurse. Although the Facility included a curriculum entitled Care Plan Development, which that the Statewide Nurse Educator workgroup had developed, based on the information contained in the Presentation Book or in the Action Plan, no indication was provided regarding whether or not the	

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		curriculum had actually been initiated. A review of the Care Plan Development Test that was included with the curriculum found that it did not adequately measure competency regarding the actual development of a nursing care plan. It essentially only addressed technical issues for acute care plans, such as the need for signatures, dates, the timeframe for implementation, and when the acute care issue should be resolved. It was not clear how the quality of the care plans developed in alignment with the scenario included in the curriculum would be evaluated. In addition, a review of a curriculum the Facility provided regarding Care Plan/Summary Class for Case Managers, dated January 5th and 6th, 2012, indicated that some training was provided regarding "creating a fundamental care plan with focus on nursing diagnosis," using scenarios. Although this appeared to be a promising curriculum, neither the scenarios nor examples of the care plans developed were provided to evaluate the quality of the training. In addition, to sufficiently address adequate clinical interventions regarding nursing care plans, the use of Nursing Protocols should be incorporated into all training addressing nursing care plans, and they should be used to measure the participants' competency in this area. Also, the training rosters that were included with this curriculum did not include the percentage of staff trained that were required to attend the training. Despite the consistent problematic findings from the Monitoring Team's past reviews, no adequate competency-based training had been provided to increase the quality of the clinical content contained in the plans. ▪ A Nursing Care Plan skeleton with instructions was being used at the time of the review. However, since the templates used for the Nursing Care Plans had been the same for the last four reviews without modification, it was unclear why this was included in the Provision Action Information report. ▪ The Integrated Risk Rating information was being "fine-tuned" with education in process. However, no training rosters or description of the training was provided in the Presentation Book for Section M.3. In addition, based on the information contained in the Presentation Book, no indication was provided regarding how information regarding the Integrated Risk Rating form addressed the requirements of this provision. The records of 20 individuals, who the Facility identified as being at high risk for specific health indicators were reviewed, including: Individual #119 for respiratory distress; Individual #25, Individual #199, and Individual #126 for weight issues; Individual #163, Individual #87, and Individual #95 for challenging behaviors; Individual #393, and Individual #184 for falls; Individual #147 for osteoporosis; Individual #235, Individual #511, Individual #447, and Individual #538 for urinary tract infections; Individual #139,	

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		Individual #35, and Individual #397 for dental; Individual #57, Individual #31, and Individual #465 for fractures. Of the 20 individuals' Health Management Plans reviewed: ▪ Twelve (60%) were found to have a HMP addressing their high-risk health/mental health indicator. Those that did not have a related HMP included: Individual #119, Individual #126, Individual #163, Individual #184, Individual #511, Individual #57, Individual #31, and Individual #465. ▪ None (0%) of the goals listed in the 12 HMPs were clinically appropriate. ▪ None (0%) of the nursing interventions contained in the 12 HMPs indicated who would implement the intervention, how often they were to be implemented, where they were to be documented, how often they would be reviewed, and/or when they should be considered for modification. ▪ None (0%) of the 12 HMPs were found to be clinically adequate. ▪ None (0%) of the 12 HMPs included proactive interventions addressing the health indicator. ▪ None (0%) of the 12 HMPs were adequately individualized. ▪ Due to the nonspecific interventions contained in the 12 HMPs, validating the implementation of the interventions was not possible, rendering the HMPs inadequate as guides for the provision of care. Consistent with the findings from the previous reviews, ABSSLC's Nursing HMPs continued to lack the following key elements: ▪ Clinically appropriate goals/objectives related to the etiology of the identified health/mental health problems; ▪ Specific interventions addressing risk indicators; ▪ Proactive interventions directed at preventing or minimizing the specific health risks; ▪ Individual-specific interventions based on the individuals' needs; and ▪ Adequate specific directions for caring for individuals who were identified as being at high risk related to their health/mental health issues; The Facility should review how and where its nursing resources are dispersed in order to consistently implement and maintain clinically appropriate Health Management Plans. It is essential that the Facility address the lack of clinically adequate HMPs for the individuals under their care. The Facility should continue to develop and implement appropriate HMPs based on priority, and risk for all individuals at ABSSLC Regarding HMPs addressing infectious illness, the Facility's Gastrointestinal (GI) Outbreak list indicated that 28 individuals were affected by the outbreak (i.e., Individual #414, Individual #293, Individual #413, Individual #513, Individual #172, Individual	

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		#159, Individual #442, Individual #393, Individual #87, Individual #59, Individual #115, Individual #534, Individual #22, Individual #247, Individual #323, Individual #517, Individual #302, Individual #444, Individual #461, Individual #6, Individual #201, Individual #138, Individual #368, Individual #350, Individual #123, Individual #202, Individual #312, and Individual #454). ▪ Of the 28 individuals, 14 (50%) were found to have had HMPs addressing the infectious issue. Individuals who did not have HMPs addressing the infectious issue included: Individual #414, Individual #293, Individual #413, Individual #513, Individual #172, Individual #159, Individual #442, Individual #393, Individual #87, Individual #59, Individual #115, Individual #534, Individual #22, and Individual #247. ▪ Of the 14 Nursing Care Plans reviewed addressing infectious diseases, none (0%) were found to be adequate. In addition, a review was conducted of 28 individuals (i.e., Individual #100, Individual #504, Individual #313, Individual #2, Individual #42, Individual #545, Individual #201, Individual #444, Individual #287, Individual #101, Individual #351, Individual #524, Individual #206, Individual #327, Individual #192, Individual #376, Individual #203, Individual #272, Individual #502, Individual #212, Individual #361, Individual #128, Individual #483, Individual #107, Individual #70, Individual #257, Individual #439, and Individual #394), who had a variety of infectious illness, to determine if the individuals had appropriate care plans to address their needs. Based on this review: ▪ Of the 28 individuals, 20 (71%) were found to have had HMPs addressing the infectious issue. Individuals who did not have HMPs addressing the infectious issue included: Individual #212, Individual #361, Individual #128, Individual #483, Individual #107, Individual #70, Individual #257, Individual #439, and Individual #394. ▪ Of the 20 Nursing Care Plans reviewed addressing infectious diseases, none (0%) were found to be adequate. However, an increase was noted in attempts to individualize some of the HMPs with the assistance of the Infection Control Nurse. From the review, the HMP for Individual #272 was noted to be the most promising attempt at individualizing, and including specific clinical information addressing an infectious illness. Overall, some of the deficiencies noted in the HMPs reviewed included: ▪ The significant lack of individualization of the HMP template; ▪ 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; ▪ Inappropriate goals that did not address the prevention of the spread of the infectious illness;	

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		▪ The lack of specific interventions addressing teaching and education for staff, as well as the individual regarding the prevention of the spread of the infection; and ▪ The lack of proactive interventions. Consistent with previous findings, ABSSLC had no system in place to ensure that individuals with infectious diseases were being provided the appropriate infection control measures, or clinically appropriate interventions to prevent the spread of infections. Although there was some very limited improvement seen in some of the HMPs, it was troubling to find that individuals with contagious/infectious illnesses such as conjunctivitis, and GI symptoms did not have HMPs or adequate HMPs addressing these illnesses. The Nursing Department, in conjunction with the Infection Control Nurse 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. In order for the Facility to make progress regarding this provision of the Settlement Agreement, the Health Management Plans should be: • Individualized to meet the individuals' needs, with appropriate goals, specific nursing interventions that include proactive interventions, and specific 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 interventions will be reviewed and by whom; and • In alignment with nursing protocols. 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. In alignment with this collaboration, 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 risks 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	Based on a review of ABSSLC's Self-Assessment as well as the Presentation Book, the Monitoring Team found the following: ▪ The Nurse Educator reviewed nursing training records to determine if all nurses attended required training for Nursing Policies for Hospitalizations, Transfer and Discharges, Transfer to Hospital form, Hospital Liaison report, and Post Hospital	Noncompliance

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	health status of the individuals served.	Nursing Assessment. The Facility reported that 90% of 174 nurses had completed the training. However, no training rosters or description of how the material was presented was included in the Presentation Book. Consequently, there was no way to determine the quality of the training, such as if the training consisted of a discussion of the policies and protocols, or if staff just read the material and then signed the rosters. In addition, without the training rosters as well as an indication of how many staff were required to participate in the training, there was no way to verify staff attendance. ▪ The Nurse Educator reviewed nursing training records regarding specialized training related to positioning instructions, use of adaptive equipment, and instructions to support prescribed diet texture and fluid consistency for medication administration. Although the Facility reported that 85% of 174 nurses have completed the training, no training rosters or description of the training was provided in the Presentation Book. ▪ The Facility reported that 100% of nurses received Nurse Protocol card key rings for ready reference and these would be included in all future nurses' orientation. The Facility indicated from the Self Assessment that data was not available to analyze the efficacy of the implementation of the protocols at the time of the review. ▪ Regarding the Facility's self-rating, the information contained in the Self-Assessment indicated that: "Based on the findings of the self-assessment, this provision is not in compliance due to being in the infancy stages of Policy and Procedure training and needs more audits to monitor for competency. These will continue. Information related to efficacy of the Nurse Protocol cards will be analyzed in the future." From discussions with the CNE, the Facility had implemented the initial State Office nursing protocols in November 2011. However, it was unclear if training was provided prior to implementation, or if the protocols had just merely been distributed to all the nurses. The introduction of the use of nursing protocols to guide nursing assessments, reporting protocols, and documentation of health issues, and to assist in the development of clinically adequate HMPs was a positive step forward and should be continued. However, at the time of the review, no evidence was found in the HMPs or the nursing documentation that the nursing protocols were actually being used to drive the identification and implementation 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. Thus, no supporting documentation was found to substantiate the nursing protocols had actually been implemented.	

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		From the consistent problematic issues found at ABSSLC regarding nursing assessments, Health Management Plans, and the overall nursing care and documentation, it was evident that there continued to be a significant lack of understanding regarding the importance of nursing protocols. This was especially concerning based on the consistent problematic issues found by the Monitoring Team regarding individuals with high-risk health indicators, and changes in status warranting Infirmary, and hospital admissions. Due to the lack of the actual implementation of appropriate nursing protocols, no structured system was in place guiding nursing practice and documentation to ensure that: ▪ Clinically appropriate nursing assessments were conducted for significant health issues and documented at the appropriate clinical frequency; ▪ Clinical baseline data was established to quickly recognize changes in health status; ▪ Timely communication occurred with practitioners/physicians or other disciplines regarding changes in status; ▪ Appropriate and clinically adequate HMPs were developed that outlined specific nursing interventions for specific health issues; and ▪ Audits addressing nursing practice accurately reflected quality standards by which to measure the Facility's nursing care, and documentation. Although the initial nursing protocols had been introduced to the Facility in November 2011, the findings from this review and the previous four reviews indicated that ABSSLC continued to fail to adequately and timely address the health care needs of the individuals residing at the Facility. 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.	Based on a review of the Facility's Self-Assessment and the Presentation Book, the Monitoring Team found the following: ▪ The Facility reported that in December 2011, it had recently implemented a new Change of Status Notification form, and provided "orientation of all nurses." However, no information was provided in the Presentation Book for Section M.5 specifically describing what information was provided or how it was presented to the nurses. In addition, no training rosters addressing this subject were provided. ▪ The Facility indicated that all interdisciplinary scopes of practice were reviewed to determine if at-risk assessments should be incorporated into specific discipline assessments to achieve best practice for the individuals. In addition, the Self-Assessment indicated that meetings and dialogues were currently being conducted to align the risk assessments with the appropriate disciplines. However, the Facility's Self-Assessment indicated that there was no data at the time of the review addressing this activity. In addition, the	Noncompliance

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		information contained in the Presentation Book for Section M.5 did not address either of the activities noted in the Self-Assessment for this Section. It was unclear why the curriculum addressing the State's Physical Assessment training was the only documentation contained under this section. Regarding the Facility's self-rating, the Facility indicated that: "Based on the findings of the self-assessment, this provision is not in compliance as we need more data to show that the Change of Status Notification from (sic) is capturing indicators of increased risk of each individual served. Currently, all Infirmary admissions have been noted. Campus-wide use of form undetermined at this time." Also, a review of the Facility's Provision Action Information report indicated that the Comprehensive Nursing Assessment form continued being used for the quarterly and annual nursing assessments, and that they addressed at-risk individuals. However, consistent with the findings from past reviews, the findings from the Monitoring Team noted below indicated that the quarterly and annual Comprehensive Nursing Assessments reviewed did not adequately address the risk issues. The Facility had implemented a number of steps in its efforts to move forward regarding this requirement, such as the development of a tracking tool for the at-risk meetings, the implementation of a Section I workgroup to address the At-Risk system, and the implementation of a tracking system for changes in status (as is discussed in detail with regard to Section I.1). However, the Monitoring Team found that the Facility had a significant amount of work yet to do to address the requirements of the Settlement Agreement regarding at-risk individuals. In addition, discussions with the State's Consultants indicated that the State was considering a number of changes regarding the current At-Risk process that could alter some of procedures regarding the process at ABSSLC. At the time of the review, essentially no progress was noted regarding the nursing assessments for risk indicators. As noted from the Facility's Provision Action Information, for individuals who were designated as being at high or medium risk for specific health indicators, nursing staff continued using the last quarterly or annual Comprehensive Nursing Assessment to meet the requirement of a nursing assessment for risk. Although the Summary Section of the Comprehensive Nursing Assessment was modified to include health risks, as noted below, the modification made little impact regarding the quality of the documentation addressing risk indicators. Consistent with previous findings, the Comprehensive Nursing Assessments were inadequate, and not representative of a focused assessment addressing health risk indicators. A review of records for 20 individuals determined to be at risk (i.e., Individual #119,	

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		Individual #25, Individual #199, Individual #126, Individual #163, Individual #87, Individual #95, Individual #393, Individual #184, Individual #147, Individual #235, Individual #511, Individual #447, Individual #538, Individual #139, Individual #35, Individual #397, Individual #57, Individual #31, and Individual #465, found that none (0%) had adequate nursing risk assessments due to: ▪ The lack of adequate assessments of the specific high-risk health indicators; ▪ The lack of an adequate analysis of the high-risk health indicators in the Summary Section; and ▪ The lack of a specific procedure in place defining the process regarding nursing assessments for health risk indicators. A review of these 20 individuals' records was conducted to assess nursing staff's role in the assessment of the health categories that nursing was responsible for on the Integrated Risk Rating forms. Although there was noted improvement in some of the categories on the Risk Rating forms, the review found that only six (30%) consistently contained specific clinical information to enable the IDTs to adequately evaluate and designate risk levels. For the remaining individuals, assessments addressing risks issues were not consistently completed. This was due to a lack of clinical information regarding some of the health risks indicators found on the Integrated Risk Ratings forms resulting in a lack of adequate justification for the risk ratings (i.e., Individual #119, Individual #25, Individual #126, Individual #163, Individual #87, Individual #95, Individual #184, Individual #511, Individual #538, Individual #139, Individual #397, Individual #57, Individual #31, and Individual #465). Some of the problematic issues included: ▪ Lack of specific data indicating how many seizures the individual had in the past year compared to previous years, rather than just the date of the last seizure; ▪ Lack of documentation addressing the regular bowel medication regimens, the frequency of needed bowel PRN medications, and additional factors such as medications, fluid intake, and positioning affecting the risk of constipation; ▪ Inconsistencies found between the risk levels on the individuals' Risk Rating forms and the ABSSLC's At-Risk Individuals list; ▪ Integrated Risk Rating forms were noted to have been completed up to nine months prior to Risk Action Plans or ISPs without being reviewed, and updated; ▪ Lack of consistent results of cultures and sensitivities for urinary tract infections to evaluate hygiene practices by staff; ▪ Lack of specific dates and locations of past fall and/or fractures; ▪ Lack of consistent information, such as dates, locations, and organisms of infections; and ▪ Some Integrated Risk Rating forms not completed or left totally blank. In addition, a review of the 20 records for individuals determined to be at risk, there was documentation that the Facility:	

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		▪ Established an appropriate plan within fourteen days of the plan's finalization, for each individual, as appropriate, in none of the cases reviewed (0%). ▪ Implemented a plan within fourteen days of the plan's finalization for each individual, as appropriate in none (0%) of the cases reviewed. Although the Action Plans included a date of implementation, there was no supporting documentation verifying that the action steps contained in the plan had, in fact, been implemented. In addition, a number of the action steps were nonspecific and thus, impossible to verify. ▪ Implemented a plan that met the needs identified by the IDT assessment in none of these cases (0%). ▪ Included preventative interventions in the plan to minimize the condition of risk in none of the cases (0%). ▪ When the risk to the individual warranted, took immediate action in none of the cases (0%). ▪ Integrated the plans into the ISPs in none of the cases (0%). ▪ None (0%) of the plans showed adequate integration between all of the appropriate disciplines, as dictated by the individual's needs. ▪ None of the plans (0%) had appropriate, functional, and measurable objectives incorporated into the ISP to allow the team to measure the efficacy of the plan. ▪ None of the plans (0%) included the specific clinical indicators to be monitored. ▪ The frequency of monitoring was included in the plans for none of the individuals (0%). Although the Action Plans contained a heading addressing "Monitoring Frequency," the frequency was noted generally as daily or weekly without the specific shift or day included to ensure accountability. From discussions with the State Office Consultants, the State was in the process of reviewing the At-Risk procedures, and redefining the "assessment" requirements noted in the At-Risk Individuals policy in an effort to clarify the expectations regarding risk indicators and the associated assessments. However, at the time of the review, there had not been any formal clarifications made to the At-Risk policy. The Facility, in conjunction with the State, should specifically define the nursing assessment process regarding at-risk individuals. At the time of the review, ABSSLC 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	Based on a review of the Facility's Self-Assessment and the Presentation Book, the Monitoring Team found the following: ▪ Although the documentation contained in the Facility's Self Assessment was very confusing regarding this activity, the Monitoring Team interpreted this section as meaning that the Nurse Educators and Scheduling Coordinator provided training	Noncompliance

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	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.	to the nurses regarding using the Physical and Nutritional Management Plans when administering medication. In addition, the Facility indicated that the Nurse Educators also received training regarding the auditing process for medication administration observations related to compliance with the use of the Physical Nutritional Management Plans. However, no information was provided as to who provided this training. Since the last review, the Facility decided that only the Nurse Educators would conduct these audits using the standardized Medication Administration Observation form. Although a bulleted list of topics along with training rosters entitled "Nursing Meeting" was provided in the Presentation Book for Section M.6, no specific description was provided regarding how the training was provided, and what percentage of staff that were required to attend the training, actually attended. In addition, no indication was given of what training was provided to the Nurse Educators regarding the auditing of medication observations. However, limiting the number of nurse auditors for this area was a positive step forward as the Facility attempted to begin to establish inter-rater reliability. ▪ The Facility's Self-Assessment indicated that the Nurse Educators monitored medication administration quarterly to determine if nurses were competent with medication pass. Problematic areas included that prompting was needed in the areas of privacy, positioning, checking G-tube placement, implementing Self-Administration of Medication programs, ensuring the five rights were followed, and providing instruction to the direct service professional staff. The Facility reported that 3. 63% of the 55 Medication Pass Observations had passing scores. Reported failures were due to temperature check sheets incomplete, enteral nutrition tubes were not flushed before medications administered, stoma care was not provided, signatures not complete on the Medication Administration Records (MARs), lack of proper identification of individual prior to administration, and the absence of start and/or stop dates for medications on the MARs. Redirection/training was completed at the time of the medication observations. The Facility also reported that approximately 60 plus Medication Pass Observations should be completed monthly to ensure all nurses who routinely administer medications receive observation quarterly. However, the Facility indicated that they were unable to be completed as required due to lack of nursing professionals to monitor administration of medications. As noted above, the Facility had limited the number of nurses auditing this area to the two Nurse Educators. They were responsible for the medication observations, as well as the training of new nurses and re-training of current nurses. Although the Facility identified a number of crucial problematic issues related to medication administration practices, there was no indication that an action plan had been developed to ensure that all the required quarterly medication	

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		administration observations would be conducted to ensure safe medication practices. ▪ The Facility's Self-Assessment indicated that the Medication Variance Committee reviewed implementation and use of the Medication Variance Policy. The Facility reported that: "regular data will be analyzed as it arrives." Regarding the Facility's compliance rating, the Self-Assessment stated: "based on the findings of the self-assessment, this provision is not in compliance as there is not a 100% passing compliancy with medication administrations. The two Educators have been trained in appropriate auditing." It is important to note that this section of the Settlement Agreement requires significantly more than nurses passing medication administration audits. Although very little information was provided in the Facility's Provision Action Information regarding the Facility's activities regarding the overall medication administration system, a review of the minutes from the Medication Variance Committee and the Pharmacy and Therapeutics Committee found that the following steps had been initiated since the last review: ▪ The Pharmacy began to track pharmacy technician variances addressing the wrong dose, wrong drug, wrong quantity, missing medication, and wrong person, and in September 2011, reported them in the Medication Variance Committee meetings; ▪ The Facility had begun to track medication variances regarding prescriber variances addressing medication prescribed in the presence of an established allergy, wrong dose, and medication prescribed in the presence of a current drug with the same therapeutic purpose, and in September 2011, reported them in the Medication Variance Committee meetings; ▪ The pharmacist reviewed the medications for buildings 6730 and 6740, and made recommendations for changes in the medication administration times, amounts, and routes to decrease the potential for medication errors. Unfortunately, in subsequent minutes, no indication was provided regarding whether or not changes actually were made based on these recommendations, and if there were any associated outcomes; ▪ In the minutes of the Medication Variance Committee meeting minutes, some descriptions were provided of staffing issues in alignment with the medication variance data. However, no discussion was documented of remedies addressing these issues, or any proactive measures implemented in the event of future staffing issues to ensure safe medication practices; ▪ The pharmacy had initiated the development of a procedure addressing individuals who warrant hospitalization, and the need to bring medication with	

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		them, if it was not available at the community hospital; and ▪ The pharmacist had begun to review the total anticholinergic burden of an individual's medication regimen on the Quarterly Drug Regimen Review, and designate a rating of Low, Moderate, or High with the associated symptoms to be monitored. The minutes of the Pharmacy and Therapeutics indicated that consideration should be given to discussions regarding the risk designation of the anticholinergic burden, and its effects on other health risk indicators with individuals' teams to augment the At-Risk process. Although there were some indications from the minutes of the meetings reviewed that the Facility was making attempts to move forward regarding the medication administration system, the overall format of the Medication Variance Committee meeting minutes lacked specific content in order to determine precisely what issues were discussed. In addition, it was not clear from the minutes what specific actions were being taken, when they were implemented, and how effective they were in addressing the problematic issues. Including these components in the minutes would significantly enhance the content, close the loop on issues that actually have been resolved, and indicate what issues continued to need interventions. Although the Facility had decreased the number of nurses auditing the medication administration observations, inter-rater reliability had not yet been appropriately established for the monitoring tool. A review of the raw data for the Medication Administration Observation tools completed since the last review found that few noted any type of problematic issue. This was not in alignment with other information noted from meeting minutes, medication variance data, and the observations of the Monitoring Team during the review. In addition, consistent with past review findings, no documentation was found on the completed Medication Administration Observation tools indicating when, and how the problems found were resolved. Although, as noted above, the Facility's Self-Assessment identified a number of relevant problematic issues from medication observations that were more in alignment with the Monitoring Team's findings, the medication administration observation tools the Facility provided did not reflect these findings. Thus, it was unclear how these findings were made. This was concerning, because this was the most promising aspect of the Facility's findings reported in the Self-Assessment. In addition, from discussions with one of the Nurse Educators, and the CNE regarding the determination of passing or failing a medication administration observation, the Facility had been calculating a single compliance score from the items contained on the Medication Administration Observation monitoring tool. However, since the items on the tool were not weighted according to priority, and safety, single compliance	

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		percentages could easily reflect extremely high scores, yet the nurses observed could have inadequately performed a critical procedure. For example, a nurse could have drawn up an exceedingly wrong dosage of insulin, but with the current procedure, this would not be accurately reflected in the single compliance score for that particular medication observation. Since the previous review, ABSSLC continued to have some significant problematic issues regarding its overall medication administration system. From review of the Medication Variance Committee meeting minutes, the Pharmacy and Therapeutics Committee meeting minutes, emails between the nursing and the Pharmacy, medication variance data, and discussions with Nursing Department staff, the following were some of the problematic issues identified: ▪ The Facility continued to have problematic issues regarding a number of unexplained medications that were being returned to the Pharmacy each month, which could be reflective of medication variances. For example, an email dated 8/25/10 to the pharmacy indicated that there had been a "massive amount" of overages of medications for Residence 6730; ▪ Staffing issues, such as vacant nursing positions, leaves of absences, and staff fatigue had been repeatedly identified during past reviews as issues resulting in increases in medication variances. However, no indication was provided that a procedure was developed and implemented to address these situations in relation to safe medication practices. For example, such interventions could have included increasing staff for medication administration times, and/or increasing the medication observations. ▪ From discussions with the CNE, and observations of the Pharmacy and Therapeutics Committee meeting during the review, a number of medication variances for one month were the result of the inappropriate procedures of one specific nurse. Although the nurse was terminated, no documentation described the extent of the issue, and what interventions were taken to monitor the affected individuals to ensure they experienced no ill effects. ▪ Results of the Medication Administration Observations, and pharmacy inspections were not included in the Medication Variance Committee meeting minutes, and not aggregated with other data related to the Facility's medication administration system. A review of the medication variances reported by the Facility indicated the following: ▪ July - 75 total variances and 12 unreconciled; ▪ August - 77 total variances and 62 unreconciled; ▪ September - 66 total variances and 56 unreconciled; ▪ October - 24 total variances and 16 unreconciled;	

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		▪ November - 29 total variances and no data for unreconciled; ▪ December - 31 total variances and no data for unreconciled; and ▪ January 2012 - 48 total variances and no data for unreconciled. As noted in past reports, from the low number of total variances noted above, ABSSLC continued to have a significant problem regarding the under-reporting of medication variances. Based on observations of medication administration at the Infirmary, the following problematic issues were found. Specifically, the nurse did not: ▪ Ensure individuals were in the proper positioning prior to and after medication administration. Neither the nurse administering the medication, nor the Nurse Educator conducting the Medication Administration Observation were familiar with or did they review the PNMP to verify correct positioning prior to medication administration; ▪ Direct the direct support professionals on the position to maintain after the medication was administered; ▪ Provide education to the individuals regarding the medications that they were receiving; ▪ Ensure that the individuals' adaptive and positioning equipment was available, and used as prescribed in the PNMP; and ▪ Receive competency-based training on the PNMPs for individuals for whom she was responsible for administering medications. Based on these consistent problematic issues observed during medication administration at ABSSLC, the Facility should continue to develop and implement a system to ensure that prior to nurses providing care to individuals with a PNMP that they are provided competency-based training regarding the PNMPs. In addition, training should be provided to all nurses that are designated as auditors for medication administration observations regarding how to appropriately assess compliance regarding positioning and other medication administration interventions, including following the instructions in the PNMPs. Also, as mentioned with regard to Section M.1, a procedure should be developed and implemented to establish inter-rater reliability and assist in generating reliable data regarding medication administration observations. Although a number of problematic issues continued to be noted regarding the medication administration systems at ABSSLC, the Facility had taken some steps to review some of the elements of the medication administration system. However, from review of the documentation, the steps that the Facility initiated were not clearly described, and outlined in an organized manner. The Facility had much work to do to	

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		address the requirements of this section of the Settlement Agreement. The Facility should continue its efforts to critically review all aspects of the medication administration system in order to accurately identify problematic areas, and implement actions aimed at long-term resolutions. The Facility also should continue to develop and implement strategies to increase the reliability of the medication variance data, such as continuing to conduct regular reviews, spot check the Medication Administration Records (MARs), and document these as audits. In addition, further collaboration should occur between the Pharmacy, Nursing, and the Medical Departments in constructing a solid process that results in a critical review of the overall medication system. 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. ABSSLC should continue its efforts in recruiting, maintaining, and evaluating reallocations of nursing positions to meet the requirements of the Settlement Agreement. (Section M.1)
2. The Facility, in conjunction with the State, should ensure that each monitoring tool has appropriate instructions identifying 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. The presentation of 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)
6. The Facility should ensure that all auditors 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 continue to implement and expand the use of nursing protocols to guide nursing practices in conjunction with the adequate competency-based nursing skills training. (Section M.1)
8. A formalized immunization schedule and system to track immunizations should be implemented to ensure all individuals have received all the required current immunizations as outlined in the Health Care Guidelines. (Section M.1)
9. The results of the Infection Control Rounds should be included in the minutes of the Infection Control Committee meeting. (Section M.1)
10. The Facility should expand its pool of staff that conducts environmental monitoring auditing. Including different staff members, such as residential and programmatic staff, would prevent auditors from becoming desensitized, and not accurately and adequately assessing the environment. (Section M.1)
11. The Facility should develop and implement a system to ensure the adequacy and implementation of Health Management Plans addressing infectious and communicable diseases. (Section M.1)
12. The Facility should continue to focus and expand its efforts on the implementation of the clinical Real Time auditing tool assessing the clinical practices and treatments of infectious and communicable diseases. This should include 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 (conducting an audit after the event) would not be clinically appropriate, nor would choosing only a percentage of these cases to audit. (Section M.1)

13. The Facility should develop a list of individuals who have had and those who still need their immunizations researched in order to render them current. (Section M.1)
14. The Facility should continue to 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)
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. Such expertise also should be used to obtain professional feedback regarding the quality and completeness of the Infection Control Program. (Section M.1)
16. The Facility should review all data related to its emergency systems, and analyze the findings from the Mock Drills to ensure that any training provided translates into improved practices in the residences. In addition, trends from the actual codes (4444 calls) should be identified and analyzed, so that appropriate corrective actions can be timely implemented. (Section M.1)
17. The Facility should ensure that the required numbers of Mock drills are conducted as required by the policy. (Section M.1)
18. The Facility should implement a system to ensure that the emergency equipment is being checked daily as required. (Section M.1)
19. The Facility should resume the Emergency Response Committee meetings to ensure that the Facility's emergency systems and data are regularly reviewed. (Section M.1)
20. The Facility should provide appropriate competency-based training from a competent source to ensure that the Comprehensive 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. With regard to transition/discharge assessments, nursing should provide a clear and comprehensive analysis summarizing the individual's health/mental health issues since they have been at the Facility, as well as their current status. This should be available from the summaries from the Quarterly/Annual Comprehensive Nursing Assessments. In addition, Nursing Care plans addressing all health issues, including individual-specific nursing interventions the individual needs should be provided to the receiving staff. Also, a summary of the goals and progress of any nursing programs should be included in the documentation for transition/discharge. (Section M.2)
22. ABSSLC should review and revise its current nursing discharge procedures and documentation requirements to ensure that upon an individual's discharge from the Facility, the nursing documentation is specific and detailed enough to maintain continuity of care. (Section M.2)
23. The use of Nursing Protocols should be incorporated into the training regarding Health Management Plans, and used to measure the participants' competency. (Section M.3)
24. Competency-based training should be provided to the nursing staff regarding the criteria and structure of the development of adequate Health Management Plans using Nursing Protocols. (Section M.3)
25. The Facility should review how and where its nursing resources are dispersed in order to consistently implement and maintain clinically appropriate Health Management Plans. (Section M.3)
26. 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 into 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)
27. It is critical that the Facility ensures the use of 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)
28. The general nursing protocols should be individualized to the Facility systems, and the individuals per their Nursing Care plans. Nursing protocols should be used to guide the development of nursing care plans, nursing assessments and reassessments for changes in status, Quarterly/Annual Comprehensive Nursing Assessments addressing health and risk indicators, or nursing documentation found in the IPNs.

(Section M.4)

29. The Facility, in conjunction with the State, should specifically define the nursing assessment process regarding at-risk individuals. (Section M.5)
30. The Facility should develop and implement a system to ensure that prior to nurses providing care to individuals with a Physical and Nutritional Management Plan, they are provided competency-based training regarding these plans. (Section M.6)
31. The Facility should critically review all aspects of the medication administration system in order to accurately identify problematic areas, and implement actions aimed at long-term resolutions. (Section M.6)
32. The Facility also should 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. (Section M.6)
33. 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. (Section M.6)
34. Further collaboration should occur between the Pharmacy, Nursing, and Medical Departments in constructing a solid process that lends to a critical review of the overall medication system. (Section M.6)

SECTION N: Pharmacy Services and Safe Medication Practices	
Each Facility shall develop and implement policies and procedures providing for adequate and appropriate pharmacy services, consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o Any policies, procedures, and/or other documents addressing the provision of pharmacy services; o Any pharmacy surveys completed within the last year, plans of correction and/or internal auditing procedures and reports related to pharmacy services; o All Drug Utilization Evaluation (DUE) reports completed since the Monitoring Team's last visit, including background information, data collection forms utilized, results, any minutes reflecting action steps based on the results; o Any follow-up studies completed for any prior DUE reports; o Minutes of Pharmacy and Therapeutics Committee meetings and any attachments, since the Monitoring Team's last visit; o Minutes of any committee addressing polypharmacy for non-psychotropic medications; o Minutes of any committee addressing medication error/variance since the last compliance visit; o Minutes of the committee addressing seizures with any attachments since the last compliance visit; o DUE calendar for next 12 months; o For quarterly drug regimen reviews, two most recent (with dates of completion) per residence that have been reviewed and signed by the primary care provider for the following individuals: Individual #20, dated 7/19/11, 10/18/11; Individual #119, dated 9/7/11, 12/6/11; Individual #25, dated 8/31/11, 11/17/11; Individual #163, dated 9/2/11, 12/2/11; Individual #488, dated 9/9/11, 12/8/11; Individual #413, dated 7/12/11, 10/11/11; Individual #30, dated 9/12/11, 12/12/11; Individual #282, dated 8/17/11, 11/15/11; Individual #517, dated 8/2/11, 11/1/11; Individual #328, dated 9/2/11, 12/2/11; Individual #483, dated 8/16/11, 11/4/11; Individual #7, dated 9/7/11, 12/6/11; Individual #480, dated 7/22/11, 10/20/11; Individual #4, dated 9/12/11, 12/12/11; Individual #375, dated 9/8/11, 12/7/11; Individual #32, dated 8/6/11, 11/4/11; Individual #209, dated 8/3/11, 11/4/11; Individual #192, dated 7/22/11, 10/20/11; Individual #158, dated 8/31/11, 11/17/11; Individual #110, dated 8/10/11, 11/8/11; Individual #92, dated 7/12/11, 10/11/11; Individual #156, dated 8/16/11, 11/16/11; Individual #283, dated 8/17/11, 11/15/11; Individual #145, dated 7/19/11, 10/18/11; Individual #81, dated 9/2/11, 12/2/11; Individual #84, dated 8/3/11, 10/18/11; Individual #237, dated 7/7/11, 10/3/11; Individual #426, dated 7/15/11, 10/18/11; Individual #441, dated 7/12/11, 10/11/11; Individual #526, dated 9/12/11, 12/13/11; Individual #503, dated 8/10/11, 11/8/11; Individual #24, dated 8/2/11, 11/1/11; Individual #210, dated 9/2/11, 12/2/11; Individual #247, dated 8/2/11, 11/1/11; Individual #523, dated 7/7/11, 10/3/11; Individual #462, dated 8/2/11, 11/1/11; Individual #125, dated 9/8/11, 12/7/11; Individual #149, dated 7/7/11,

	10/3/11; Individual #273, dated 7/7/11, 10/3/11; Individual #191, dated 9/9/11, 12/8/11; Individual #430, dated 9/12/11, 12/13/11; Individual #498, dated 8/9/11, 11/8/11; and Individual #399, dated 8/9/11, 11/8/11; o For 10 most recent QDRRs in which recommendations were made and accepted, copies of physician orders for: Individual #484, dated 8/31/11; Individual #328, dated 9/2/11; Individual #373, dated 10/20/11; Individual #437, dated 8/2/11; Individual #515, dated 11/15/11; Individual #430, dated 12/13/11; Individual #344, dated 10/18/11; Individual #139, dated 11/1/11; Individual #370, dated 10/20/11, and Individual #399, dated 8/9/11; o For six most recent QDRRs in which recommendations were made and not accepted, copy of IPN or other entry indicating reason for non-agreement for following individuals: Individual #158, dated 8/31/11; Individual #425, dated 12/7/11; Individual #546, dated 8/16/11; Individual #363, dated 12/12/11; Individual #181, dated 12/12/11; and Individual #324, dated 12/12/11; o All single patient intervention reports in WORx system since Monitoring Team's last visit; o Since the last review, copy of any internal Pharmacy Department audits/monitoring data to review Section N of the Settlement Agreement (i.e., pharmacist review and placement of new orders in WORx system); o Copy of all "notes extracts" associated with single patient intervention reports; o For the past six months, any adverse drug reaction reports completed; o Any policies and/or procedures regarding medication error/variance, including prescription, dispensing, administration, documentation, and potential errors; o Numbers of medication errors/variances per month for prior 12 months by error type, nurse, residence, shift, unit, individual, category of severity, error mode, including graphs, charts (per month/quarter), and analysis reports, including corrective action plans, root cause analysis summaries, etc.; o Copies of the last 10 medication error forms completed and any plans of correction arising from review of the medication errors; o Copy of any communication between Pharmacy and Nursing Departments concerning medication errors/variance (emails, memos, etc.), since the Monitoring Team's last visit; o For the past two months, reports and/or summaries of any medication administration observations conducted; o Any policies, procedures and/or other documents addressing medication administration; o List of antibiograms per month for last six months by building; o Medication history for individuals with J or G/J tubes (not G tubes); o A schedule of when quarterly drug regimen reviews are conducted by residence/unit; o Polypharmacy risk assessment forms for past six months for five individuals most recently rated as being at high risk for polypharmacy, and five individuals rated as being at medium risk for polypharmacy; o All documentation for each emergency chemical restraint (include restraint checklist) for the following individuals: Individual #137 12/15/11 0843hr, Individual #74 10/17/11 0342hr, Individual #95 11/12/11 1559hr, Individual #371 11/27/11 1020hr, Individual

	#156 8/29/11 0036hr, Individual #505 9/8/11 1920hr, Individual #313 10/31/11 1532hr, 11/1/11 1510hr, 12/12/11 1700hr, 12/13/11 1021hr, Individual #529 10/19/11 1500hr, Individual #59 12/11/11 0246hr, 12/12/11 1830hr, Individual #304 8/30/11 0445hr, Individual #39 9/17/11 1145hr, and Individual #284 10/31/11 1650hr, 11/1/11 2340hr, and 11/6/11 1355hr; o Any trend analysis of chemical restraint use (graphs, etc.); o For each database maintained on use of chemical restraints, summary lists(s) of all chemical restraints administered over the last six months with the name/source of the database clearly identified; o For the last five individuals to whom pre-treatment sedation was administered, all information related to medical/dental pre-treatment sedation used prior to visits, including consents, HRC approval, relevant assessments, ISP entries, any general discussion record, action plan, and integrated progress note entries; o Presentation Book for Section N; o Dates of last two QDRRs completed on five individuals from each residence; o For 10 new orders processed during the week of the Monitoring Team's visit, snapshot copy of each computer screen in processing the order with date of patient intervention note for: Individual #151 2/7/12, Individual #108 2/15/12, Individual #120 2/8/12, Individual #279 2/8/12, Individual #472 2/6/12, Individual #201 10/31/11, Individual #97 2/8/12, Individual #430 2/13/12, Individual #215 2/9/12, Individual #539 11/3/11; o Pharmacy oversight/reviews of categorization of medication errors by nurses; o Minutes of Pharmacy and Therapeutics Committee, dated 2/15/12; o All handouts from the Pharmacy and Therapeutics Committee, on 2/15/12; o Section N: Provision Action Information, updated 1/30/12; and o Section N: Self-Assessment, updated 2/1/12. ▪ **Interviews with**: o Leah Robinson, R, Ph., Chief Pharmacist; o Marla Knight, R.Ph. Pharm D., Clinical Pharmacist; o Pat Smith, QA Director; and o Mary White, QA Nurse. ▪ **Observations of**: o Medication Variance Committee, on 2/17/12; o Pharmacy and Therapeutics Committee, on 2/15/12; and o On-site demonstration of WORx and Misys system in pharmacy, on 2/17/12.
	Facility Self-Assessment: Since the Monitoring Team's previous review, the Facility had made changes to the way it presented its self-assessment information. Using a new format from State Office, the Facility had identified activities engaged in to conduct the self-assessment, the results of the self-assessment, and a self-rating using the information cited in the section on results. Also provided was a "Provision Action Information" document that had been recently updated.

	Although a number of concerns continued to exist with the Facility's self-assessment process, over time, this format should be helpful in substantiating the Facility's findings with regard to compliance. Results and self-ratings were provided for each subsection of N. A QA/QI process had been developed to review new orders at ABSSLC. The drug interactions report was obtained monthly from the WORx software program. The clinical pharmacist reviewed the report and randomly selected 10% of the orders in the drug interactions report for review. Additionally, the QA Department randomly selected half of these reports for review. The "Medical Services Monitoring Tool – Pharmacy Services" was used to audit the sampled drug interaction reports for new orders. The QA Department provided a report for the 4th quarter of FY11. The clinical pharmacist completed audits of 25, of which seven, QA staff also audited. Inter-rater reliability was established based on similar scoring. The QA score for the quarter (June, July and August) was 99%, and the departmental score for the same time period was 98%. Due to this close agreement, it was recommended the QA Department randomly sample records independent of the pharmacy review. Additionally, two areas that scored less than 100% in pharmacy responsibilities included the monitoring of chemical restraints and safe medication practice monitoring using the MOSES and DISCUS. It was noted that the monitoring of the chemical restraint process had shown resolution. Additionally, the completion of the MOSES and DISCUS by the contract psychiatrist remained problematic. The QA Department generated a second report for 1st quarter FY12. The report indicated that the QA Department would begin to reduce the oversight monitoring for Section N from monthly to quarterly oversight. For the 1Q FY12, the pharmacy sampled 18 drug interactions. The QA Department sampled four records. Inter-rater reliability was again established due to similar scores. Compliance for Section N was calculated by the average of the total score of "yes" answers compared to the total number of questions in the tool. The three scores for the three months were then averaged. The QA score for September/October/November 2011 was 100%, and the department score was 99%. As the Monitoring Team has repeatedly indicated in its reports, composite or overall scores such as this are meaningless, because the monitoring tools are not weighted. Two areas of pharmacy practice that needed review included the safe medication practices/monitoring of the MOSES and DISCUS, and new order recommendations concerning allergies by the pharmacist. The Pharmacy Department submitted documents reflecting internal review of the new order process involving drug interactions. The completed monitoring tools ("Medical Services Monitoring Tool: Pharmacy Services") were submitted for the months sampled and monitored: August 2011, September 2011, October 2011, and November 2011. For each month a graph of the findings were provided, entitled "Pharmacy Services Analysis." The information confirmed the content of the QA quarterly reports. The monitoring tool included 33 questions. The results of each of the questions was tabulated and entered into a graph. According to the Facility's data, there was 100% compliance for 31 out of 33 areas. For August 2011, there were concerns of incomplete listing of allergies, as well as concerns about the completed MOSES and DISCUS. For each of the drug interactions, the orders were reviewed. If there was a new order with a significant drug interaction based on the drug interaction alert, a copy of the patient interventions report

	for this new order was reviewed for completeness. For September 2011, all 33 areas were 100% compliance. For October 2011, 32 of 33 areas were 100% compliant. Timely completion of the MOSES and DISCUS by the contract psychiatrist remained a concern. For the November statistics, there was 100% compliance in 31 out of 33 areas. Noncompliant areas included allergy recommendations, as well as lack of timely compliance of the MOSES and DISCUS. As discussed in detail below, a number of discrepancies were noted between the Facility's monitoring results, and those of the Monitoring Team. For Section N.1, the Facility indicated that 100% of the interventions entered into the WORx system had been reviewed. However, the Monitoring Team found that the WORx screening of medication doses to ensure appropriate therapeutic dosage range was not functioning. Side effects related to new orders also did not appear to be communicated to the PCP or reviewed for severity by the pharmacist. The Facility's self-assessment did not identify these areas needing improvement. The Facility did track a number of drug-drug interactions to closure, including a "patient intervention" note and communication with the PCP. For Section N.2, the Facility reviewed each of the most recent quarterly drug regimen reviews for monitoring of laboratory results to ensure they were ordered in a timely manner, and orders took into consideration relevant lab values. However, this section is the first section dealing with QDRRs, and specifically relates to the timeliness of the QDRR, as well as monitoring of lab results. The Monitoring Team found a timely completion rate of 29%, based on a 90-day interval from the prior QDRR. This indicated the need for improved tracking of the timely completion of this important quarterly document. For Section N.3, the Facility had conducted a review of each of the elements of this subsection. However, the Facility's review did not take into consideration some important requirements. For example, the Facility provided an important pharmacy review for all chemical restraints within a timeframe of one to 17 days from the time of the restraint. Anticholinergic burden was reviewed, but justification of benefit versus risk of side effects was not reviewed. Similarly, although the psychotropic medications individually were justified by diagnosis, justification of polypharmacy was less clear. The Monitoring Team also found a lack of evidence for the justification of non-psychotropic medication polypharmacy. Benzodiazepine use appeared to have been justified. Tracking of endocrine and metabolic risks of atypical antipsychotics had been tracked. The Monitoring Team found tracking of benzodiazepines and atypical psychotropic medications were monitored appropriately. For Section N.4, the Facility reviewed 90% of QDRRs and found that the PCPs had reviewed and responded appropriately in 97% of QDRRs. The Monitoring Team found that PCP compliance was 88%. For Section N.5, the Facility had reviewed 106 records to determine timely completion and assessment using the MOSES and DISCUS. It found a compliance rate of 83%. In the narrative section of the Self-Assessment, the Facility indicated that it remained out of compliance with this provision, which was consistent with the Monitoring Team's findings. In the compliance column, the Facility indicated it was in substantial compliance, which appeared to be an error. For Section N.6, adverse drug reaction reports were reviewed and completed in all cases. The Monitoring

	Team found that the adverse drug reaction reports were completed. However, without training of direct support professionals, nurses, and PCPs, there was considerable chance that a potential ADR would not be identified and reported. For drug utilization evaluations required by Section N.7, the Facility had completed several drug utilization reviews and follow-up reviews. The information was shared with the PCPs, and appeared to be of great practical value to the PCPs. For Section N.8, medication variance tracking had been expanded beyond nursing, to include prescribers, and to include pharmacy dispensing. In its Self-Assessment, the Pharmacy Department noted that more time was needed to collect data and identify trends, corrective action plans did not provide clarity needed to assist with resolution of the medication errors, and more work was needed to show improvement in decreasing the medication variances. The Facility determined it was compliant with sections N.2, N.3. N.4, N.5, N.6, and N.7. However, as noted above, for Section N.5, it appeared a mistake had been made, because the narrative indicated that the Facility was not in compliance, but the compliance column indicated substantial compliance. The Monitoring Team found the Facility to be in substantial compliance with Section N.7. However, as the reasons outlined above indicate the Facility was not yet in compliance with the other subsections. It is important to note that for several sections (i.e., Sections N.2, N.3, and N.4) significant improvement was noted in the data reviewed, showing important progress towards substantial compliance.
	Summary of Monitor's Assessment: The Pharmacy Department continued to make considerable progress toward compliance, and had a number of strengths. The WORx system was able to generate warnings on drug-drug interactions, potential allergies, and the addition of the Misys system allowed the pharmacists to review a panel of lab test reports to assist them in determining whether acceptable lab monitoring was taking place. Patient intervention notes indicated frequent and timely communication with the PCPs related to significant warnings generated by the pharmacy's software. A major weakness of the WORx system at ABSSLC was the inability of the software to warn the pharmacist of a nontherapeutic dose of medication. It was unclear if this function was available, but it had been disabled, or if it was not an option offered by the software. The Facility is encouraged to resolve this concern promptly. Additionally, the Settlement Agreement also requires the Facility to screen new orders for side effects. There was little demonstration that new order monitoring included this component, or that the Pharmacy Department was providing significant side effect information to the PCPs. The chemical restraint checklist form was now being forwarded to the Pharmacy Department. The Pharmacy was completing in a timely manner the essential components of its review, including review of the justification for the chemical restraint, drug-drug interaction(s), and consideration of other options or recommendations. The calendar of drug utilization evaluations and follow-up studies represented a well-established system.

	It was having a practical impact on the clinical practices of the PCPs. Pharmacy had expanded tracking of medication variances to include pharmacy variances and prescriber variances. Problems were noted with two of the many components of the QDRR. There was lack of information concerning justification for use of anticholinergics, as well as justification for polypharmacy. Other areas monitored by the QDRR appeared to be complete. Although the adverse drug reaction (ADR) reporting process was identifying some ADRs, the system was not sustainable unless more staff throughout the Facility participated in its implementation. This will require extensive teaching of direct support professionals, nursing staff, and PCPs in order for them to recognize potential adverse drug reactions and report them. Medication errors remained a challenge. The Pharmacy Department will need to partner with the Nursing Department to initiate root cause analyses, medication room inventory checks, shortened time periods for medication refills to assist in determination of cause of medication errors, etc.

#	Provision	Assessment of Status	Compliance
N1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, upon the prescription of a new medication, a pharmacist shall conduct reviews of each individual's medication regimen and, as clinically indicated, make recommendations to the prescribing health care provider about significant interactions with the individual's current medication regimen; side effects; allergies; and the need for laboratory results, additional laboratory testing regarding risks associated with the use of the medication, and dose adjustments if the prescribed dosage is not consistent with Facility policy or current drug literature.	The Chief Pharmacist, a Clinical Pharmacist, two additional pharmacists, and four certified pharmacy technicians staffed the Pharmacy Department. The responsibilities of the Pharmacy Department had expanded to include assisting the local hospital(s) in providing medication prescribed to the individuals at ABSSLC when the hospital did not carry the needed medication. A procedure was developed on 1/12/12, entitled: Proposed Procedure for Supplying Hospitalized Individuals with Out of Stock Medication. This allowed the hospitalized individuals to receive medications from ABSSLC until the hospital could obtain a supply. According to the Pharmacy Department, the WORx software program was utilized to assist in identifying drug-drug interactions, potential allergic reactions based on individuals' histories, and to ensure therapeutic dosages were ordered. Additionally, the Pharmacy had access to the Misys system, and all pharmacists were provided an in-service on this software system. This allowed pharmacists to monitor lab tests, lab protocols, and enter "patient interventions" concerning labs. The pharmacists followed protocols for antiepileptic medication and psychotropic medication, as well as other common medications benefiting from periodic lab monitoring. This allowed discussion with the PCPs, and documentation concerning the need for lab monitoring based on these protocols.	Noncompliance

#	Provision	Assessment of Status	Compliance
		The "patient intervention" file was submitted for the months of August through December 2011, and January 2012. For August, there were 80 interventions. In September 2011, there were 39 interventions. In October, there were 63 interventions. For November, there were 91 interventions. In December, there were 63 interventions. For January 2012, there were 93 interventions. For these 429 interventions, the drug and dosage were recorded, when applicable, along with the next step (communication with PCP, communication with nurse, etc.). A sample of 10 new prescription orders was reviewed. The following summarize the results: ▪ For 10 new prescriptions (100%), a review was completed of drug-drug interactions with the current drug regimen prescribed. In the sample of 10, there were three orders involving six drug-drug interactions. ▪ For 10 (100%), allergies were reviewed. In the sample of 10, there were two orders involving allergies. ▪ For none (0%), significant side effects were reviewed. ▪ For six (60%), current laboratory results and potential need for further testing or review were addressed. The pharmacist reviewed monitoring of follow-up labs in five orders. The pharmacist made a calculation based on lab data and determined the medication was contraindicated for one order. For four other orders, there was no additional current lab or monitoring indicated. ▪ For none (0%), consideration was given to dosage adjustments, as there was no clinical need to change the dosage. ▪ For 10 (100%), the PCP was contacted to review any concerns. This was documented in the "patient intervention" section of the WORx software. Based on a review of 429 intervention reports, the information submitted did not include whether the PCPs had signed off on these reports. It may not have been part of the process at ABSSLC at the time of the review, or this information was not submitted. . During demonstration of the WORx software capability in assisting the pharmacists to complete a new order, it was observed that drug-drug interactions and potential allergies created a warning system on the computer screen, which then would lead to a "patient intervention" entry in WORx. However, it was learned that the WORx software at the ABSSLC pharmacy was unable to screen for nontherapeutic dosages ordered. Examples of supra-therapeutic or excessive/toxic doses of medications were entered into the system as a test of WORx's ability to identify the risk, and the software did not identify the risk or alert the pharmacist. This inability of the software to assist in providing acceptable warnings of excessive doses places the dispensing system at risk. It is recommended that this concern be urgently addressed to ensure the safety of the individuals, as well as to meet minimal standards required by the Settlement Agreement.	

#	Provision	Assessment of Status	Compliance
		Further, it did not appear that "side effects" were reviewed by the pharmacist, discussed with the PCP, or reflected in a patient intervention entry note. As none of the order entries reflected side effect concerns, there might be a systemic need to address this, when applicable to the order, and provide evidence of this communication between the pharmacist and the PCP. The Facility submitted the drug regimen review profiles for the four individuals with J-tubes. Review of the list indicated there were no medications given which were not clinically appropriate to be administered through the J-tube. The pharmacy had created a system to ensure medications were not prescribed that might have reduced absorption or lose the intended clinical effect when administered through a J-tube. For those individuals with J-tubes, previously the pharmacy had listed medications that should not be given through J-tubes as allergies. Although this alerted the pharmacist to not dispense the medication, it gave false information, and potentially did not allow IV administration of needed medications (some antibiotics) due to this notation. This was changed, and the information was correctly documented in a separate notes section for pharmacy review.	
N2	Within six months of the Effective Date hereof, in Quarterly Drug Regimen Reviews, a pharmacist shall consider, note and address, as appropriate, laboratory results, and identify abnormal or sub-therapeutic medication values.	A schedule for the drug regimen reviews was submitted for the calendar year 2012. It differed from the 2011 schedule. The 2011 schedule assigned separate months when the QDRR should be completed per residence. For the 2012 schedule, QDRR completion for each residence was by three-month time periods. These start and end dates of the 90-day periods were unique to each set of residences. For each residence, the most recent QDRRs for five individuals were submitted, as well as the prior dates of completed QDRRs. Information provided (i.e. the list of dates of QDRRs) was dated 2/21/12. Each of the prior QDRRs was reviewed for date of completion and compared to the most current QDRR's date of completion. A total of 110 QDRRs were reviewed for timeliness. Calculation of timely completion of QDRRs was based on completion of the QDRR within 90 days of the prior QDRR, or if the most recently listed QDRR was within 90 days of the date of the document (i.e., 2/21/12). QDRRs that had been completed more than 90 days after the prior QDRR, or if the most recently listed QDRR (as requested) was more than 90 days from the date of the information provided (2/21/12), the QDRR was considered beyond the acceptable time frame. Based on the information submitted, 32 of the 110 QDRRs were completed within 90 days (29%). The completion date for overdue QDRRs ranged from 91 to 106 days from the prior QDRR. For those QDRRs listed that were more than 90 days prior to 2/21/12, the cut off date of 2/21/12 was used for this calculation, because two QDRR dates were not available.	Noncompliance

#	Provision	Assessment of Status	Compliance
		A sample of 86 QDRRs also was reviewed. These are listed above in the documents reviewed section. The following summarizes the results of this review: ▪ Laboratory information was submitted as part of 85 QDRRs (99%). For one QDRR, there was no second page. The second page had detailed laboratory information as part of the QDRR form. ▪ The lab results included exact values or indication of normal range for Vitamin D levels, complete blood counts (CBC), electrolytes, glucose, Hgb A1C, lipid panel, hepatic function, ammonia level, thyroid function, as well as blood levels of specific medications (most commonly noted were antiepileptic drug levels with therapeutic ranges) in 85 of 86 QDRRs (99%). ▪ All labs (100%) had the date the lab was drawn. ▪ Abnormal values were listed in nine QDRRs. This information was provided in the notes/comments section line for that particular lab or as part of a recommendation in seven of the nine QDRRs (77%). ▪ The lab testing that was completed, and the frequency with which laboratory testing was completed indicated that the PCPs generally were providing appropriate lab monitoring of medication side effects, adverse effects, and therapeutic drug levels. The Facility remained out of compliance with this provision. The timeliness of the completion of QDRRs was an area requiring additional attention.	
N3	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, prescribing medical practitioners and the pharmacist shall collaborate: in monitoring the use of "Stat" (i.e., emergency) medications and chemical restraints to ensure that medications are used in a clinically justifiable manner, and not as a substitute for long-term treatment; in monitoring the use of benzodiazepines, anticholinergics, and polypharmacy, to ensure clinical justifications and attention to associated risks; and in monitoring metabolic and endocrine risks associated with the	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. <u>"Stat" Emergency Medications/Chemical Restraint Use</u> The Facility submitted completed Restraint Checklist and Face-to-Face Assessment, Debriefing, and Reviews for Crisis Intervention Restraint forms for 18 chemical restraints used from 8/29/11 to 12/15/11. These are listed above in the documents reviewed section. The chemical restraint documentation indicated that 12 individuals had received the 18 chemical restraints. A separate list compiled by the pharmacist indicated agreement in 100% of cases of chemical restraint use. All chemical restraints generating a restraint checklist and Face-to-Face Assessment, Debriefing, and Reviews for Crisis Intervention Restraint form were also part of the pharmacy database.	Noncompliance

#	Provision	Assessment of Status	Compliance
	use of new generation antipsychotic medications.	For the 18 chemical restraints, the pharmacy sections were reviewed for adequacy of completion and compliance. The following summarizes the review of these documents: ▪ Of the 18 chemical restraint forms, 18 forms (100%) included information concerning the justification of use due to the behavior. ▪ One (6%) included information concerning whether the maintenance medication and/or the BSP had been changed to reduce chemical restraint use, especially for an individual that had multiple chemical restraint events. ▪ Effectiveness of the chemical restraint was documented in 18 out of the 18 chemical restraint forms completed (100%). ▪ Side effects and adverse effects were noted in18 of the completed chemical restraint forms (100%). ▪ Risk analysis (drug/drug interactions) for use of the medication was documented on 18 of these forms (100%). ▪ There were five statements that were considered recommendations. ▪ The range of time from the date of the chemical restraint use to completion of the forms was from one to 17 days. Three were completed in one day, four were completed in two days, four were completed in three days, three were completed in four days, and one was completed in seven days. Three were completed beyond seven days. The psychiatrist also had a designated space for completion on the Face-to-Face Assessment, Debriefing, and Reviews for Crisis Intervention Restraint. Review of these documents showed: ▪ Of the 18 completed, there were 18 forms (100%) on which the psychiatry comment section was signed and dated. ▪ For none of the chemical restraints used (0%), by describing the behaviors and steps taken, clinical justification was provided. ▪ For none of those who required frequent chemical restraints (0%) was comment made regarding whether maintenance medication had been changed, the BSP had been amended, or other environmental changes were completed. ▪ Side effects were mentioned in none of the reviews (0%). ▪ Effectiveness was documented in five of the cases (28%). ▪ Information discussing the risks of drug-drug interactions, or other risks was addressed in one (6%). ▪ There were three recommendations documented. The pharmacy submitted a trend-line of chemical restraint use. Peak chemical restraint use had declined over time, from a peak of 36 chemical restraints used in November of 2009, to 18 used in September 2010, to 10 in May of 2011, and six in December 2011.	

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		Polypharmacy Of the 86 QDRRs reviewed, polypharmacy was noted in 23 reviews for 22 individuals. One individual had two sets of medication polypharmacy, and each is tabulated independently. ▪ Justification by diagnosis was documented in 21 of 23 (91%). ▪ Potential interactions with other drugs or food were reviewed in six (26%). ▪ Justification of the polypharmacy was documented in 14 of the 23 (61%). ▪ Location of the document concerning polypharmacy justification was listed in 12 of 23 (52%). ▪ For 13 (57%), the QDRRs reviewed whether monitoring/evaluation had occurred of effectiveness and appropriateness of the drug regimen. At the 2/15/12 Pharmacy and Therapeutics (P&T) Committee meeting, a "polypharmacy summary for January 2012" was submitted, which referred to psychotropic medications. There were 40 individuals considered to have active polypharmacy, in which the drug regimen and dosages were reviewed for optimal effect. There were 11 individuals considered to have stable polypharmacy, in which further reductions were associated with an increase in behavior or psychiatric symptoms. As discussed with regard to Section J, justification had not necessarily been provided to substantiate this "stable" category. There was one newly admitted individual prescribed polypharmacy. There were 199 receiving psychotropic medications. Of these 26.1% were receiving polypharmacy. There were 19.2% of individuals who were receiving polypharmacy who also had intraclass polypharmacy. For those individuals receiving psychotropic medications, 5% had intraclass polypharmacy. Additionally, those individuals prescribed multiple medications for psychiatric diagnoses or neurological conditions were also placed at a heightened risk level (high or medium risk), when the Pharmacy Department completed the polypharmacy/side effects category of the Integrated Risk Rating Form. Currently, no committee at ABSSLC addressed the polypharmacy of non-psychotropic medication. To improve efficiency of collection of data in such areas as justification for polypharmacy for these other categories of medication, the Facility should consider establishing such a committee to provide an interdisciplinary approach to review and discuss data in determining justification and effectiveness of polypharmacy. Separately, the Facility provided graphs concerning the decreased prevalence of psychotropic polypharmacy. For one graph entitled: "Number of psychotropic drugs used," the total number of drug orders decreased from 748 in the 1st Quarter of 2010 to 437 in the 3rd Quarter of 2011 (a 42% reduction over seven quarters). The average number of psychotropic medications per person, a more direct measure of	

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		polypharmacy, also had decreased from 3.12 psychotropic medications per individual in the 2nd Quarter of 2010 to 2.16 psychotropic medications per individual in the 3rd Quarter of 2011. Benzodiazepine Use Benzodiazepine use was noted in 10 of the 86 QDRRs. ▪ Of these, 10 (100%) documented justification with appropriate diagnoses; and ▪ All 10 QDRRs (100%) indicated whether side effects or other adverse risks were present. Anticholinergic Monitoring Of the 86 QDRRs, all (100%) were screened for medications associated with potential significant anticholinergic side effects. A total of 45 QDRRs identified anticholinergic medications. The results of the review of these QDRRs are as follows: ▪ None (0%) listed a document that provided clinical justification (benefit of medication versus risk of side effects); ▪ 45 (100%) QDRRs addressed side effects/significant risks; and ▪ 24 (53%) QDRRs listed drug/drug or drug/food interactions. It was noted that the Pharmacy Department had begun to quantify the total anticholinergic burden of the medication regimens prescribed during the QDRR process. Separately, the Facility submitted graphs demonstrating decreased use of anticholinergics at ABSSLC. From the 1st Quarter of 2010 to the 3rd Quarter of 2011, the number of anticholinergic medications was decreased by approximately 50%. Additionally, 19 of the current prescriptions were for oral atropine drops to reduce secretions, which minimized systemic effects. Anticholinergic medications with significant systemic effects were prescribed at less than 50% of the 1st Quarter 2010 level. Although additional work was needed with regard to the justification and monitoring of these medications, this showed that significant attention had been paid to this class of medications. New Generation Antipsychotic Endocrine and Metabolic Side Effects Out of the 86 QDRRs reviewed, 25 listed atypical antipsychotic medication. Of these, 25 (100%) included lab values that reviewed endocrine and metabolic risks (i.e., BMP, glucose level, Hgb A1C, and/or lipid panel as appropriate). Although progress continued to be noted, the Facility remained out of compliance. Areas that continued to require improvement included the review of chemical restraints, review and justification for polypharmacy, and monitoring and justification for anticholinergic medications.	

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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.	Review of 86 QDRRs showed the following: ▪ Of the 86, 86 QDRRs (100%) had the PCP signature. ▪ Of the 86, 86 (100%) had the date the PCP reviewed the document. ▪ The PCP signed and dated the QDRR on average seven days after completion by the Pharm D. ▪ Evidence of PCP review of recommendations and agreement or disagreement with justification and plan was documented in 75 out of 85 (88%). For one QDRR, no agreement was indicated, as there were no recommendations. o There was disagreement by the PCP for none of the QDRRs. There was agreement in 75/75 (100%) of the QDRRs. ▪ Psychiatry reviewed the QDRR when there was polypharmacy due to psychotropic medication. At times, a psychiatrist signed the QDRR when there was no polypharmacy of psychotropic medication. A psychiatrist reviewed 20 QDRRs, and agreement or disagreement with justification and plan was documented in 19 out of 20 (95%). ▪ The psychiatrist signed and dated the QDRR an average of 15 days after the completion by the Pharm D. With regard to the physicians' review of the QDRRs, the root of the confusion might be the actual form. There was no place on the form to check when there was no recommendation made other than to agree that there was no recommendation. The two choices provided was that the PCP agreed with the recommendation or that the PCP did not agree with the recommendation. Based on that, the PCPs responded differently. ▪ Given that a number of comments in the QDRRs could be considered recommendations and the PCP could have followed them (e.g., orders for increased monitoring parameters, etc.), checking the "agree" or "disagree" box would have been applicable even without a formal recommendation listed under the recommendation section. Some of the comments actually were recommendations that would be important for nursing staff's administration of the medication (e.g., Individual #84), such as the instructions on Boniva, but this would also be important for the PCP to know to remind nursing staff or discuss with them when making rounds in the residence. It would likely be a recommendation the PCP would agree with, even if it did not require a PCP order. ▪ Inconsistencies were seen with the way PCPs addressed this issue. In reviewing serial QDRRs, the same physician marked the box the first time even if no formal recommendation had been made, but did not on the second (e.g., Individual #413). Similarly, a QDRR with no recommendations was signed and a box was marked during the prior quarter, but left unmarked in the current quarter by a different PCP (e.g., Individual #426).	Noncompliance

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		▪ For Individual #498, there was a recommendation made, and although it required nursing action and not PCP action, there was still room for agreement that it should have been done. ▪ For Individual #163, there was a recommendation for monitoring of anticholinergic symptoms, which could have been addressed by the physician ordering that this information be recorded as documentation on the MAR, or written periodically in a medical quarterly review, but the box was left unmarked. ▪ For Individual #110, it was also unclear the reason for placing comments regarding the option of Loratadine and multivitamins/minerals being administered in liquid form in the comments section, when the follow-up QDRR continued to record that, at least for the multivitamin/mineral, the tablet form was still recorded. If the pharmacist was recommending a change in the medication, then it should be under the recommendation section. ▪ For Individual #158, there was no pharmacist comment, and the recommendation was "none at this time." If the PCP reviewed the clinical pharmacist material in the QDRR and agreed with that statement that there was no recommendation at that time, the agreement box would still apply, given the only other response would be to disagree. Credit was given by removing the one QDRR (i.e., Individual #328) without recommendations, because that PCP actually commented that the boxes were not applicable by writing the word "none" by the recommendation boxes. This notation clearly demonstrated the PCP reviewed the material to some extent, and determined there was no agreement or disagreement to be made. All aspects of Facility monitoring require clear and consistent evidence to determine compliance. When a PCP leaves both boxes (agree or disagree) unmarked, there is no information to determine if the PCP reviewed the QDRR sufficiently to understand the content, and whether based on that review, agreed with the phrase under recommendations: "none at this time." To ensure some consistency in response, going forward, the QDRR might need to be augmented with an additional box that there were no recommendations, or that the PCP agrees with the clinical pharmacist that there is no recommendation to be made. Further, items in the comments section such as when medication can be changed from tablet to liquid, or when a need existed for increased monitoring of various physiological side effects were actually recommendations. However, since they were not listed in the recommendation section, the PCPs might not have considered writing parameters or requesting a change in tablets to liquids, etc. Standardizing the information to be placed in the comment section or recommendation section would be important. In addition, all	

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		the PCPs need instruction to be able to respond to the QDRR form in a unified manner. Lastly, the Facility should create a monitoring tool to ensure the PCPs do respond appropriately and complete the documents according to guidance they have during any future in-service. Consideration should be given to having the QA Department review the content of the comments versus recommendations section of the QDRR to ensure they are consistent from one document to the next, and create a set of criteria or guidelines in differentiating the content of both. All of these areas will be closely reviewed during the Monitoring Team's next visit to ensure progress has been made. Given the confusion the form has created among clinical staff, this area remains in need of improvement and out of compliance. To determine if the recommendations that were agreed upon were actually acted upon, the Facility submitted 10 active records in which recommendations were made on the QDRR. These are listed above in the documents reviewed section. In the sample of 10, 10 (100%), there was documentation that the PCP/psychiatrist acted upon the recommendation. Examples of recommendations that were implemented included reducing Celexa dosage, ordering an electrocardiography (EKG) due to Chlorpromazine dosage change, decreasing a dosage of Simvastatin, reducing intraclass polypharmacy, using medication with less anticholinergic side effects, follow-up Vitamin D levels after changes in Vitamin D dosage, switching to liquid forms of medication in those with risk of choking and aspiration, reducing polypharmacy for acid reducing medications, and increased monitoring of anticholinergic side effects. Evidence of implementation included copies of orders and/or copies of test results. The Facility submitted six active records in which recommendations from the QDRR were not followed. These are listed in the documents reviewed section. In six cases (100%), the response, rationale, and plan were written on the QDRR. For the last review, the Facility was found in compliance with this provision. However, due a decrease in the Facility's performance related to the physicians' review and response to the QDRRs, the Facility was no longer compliant with this provision.	
N5	Within six months of the Effective Date hereof, the Facility shall ensure quarterly monitoring, and more often as clinically indicated using a validated rating instrument (such as MOSES or DISCUS), of tardive dyskinesia.	As reported with regard to Section J.12, this provision of the Settlement Agreement mandates systemic, quarterly monitoring for the emergence of motor side effects related to the utilization of antipsychotic medication with the Dyskinesia Identification System: Condensed User Scale, and the monitoring of more general systemic side effects related to psychotropic medication with the Monitoring of Side Effects Scale every six months. An additional component of this process was also the latency between the time the nurse completed the exam, and the PCP reviewed and signed the documentation. The review of the sample of the records of 30 individuals prescribed psychotropic	Noncompliance

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		medication indicated the MOSES evaluation was current (completed within the last six months) and had been performed at least every six months for all but the following two individuals, who had missing documentation: Individual #544, for whom the two-page forms were all missing the second page that contained the signatures and dates, and Individual #384, for whom the documentation for the 11/7/11 evaluation was complete, but the essential second pages from the prior evaluations for the year were missing. Thus, documentation could be identified for 28 of the 30 individuals (93%). The records of 22 of the 30 individuals (73%) contained documentation that the PCP had reviewed the MOSES evaluation in a timely manner. The six individuals whose MOSES documentation was not reviewed in a timely manner (latency between dates) were those of: Individual #253 (11/8/11 - 11/28/11), Individual #274 (6/6/11 - 6/22/11), Individual #163 (10/4/11 - 10/24/11), and Individual #61 (6/1/11 - 6/22/11), Individual #296 (11/2/11 - 11/30/11), and Individual #125 (11/30/11 - 12/13/11). In addition, as noted above, the necessary information to document the interval between the evaluation and the PCP review was missing for Individual #54 and Individual #384, resulting in the overall completion rate of 73 percent. The purpose of the DISCUS is to detect the emergence of motor side effects related to the use of antipsychotic medication. The review of the records of the sample of 30 individuals indicated that the following ten individuals were not receiving antipsychotic medication at the time of the review: Individual #164, Individual #325, Individual #59, Individual #263, Individual #83, Individual #9, Individual #216, Individual #544, Individual #88, and Individual #460. Thus, monitoring with the DISCUS was not required. However, the review of the sample of 30 individuals indicated that the Facility's practice was to perform the DISCUS for all individuals who received psychotropic medication, because the results for these ten individuals did not differ from those of the other 20. Documentation that the DISCUS was current, and had been performed quarterly for the past year was identified for all but the following four individuals (date of most recent DISCUS evaluation): Individual #164 (most recent evaluation 9/19/11), Individual #216 (most recent evaluation 7/13/11), Individual #313 (interval of greater than 90 days between 6/16/11 and 10/5/11 evaluation), and Individual #59 (interval of greater than 90 days between 5/4/11 and 11/10/11 evaluations. Thus, the DISCUS had been performed as specified for 26 of the 30 individuals (87%) that the Facility included in their protocol for monitoring with the DISCUS. The documentation related to the DISCUS was reviewed with regard to the length of time between when the nurse performed the evaluation, and when the PCP reviewed it. Seven individuals' records indicated a significant delay between the date the nurse completed the DISCUS evaluation, and the PCP reviewed and signed it (latency before review),	

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		including: Individual #125 (11/30/11 - 12/15/11), Individual #263 (11/8/11 - 11/28/11), Individual #81 (6/1/11 - 6/22/11), Individual #163 (10/4/11 – 10/24/11), Individual #274 (12/27/11 - 1/13/12), Individual #293 (11/2/11 - 11/30/11), and Individual #9 (9/20/11 - 10/24/11). Thus, the PCP reviewed the DISCUS in a timely manner for 23 of the 30 individuals (77%). The numbers and specific information for the individuals whose records comprised this sample have been provided to enable the Psychiatry Department to ascertain if the missing documentation was due to the evaluation not being completed, clerical errors in filing, or omissions of documents in the process of assembling them for this review. Progress in completing these evaluations according to the timelines established in the Settlement Agreement will be monitored in future reviews. The DISCUS and MOSES also are necessary to monitor for the side effects of Reglan, which although prescribed for gastroesophageal reflux disease (GERD), has pharmacological properties that are similar to those of antipsychotic agents. A list was obtained from the Pharmacy of all individuals prescribed Reglan to develop the sample for this analysis. This list was then cross-referenced with the Facility-wide list of individuals receiving psychotropic medication in an effort to generate a list of individuals receiving Reglan, but not also prescribed psychotropic medication. The following sample of five individuals (21% of the 24 individuals who fit the above criteria) was selected: Individual #25, Individual #333, Individual #498, Individual #21, and Individual #212. The review of the records of these individuals indicated that the MOSES examination had been performed as required for the following: Individual #333, Individual #498, Individual #25, and Individual #21. No MOSES was included in the requested documentation for Individual #212. Thus, these evaluations had been completed as expected for 80 percent of the sample. With regard to the elapsed time between the nurse's completion of the evaluation and the PCP's review, timely review occurred for only one individual, Individual #498 (20%). No documentation was available in the record of Individual #212. The latency before the review for the other three was as follows: Individual #25 (1/12/12 - 1/31/12, and 10/19/11 - 11/7/11), Individual #333 (11/9/11 - 11/30/11, and 8/25/11 - 9/20/11), and Individual #71 (8/15/11 - 8/30/11). The same methodology was utilized to select the sample of individuals receiving Reglan for completion of the DISCUS. The results of this review indicated that these evaluations were completed as specified for only three of the five individuals: Individual #212, Individual #333, and Individual #21 (60%). The review of this documentation for the remainder of the sample indicated that there was a greater than 90-day interval between the 7/8/11 and 10/19/11 DISCUS for Individual #25. There was also a prolonged	

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		interval between the 9/28/11 and 1/20/12 DISCUS for Individual #498. For this sample of DISCUS evaluations, the PCP had conducted a timely review for only two individuals in the sample: Individual #212 and Individual #498 (40%). The prolonged intervals between the nurse's actual evaluation and the PCP's review were as follows: Individual #25 (1/12/11- 1/31/12), Individual #333 (11/9/11 - 11/30/11, and 8/25/11 - 9/15/11), and Individual #21 (8/15/11 - 8/30/11). During the Monitoring Team's prior reviews, the subject of the latency between the completion of the MOSES and DISCUS, and the date the PCP reviewed and signed them had been discussed with the Psychiatry Department. At that time, staff indicated that any abnormal findings on these examinations were reported immediately to the PCP. However, there did not appear to be any documentation of this process. To the extent that new abnormal findings on an evaluation are identified and reported immediately to the PCP, it would be useful to devise a mechanism to document this process. The mechanism to ensure routine evaluations are reviewed in a timely manner also will need to be improved. The monitoring of individuals prescribed Reglan, but not receiving a psychotropic agent also should be improved, because this medication can cause significant side effects. These might include acute extrapyramidal motor side effects (EPS), which could require treatment with anticholinergic agents, as well as tardive dyskinesia, which can be irreversible, if not promptly identified and addressed. Due to the deficiencies in the completion of these important side effect monitoring tools according to the schedules required by the Settlement Agreement and the numerous delays in the review of these documents by the PCP, the Facility remained out of compliance with this provision.	
N6	Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall ensure the timely identification, reporting, and follow up remedial action regarding all significant or unexpected adverse drug reactions.	Eight potential ADRs were identified. Copies of "Medication Adverse Reaction Reports" were submitted for each. Adverse drug effects included phlebitis, breakdown of the G-tube bulb, cellulitis, local injection reaction, rash, atypical fracture, bone marrow depression, and muscle rigidity. The review of the documents identified the following concerns: ▪ For one individual, Lovaza was given and associated with breakdown of the G-tube bulb. The clinical pharmacist then recommended that it be administered whole and not crushed or pierced. The recommendation was to change to an alternate lipid-lowering agent. However, the response from the PCP was to mix Lovaza and give with formula feeding. If Lovaza had an adverse effect on the G-tube bulb, this could theoretically reoccur with the new methodology for administration. Additionally, it was being mixed with the formula feeding, which suggested the capsule was crushed or pierced, when the clinical pharmacist stated it should not be administered this way.	Noncompliance

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		▪ Additionally, an individual on Boniva intravenous (IV) developed cellulitis, and this was initially reported as an adverse drug reaction. However, the Facility provided no information whether the Nursing Department reviewed the subject of sterile technique in starting an IV site, because it is unlikely that the medication actually caused an infection, and more likely the IV puncture site was contaminated and introduced infection. ▪ Similarly, as nursing pointed out, there was a local reaction when a small vein was used for administration of medication. One might expect phlebitis and local reactions when using small blood vessels, and this might be the sequelae of using small vessels. This might have had little to do with the medication and more to do with nursing protocols and guidance. There was no tracking process to ensure that when a reported ADR was due to potential nursing practices that this information was forwarded to the Nursing Department with feedback requested regarding closure, and a closure date documented. Overall, the forms were typed, and appropriate sections completed, with summary of findings and rationale for consideration of an adverse drug reaction. Although it appeared several reported potential ADRs were reviewed and ruled out, the ADR form did not clearly state that the ADR was ruled out after a narrative evaluation was documented. A simple check box for "ADR confirmed" or "ADR ruled out" would provide clarity regarding the conclusion. It is important to note that the ADRs had each been discussed at the morning medical meeting, providing early input from PCPs and nursing staff. More problematic, the current ADR system relied on the clinical pharmacist to be alerted to potential ADR through attendance at morning meetings and through other informal means. This is not a sustainable system. Staff should be trained on what to recognize as a potential ADR so that it can be raised at the morning medical meeting. To date, there appeared to be no formal training of most departments that would see a potential ADR (direct support professionals, nurses, etc.). It is important that a training program be developed and implemented, and attendance rosters completed to track the percentage of direct support professionals, nurses, etc., having completed training in identification of a potential ADR.	
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	The Facility submitted drug utilization evaluations and follow-up studies completed in the prior six months. In October 2011, "Levothyroxine monitoring" was completed and discussed at the 10/26/11 P&T Committee meeting. Criteria included those individuals on Levothyroxine. Three indicators were researched. For the first indicator, whether a TSH had been drawn within the prior 12 months, the records demonstrated 100% compliance. For the indicator that an abnormal TSH was followed by a free T4 level,	Substantial Compliance

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	accordance with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	compliance was 97%. For the third indicator, whether a change in Levothyroxine dosage was followed by a TSH order six to 12 weeks after the dosage change, compliance was 91.6%. In November 2011, another DUE was initiated on "Cardiac Monitoring of Lithium, Imipramine, Trazodone, and Propranolol Therapy," and background information was discussed at the 10/26/11 P&T Committee meeting. The DUE was to determine whether an EKG had been performed within the last 12 months for those individuals taking one of these psychotropic medications, or prescribed Propranolol for a psychiatric diagnosis/side effect. Results were available in a January 2012 report. The results indicated that an EKG had been performed within the last 12 months in 100% of those prescribed the target psychotropic medications or Propranolol for their side effects. A third study also occurred in November 2011 as a follow-up to a prior DUE, an audit of Valproic acid and Divalproex sodium. Monitoring by lab tests were reviewed, based on whether the drug was prescribed for seizures or behaviors. A report in January 2012 summarized the findings. For the sample of 20 chosen, each had an indication of a seizure or behavior for which Valproic acid was indicated. Further, in 100% of cases, the appropriate laboratory monitoring was completed. An additional DUE follow-up was discussed at the 2/15/12 P&T Committee meeting. This was a Zostavax drug utilization evaluation follow-up. The audit sample included the individuals who turned 60 within the past year, and individuals from the original study who had not received the vaccine to date. Compliance was only 37.5%. There were two orders for the vaccine, but it had not been given. There was one individual that had received the vaccine. There were five individuals that had turned 60, but had not been given the vaccine. A DUE was ongoing for Reclast and kidney function. A copy of the data collection form was distributed at the 2/15/12 P&T Committee meeting. For each individual an estimated Glomerular filtration rate (GFR) was calculated. Questions included whether the individual had a diagnosis of kidney disease, if the individual routinely took diuretics, and whether the individual had frequent problems with dehydration. Findings were not discussed. A calendar was submitted for the calendar year 2012 that identified the medications to be included in drug utilization reviews. These included: January 2012: Reclast and kidney function monitoring/creatinine clearance, follow-up study on Zostavax, April 2012: Risperdal monitoring of metabolic effects, follow-ups; July 2012: Zyprexa monitoring of metabolic effects, follow-ups; October 2012: "Chronic hepatitis B/C and HIV carriers: have they had Hepatitis A vaccine?" and follow-ups.	

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		The calendar of drug utilization evaluations and follow-up studies represented a well-established system. It was having a practical impact on the clinical practices of the PCPs, and followed the requirements set forth in the Health Care Guidelines. As a result, the Facility remained in compliance with this provision.	
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.	<u>Policies and Procedures regarding Medication Variances</u> The Facility had approved and implemented a State Office SSLC Statewide Policy and Procedure: Policy # 053, Effective 9/23/11, entitled: Medication Variances. This policy described the different types of variances, defined the categories of severity of medication variances, and assessment/quality assurance expectations. <u>Pharmacy Review of Categorization of Errors</u> The Pharmacy Department was not active in verifying the Nursing Department's categorization of medication errors to determine if they were consistent with the Pharmacy's interpretation of the medication error categorization. Information submitted indicated that the Chief Nurse Executive completed this oversight monitoring responsibility. It is recommended that the Pharmacy Department review a sample of medication errors to ensure agreement with the final categorization. <u>Committee Monitoring of Medication Errors/Variances</u> The development, progress, and tracking of a medication error process and trend analysis were reflected in the minutes of the Medication Variance Committee meetings. Currently, the Chief Nurse Executive chaired this committee. The following describes some of the findings of this committee: ▪ The 7/27/11 meeting minutes indicated a downward trend in medication errors. There were five category D errors, and the remainder of errors were mostly category C. Two residences were identified with the highest rates of errors, and the reason provided for the increased incidence was that it was due to the turnover rate of nurses in that unit, as well the need for each nurse to cover two residences on the evening shift. ▪ The 8/24/11 meeting minutes indicated that the number of medication errors had doubled from June to July. Most were due to unreconciled medication errors. ▪ The 9/28/11 meeting minutes documented that the medication error absolute numbers remained similar. There were three category D errors. The clinical pharmacist reviewed the Medication Administration (MARs) for two residences, and assisted in recommending changes in times, dosages, and routes in order to reduce medication errors. ▪ The 10/26/11 meeting minutes documented errors in three residences that	Noncompliance

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		were in part due to incorrect transcription of orders, and the primary day shift LVN being off duty for some of that time. During the Medication Station Surveys, the Pharmacy Department identified a number of concerns. Discontinued medications were not being returned to the pharmacy, and there were numerous duplicate orders for treatments. The pharmacy also began to report auto fill variances by the pharmacy technicians. These variances were corrected prior to the medications leaving the pharmacy. There were 19 wrong drugs dispensed, 25 wrong strengths/dosages dispensed, 19 wrong quantity, and 10 missing medications. Additionally, three categories of variances originating from the PCPs were initiated. These included the following: medication prescribed in the presence of an established allergy, medication prescribed at the wrong dose, and medication prescribed in the presence of a current drug with the same therapeutic purpose. From this list of categories, for September 2011, there had been seven variances due to wrong medication dosage being prescribed. ▪ The 11/30/11 meeting minutes documented 24 medication variances from the Nursing Department, 83 pharmacy tech variances, and six prescriber variances. ▪ The 2/17/12 meeting information documented that there were four prescriber variances. There were 25 unreconciled medication errors and 22 reconciled errors due to nursing staff. There were 93 pharmacy tech variances for 10,050 drug orders filled. The graphs displayed a number of variables. The totals for the months varied from graph to graph, for instance the total medical variances by type was listed as 28 in November 2011, but medication variances per shift in November totaled 39, and a third graph for reconciled versus unreconciled variances for November listed 24. The differences were not defined or interpreted. The Facility also reviewed medication errors in the P&T Committee. This committee met on 10/26/11. Monthly errors were reviewed by type (i.e., extra dose, omitted dose, wrong patient, wrong time, wrong dose, wrong route, wrong drug, and wrong technique), by category (i.e., minor incidents, serious errors, and unreconciled), by node (i.e., administering, dispensing, documenting, monitoring, and prescribing), severity (i.e., categories A through F), by residence, by unit, by unreconciled errors per month, by pharmacy variances (i.e., wrong drug, wrong strength, wrong quantity, missing medication, and wrong person/drug). From the 10/26/11 P&T meeting minutes, the total number of errors from August 2011 was 77, and in September 2011, it was 66. Of these, most were listed under the category of omitted dose. The unreconciled errors for August 2011 were 62, and for September 2011 were 56. The total errors listed in the "monthly errors by category" were 80 for August 2011, and 58 for September 2011, which varied slightly from the total errors in the graph entitled "monthly totals by type."	

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		Errors were considered errors of administration or documentation for both months. When broken down by residence, there were two residences responsible for most of the errors in August 2011, and one residence in September 2011. Unit 4 had the most medication errors for both months. An August 25, 2011 memo indicated that nursing took several steps in Residence 6730 due to the overages from that residence. During July 2011, six medication set-up checks were completed on day and evening shifts. Additional medication administration observations were requested. The P&T Committee meeting of 2/15/12 reviewed the medication variance report of October 2011 through January 2012. Statistics indicated 23 medication variances occurred in October 2011, 28 in November 2011, 30 in December 2011, and 45 in January 2012. All errors were categorized from A through D. Unreconciled errors remained constant from month to month. The ratio of unreconciled to reconciled errors per month was as follows: October 2011 17/6, November 22/2, December 24/7, and January 2012 25/22. These two committees (i.e., Medication Variance Committee and the P&T Committee) reviewed medication errors, but neither included critical review or discussion of the information or critical that might have led to additional action plans or options to be considered. Although data was presented with comparative analysis from one time period to another, succinct tasks were not assigned based on this information (either as exploratory to find more information needed for interpretation, or to resolve issues), nor were clear action plans developed that would lead to follow-up. As the Medication Variance Committee focused on medication errors, documentation should show critical thinking with identification of questions to be answered, assignment of tasks with deadlines, and follow up of these tasks at subsequent committee meetings. In order for the Committee to be valuable, it would need to demonstrate an aggressive approach to medication variance problem-solving with positive results. Although such discussions might have occurred at these committee meetings, there was little information documented concerning the content of the discussions. There was also no clear path forward from the minutes concerning the next steps of the committee in resolving the significant problem related to medication variances. <u>Medication Error Reports</u> Copies of nine medication variance reports were submitted for review. All were considered Category C of the severity index. All were omissions of medication. All but one was for one missed dosage. A follow-up note was recorded in each of the reports.	

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		Medication Observation Monitoring The Facility submitted copies of medication administration observation forms for the months of November and December. In November, 15 nurses passed medication administration observations, and eight failed. There was one in which the grading could not be determined, but was presumed a passing grade. For December 2011, nine nurses passed a medication administration observation, and three failed. None of the submitted December copies had grades, but the lack of errors found provided evidence for the Monitoring Team's interpretation. The Medication Variance Committee of 2/17/12 reported that in January 2012, eight medication observations were conducted, of which five passed and three failed. However, these failures were not due to medication pass errors, but to medication room issues (the refrigerator temperature check sheets were incomplete). The observation tool included 54 indicators. One of the more common areas of noncompliance was "Medications are stored properly." Although an important concern, it did not address the large number of medications considered overage at the end of the medication cycle, and for which there was no reconciliation as to cause. Negative findings that might assist in reducing the large number of unreconciled returned medications included: "the MAR notes start/stop dates", and "individual is identified prior to administration of medication."	

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

1. The inability of the software at ABSSLC to detect non-therapeutic dosages of medications should be expeditiously resolved to ensure the safety of individuals. (Section N.1)
2. For new orders, significant side effects should be reviewed by the pharmacist, and discussed with the PCP, or reflected in a "patient intervention" note. It was not clear if the software also did not review significant side effects to alert the pharmacist and PCP. The Facility should develop a system of communication between the Pharmacy Department and PCPs concerning new medication orders with potential for significant side effects. (Section N.1)
3. The Pharmacy Department should create a tracking system to ensure the completion of QDRRs within 90-day intervals. Given the State Office's proposal for the completion of quarterly reviews, the tracking system should be adaptable accommodate changes that might be made. (Section N.2)
4. For polypharmacy, additional attention should be given to documentation of drug-drug interactions or drug-food interactions, justification of the polypharmacy regimen, and reference to the justification (location of document) and effectiveness of the regimen. (Section N.3)
5. To assist in reviewing polypharmacy for non-psychotropic medication, a nonpsychotropic polypharmacy committee should meet and review the needed information. As part of this process, the medical team should review and justify polypharmacy in nonpsychotropic medications. (Section N.3)
6. The Facility should develop and implement systems to ensure that the MOSES and DISCUS side effect assessments, which members of the nursing staff perform, are completed as specified. The prescribing provider also should review and sign these evaluations in a timely manner.

(Sections J.12 and N.5)

7. The monitoring system for the MOSES and DISCUS of individuals receiving Reglan should be improved to increase completion rates. In addition, the prescribing provider should review the MOSES and DISCUS evaluations for individuals who are prescribed Reglan in a timely manner. (Sections J.12 and N.5)
8. A tracking system should be developed and implemented for initial reports of an ADR that are subsequently determined to be potential nursing practice concerns. Corrective actions should be taken and tracked until closure. (Section N.6)
9. A final checkbox or other easily identified entry should be included on the ADR form to indicate whether the ADR was confirmed or not confirmed/ruled out. (Section N.6)
10. The Facility should develop a sustainable ADR reporting system rather than relying on one professional to be responsible for reporting all ADRs. This will require training of direct support professionals, nurses, PCPs, etc., in early ADR recognition and the reporting route of a suspected ADR. (Section N.6)
11. The Pharmacy Department should review a sample of medication errors to ensure agreement with the final categorization. (Section N.8)

SECTION O: Minimum Common Elements of Physical and Nutritional Management	
	Steps Taken to Assess Compliance: The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o Presentation Book for Section O; o ABSSLC Presentations for 2/13/12 for Section O; o The following documents: Occupational Therapy (OT), Physical Therapy (PT), Speech Language Pathology (SLP), and Nutrition assessments; Aspiration Pneumonia/Enteral Nutrition (APEN) assessment; Head of Bed Elevation (HOBE) assessment; OT/PT/SLP consultations, for the last year; Integrated Risk Rating Form; ISP Risk Action Plan; Individual Support Plan; and ISP Addendums, for the last year; Physical and Nutritional Management Plan (PNMP) with pictures; Health Management Plans; individual-specific monitoring, for past three months; competency-based training and performance check-offs for staff; supporting documentation for implementation of ISP Integrated Risk Rating form and Risk Action Plan; and Aspiration Trigger sheets for 15 individuals (Sample O.1) including: Individual #458, Individual #253, Individual #283, Individual #468, Individual #297, Individual #91, Individual #42, Individual #511, Individual #311, Individual #395, Individual #471, Individual #407, Individual #385, Individual #492, and Individual #362; o The following documents: Physical and Nutritional Management Team (PNMT) assessment and action plan, Integrated Risk Rating form, ISP Risk Action Plan, APEN assessment, HOBE assessment, ISP and ISPAs for past year, IDT action plan, PNMP with pictures, PNMT competency-based staff training and performance check-offs related to PNMT action plan, individual-specific monitoring for PNMT action plan for the past six months, supporting documentation for implementation of PNMT assessment and action plan, Health Management Plans, PNMP Clinic notes for past year, and PNMT Discharge Plan/Summary for 12 individuals (Sample O.2), including: Individual #429, Individual #6, Individual #212, Individual #350, Individual #117, Individual #407, Individual #457, Individual #80, Individual #414, Individual #103, Individual #454, and Individual #498; o The following documents: OT/PT/SLP assessments, nutrition assessment, APEN assessment, HOBE assessment, ISP and ISPAs for past year, PNMP with pictures, pleasure/therapeutic feeding program/plan, therapy (OT and/or SLP) progress notes for pleasure/therapeutic feeding program, individual-specific monitoring for past three months, staff competency-based training, and OT/SLP/Registered Dietician (RD) consultations for the past year, Integrated Risk Rating form, and Risk Action Plan for 11 individuals (Sample O.3), including: Individual #184, Individual #101, Individual #49, Individual #122, Individual #373, Individual #366, Individual #265, Individual #21, Individual #285, Individual #429, and Individual #403; o The following documents: PNMPs, dining plans and diet cards for 42 individuals (Sample O.4), including: Individual #377, Individual #194, Individual #513, Individual #138, Individual #118, Individual #254, Individual #524, Individual #278, Individual #295,

	Individual #529, Individual #312, Individual #368, Individual # 80, Individual #206, Individual #35, Individual #343, Individual #337, Individual #451, Individual #202, Individual #493, Individual #228, Individual #518, Individual #75, Individual #176, Individual #141, Individual #465, Individual #364, Individual #158, Individual #472, Individual #31, Individual #124, Individual #347, Individual #327, Individual #370, Individual #250, Individual #543, Individual #519, Individual #73, Individual #17, Individual #235 and Individual #270; o PNMT Assessment/Review Tracking, from 11/10 through 2/12; o PNMT Document Tracker, from 6/11 through 7/11; o Action Plan Log, from 3/11 through 11/11; o PNMT Review and Recommendations, from 6/11 through 10/11; o PNMT Roster, dated 1/11; o PNMT Follow-up Log for Multiple Individuals, from 10/11 through 12/11; o List of PNMT Core Members, dated 1/12; o PNMT Curriculum Vitae and corresponding Certificates of Achievement, various dates; o PNMT Operating Procedures Manual, revised 1/12/12; o PNMT Continuing Education Programs, from 8/11 through 12/11; o PNMT Training Sign-In Rosters, from 9/11 through 11/11; o PNMT Meeting Agendas and Notes, from 8/11 through 12/11; o PNMP Clinic-Notes, from 8/11 through 1/12; o List of Individuals with Physical and Nutritional Management (PNM) Needs, undated; o List of Individuals without PNM Needs, undated; o PNMPs for Multiple Individuals, from 10/10 through 12/11; o PNMP Monitoring Form - Routine (template), undated; o Habilitation Therapies (HT) Monitoring Form (template), revised 11/1/11; o Mealtime Observation Form (template), revised 6/11; o Steridient Monitoring Log, revised 10/18/06; o Mealtime Monitoring Dates, from 10/11 through 12/11; o PNM Competency/Performance Checklists (templates), undated; o QA/QI Data Summary-Sections O, P, and R, dated 1/13/12; o Dining Plan template, dated 7/20/11; o OT/SLP Eating Evaluation/Nutritional Management Plans (NMPs) for multiple individuals, from 12/11 through 1/12; o List of Individuals with Diet Texture Changes, from 1/11 through 12/11; o List of individuals with an unplanned weight loss of greater than 10 percent, from 1/11 through 1/12; o List of individuals with Body Mass Index (BMI) less than or equal to 20, undated; o List of individuals with BMI greater than or equal to 30, undated; o List of individuals who require mealtime assistance, undated; o List of individuals who have had a choking incident, from 3/11 through 12/11; o Chronic Respiratory Compromise List, undated; o Dehydration Roster, from 1/11 through 12/11;

	o List of individuals with injuries as a result of a slip, trip, or fall, from 7/11 through 12/11; o List of individuals with decubitus issues, from 2/11 through 12/11; o List of individuals who have suffered a fracture, from 1/11 through 11/11; o List of individuals who have had a fecal impaction, from 1/11 through 11/11; o List of individuals who are non-ambulatory or require assisted ambulation, undated; o List of individuals with poor oral hygiene, undated; o Reports for multiple individuals who received a Modified Barium Swallow Study (MBSS), from 8/11 through 12/11; o Schedule of Meals - by home, revised 1/9/12; o Schedule of all PNM-related Meetings during the On-Site Review, 2/13/12 through 2/17/12; o PNM Curricula used to train new staff (templates), various dates; o Agenda and Curricula for competency-based Training In-Services and Annual refresher Training related to PNM (templates), undated; o Competency-based Training Checklists for PNMPs and Dining Plans (templates), dated 12/13/09; o Agenda for new staff orientation, draft March to August 2012; o ABSSLC Communicable Disease Report, date range 7/1/11 to 12/31/11; o Draft PNMP template, revised 1/12; o ABSSLC At-Risk Individuals, dated 2/13/12; o Enteral Feedings Including Pleasure Eating/Drinking as of 1/6/11; o ISPs for multiple individuals, from 2/11 through 2/12; o PNMT evaluations for multiple individuals, completed in 2011; o List of individuals admitted to Infirmary, from 1/10 through 12/11; o List of individuals admitted to hospital, from 1/11 through 12/11; o Policies and Procedure Index, dated 1/6/12; o Training and Development Schedules, from 3/12 through 8/12; o Staffing numbers and Ratio to Individuals by Department, dated 12/31/11; o List of Admissions between 7/11 and 1/12, dated 1/23/12; o List of Deaths between 7/11 and 1/12, dated 1/23/12; o List of Community Placements between 7/11 and 1/12, dated 1/23/12; o Agendas for Habilitation Therapy Staff Meetings between 8/1/11 and 2/21/12, dated 2/21/12; o Change of Status Process, dated 12/11; o Post Hospital/Emergency Room (ER)/Long Term Acute Care (LTAC) Nursing Assessment Form (template), dated 6/11; o Medication Administration Observation Form (template), dated 1/18/12; o Lifting/Transfers Core Competency Training Class Procedures, undated; o "Secrets of Mealtime Success," revised 6/16/08; o Mealtime Set-Up for Visually Impaired/Blind, undated; o Guidelines for Proper Positioning for Individuals identified as Medium to High Risk of Aspiration Pneumonia, dated 1/12;

	○ Meeting Minutes for Ensuring Proper Positioning for Diagnostic Procedures Workgroup, dated 10/25/11; ○ QA Process Flowchart, undated; and ○ QA Policy, dated 1/26/12. ▪ **Interviews with**: ○ Bobbie Holden, Director of Habilitation Therapies; ○ Dr. Craig, PNMT PCP Liaison; ○ Debbie Sessions, MS, CCC/SLP, PNMT Coordinator; ○ Tammy Bayer, RN, PNMT member; ○ Amy Gleaton, OTR, PNMT member; ○ Karen Mayfield, PT, PNMT member; ○ Nicole Spalding, RD, PNMT member; and ○ Tricia Reyes, RD, PNMT member. ▪ **Observations of**: ○ Habilitation Therapy Staff meeting, on 2/13/12; ○ PNMT meeting, on 2/13/12; ○ PNMP meeting in pilot home 6480, on 2/16/12; and ○ Observations in Infirmary and the residences, including the dining rooms in 6480, 5961, 5962, 6521, 5971, and 5972.
	Facility Self-Assessment: Based on a review of the Facility's Self-Assessment, with regard to Section O of the Settlement Agreement, the Facility found it was in noncompliance with all of the subsections of Section O. This was consistent with the Monitoring Team's findings. The Facility submitted three documents, including: ABSSLC Self-Assessment; Action Plans for Sections O.1, O.2, and O.3; and Provision Action Information. There were no action plans developed for Sections O.4 through O.8. The ABSSLC Self-Assessment listed the steps the Facility staff completed to conduct the self-assessment, and the subsequent results for the completion of these tasks. The Action Plans documented the status of action steps that had been completed, were in process, and/or had not been started. The ABSSLC Provision Action Information listed actions completed since the Monitoring Team's previous visit. In comparison with the previous Plan of Implementation document, these three documents provided a more focused presentation of what had been accomplished, and future plans for moving forward in meeting the requirements of the Settlement Agreement. However, within the Self-Assessment document, the Facility did not provide evidence to substantiate the self-assessment activities, results, and self-rating. In addition, the self-assessment activities described were inadequate to measure compliance with the requirements of the Settlement Agreement. Based on interview with the HT Director, Section O monitoring tools had been completed, but the resulting compliance ratings were not discussed in the Facility's Self-Assessment. The QA/QI Data Summary for Section O stated: "for the 1st quarter of Fiscal year 2012 (September, October, November), the QA monitoring compliance score was 90%. The department overall compliance score for the same period was 89%. The overall compliance score from last quarter had QA at 92% and the department 4th quarter was

	not completed. The indicators are not weighted. Inter-rater reliability scores are not available at this time." These cumulative compliance scores did not provide sufficient information and/or data to analyze the Facility's progress with compliance for individual indicators. Individual-specific compliance scores for each indicator will be required for the Facility to accurately interpret and analyze their progress with compliance. The Facility should develop a unified system to present data from the monitoring tools in a meaningful way to enable the results to be easily analyzed and trends identified. As discussed below in subsections of the report, the presentation of data should include the total population being reviewed (N), and the sample of the population (n) to produce a percent sample to indicate the relevance of compliance scores. In comparison with previous self-assessment information, the Facility's new Self-Assessment, Action Plans, and Provision Action Information for Section O provided more information on action steps completed and future action plans. However, no future action plans were presented for Sections O.4 through O.8 to set forth strategies to move the Facility forward in achieving compliance within these sections. In addition, the Presentation Book for Section O should include supporting documentation to validate the results of the Self-Assessment activities and completed Action Steps.
	Summary of Monitor's Assessment: A PNMT Coordinator position was established to provide ongoing leadership and direction to the PNMT, and in August 2011, a SLP was hired as the PNMT Coordinator. The two dedicated PNMT members were the PNMT Coordinator (SLP) and Nurse. The PNMT OT, PT, and RD members' responsibilities were shared between two OTs, two PTs, and two Registered Dieticians. A Facility physician joined the PNMT in January 2012. The Monitoring Team observed a PNMT meeting in which the physician provided individual-specific recommendations, and educational instruction to PNMT members. The appointment of the physician to the PNMT should assist the PNMT members in achieving positive clinical outcomes for individuals the PNMT supports. The HT Department had drafted a Facility policy to further define the roles and responsibilities of the PNMT. This was a constructive move forward in achieving positive outcomes for individuals at highest risk. However, additional information should be included in the policy in reference to PNMT continuing education requirements, PNMT assessment and action plan development and implementation timelines, and further description of the PNMT discharge process, including a description of a PNMT Discharge Plan. Although the PNMT continued to revise their processes for the PNMT assessment format and action plan documentation, these processes only recently been had implemented. In addition, the HT Department had not yet implemented an auditing process of PNMT assessments, action plans, and related documents to assess the quality of PNMT work products and to determine if progress was being made. The HT Department identified 178 individuals as having "no PNM needs." However, the Monitoring Team's review for some of these individuals found they did have PNM needs, because they were ranked as being at high risk for aspiration, choking, skin integrity, and/or falls. State Consultants had recommended the HT Department personnel create standards of practice and core

	competencies to streamline information provided on PNMPs. The HT Department personnel designated Residence 6480 as a pilot home to initiate revisions to individuals' PNMPs. To begin the PNMP revision process, for six individuals, therapists and IDT members worked in partnership to develop a user-friendly PNMP format. The draft PNMP template reflected significant positive changes from the previous PNMP template. The revised PNMP format incorporated the individual's triggers, high and medium risk factors, and outcomes. However, competency-based training and performance check-offs for PNMP core competencies and individual-specific PNMP strategies were not yet being implemented. In addition, a PNMP audit tool had not yet been developed to track compliance with the Facility PNMP procedures. The Monitoring Team continued to observe staff non-compliance with prescribed PNMP and dining plan strategies. Therapists had not yet audited PNMP Coordinators and OT/PT Techs during mealtimes to validate their competency in coaching and mentoring staff. In addition, the Facility did not yet have a system in place to ensure that individuals at higher risk were monitored more frequently. New employees completed physical management performance check-offs, including: stand/pivot transfers, two-person assist from the floor, rolling and repositioning in bed, two-person manual lift, three-person side-by-side lift, mechanical lift, bathing trolley, and concerto bathing table safety. The HT Department was still in the process of developing and implementing additional PNM core competencies performance check-offs for New Employee Performance Training. In addition, the Facility had not yet fully implemented core competency check-offs for existing staff. The State PNM consultants recommended the HT Department "utilize one monitoring tool for effectiveness and compliance to eliminate the HT, PNMP, meal and PNMP monitoring separately." The HT Director discussed the implementation of a new universal monitoring form. At the time of the review, only therapists recently had begun implementing the new Compliance Monitoring tool. The monitoring results had not been tracked and/or trended to provide an analysis of the monitoring data. Consequently, the HT Department did not have monitoring data available. The Monitoring Team's review of individual's APEN assessments continued to show that these assessments were inadequate and did not meet the intent of the Settlement Agreement.

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O1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide each individual who requires physical or nutritional management services with a Physical and Nutritional Management Plan	Due to the multiple requirements included in this provision of the Settlement Agreement, as well as the requirements of this overarching provision of the Settlement Agreement being further detailed in other components of Section O, 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 evaluations 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	Noncompliance

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	("PNMP") of care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan. The PNMP will be reviewed at the individual's annual support plan meeting, and as often as necessary, approved by the IDT, and included as part of the individual's ISP. The PNMP shall be developed based on input from the IDT, home staff, medical and nursing staff, and the physical and nutritional management team. The Facility shall maintain a physical and nutritional management team to address individuals' physical and nutritional management needs. The physical and nutritional management team shall consist of a registered nurse, physical therapist, occupational therapist, dietician, and a speech pathologist with demonstrated competence in swallowing disorders. As needed, the team shall consult with a medical doctor, nurse practitioner, or physician's assistant. All members of the team should have specialized training or experience demonstrating competence in working with individuals with complex physical and nutritional management needs.	through O.7 of the Settlement Agreement. The Monitoring Team's samples for Section O are as follows: ▪ Sample O.1 – Eight individuals who had experienced a change in health status as documented in the ABSSLC Communicable Disease Report (date range 7/1/11 to 12/31/11), or an admission to the Infirmary or hospital including: Individual #458 (diagnosis pneumonia), Individual #253 (diagnosis pneumonia), Individual #283 (diagnosis chronic vomiting), Individual #468 (diagnosis respiratory distress), Individual #297 (aspiration pneumonia), Individual #91 (admitting diagnosis - rule out pneumonia), Individual #42 [admitting diagnosis - dehydration, urinary tract infection (UTI), possible kidney stone], and Individual #511 (diagnosis pneumonia); as well as seven of the 32 individuals (22%) identified at high risk for aspiration including: Individual #311, Individual 395, Individual #471, Individual #407, Individual #385, Individual #492, and Individual #362. ▪ Sample O.2.a – Six of the 13 individuals (46%) formally followed by the PNMT, including: Individual #6, Individuals #212, Individual #103, Individual #350, Individual #452, and Individual #498; and Sample O.2.b for three of the four individuals (75%) discharged by the PNMT, including: Individual #429, Individual #117, and Individual #407. ▪ Sample O.3 – 11 of the 92 individuals (12%), who received nutrition through non-oral methods, including: Individual #184, Individual #101, Individual #49, Individual #122, Individual #373, Individual #366, Individual #265, Individual #21, Individual #285, Individual #429, and Individual #403; ▪ Sample O.4 – Observations of staff compliance with PNMPs and dining plans in residences for 41 individuals, including: Individual #377, Individual #194, Individual #513, Individual #138, Individual #118, Individual #254, Individual #524, Individual #278, Individual #295, Individual #529, Individual #312, Individual #368, Individual #80, Individual #206, Individual #35, Individual #343, Individual #337, Individual #451, Individual #202, Individual #493, Individual #228, Individual #518, Individual #75, Individual #176, Individual #141, Individual #465, Individual #364, Individual #158, Individual #472, Individual #31, Individual #124, Individual #347, Individual #327, Individual #370, Individual #250, Individual #543, Individual #519, Individual #73, Individual #17, Individual #235, and Individual #270; ▪ Sample O.5 – 32 of 32 individuals (100%) identified at high risk for aspiration, including: Individual #429, Individual #311, Individual #362, Individual #162, Individual #281, Individual #361, Individual #6, Individual #452, Individual #183, Individual #212, Individual #457, Individual #337, Individual #472, Individual #82, Individual #88, Individual #403, Individual #285, Individual #435, Individual #385, Individual #471, Individual #323, Individual #407,	

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Individual #344, Individual #63, Individual #395, Individual #498, Individual #297, Individual #414, Individual #70, Individual #100, Individual #103, and Individual #259.

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].
Based on interview and documentation, a PNMT Coordinator position was established to provide ongoing leadership and direction to the PNMT, and in August 2011, a SLP was hired as the PNMT Coordinator. In September 2011, the former PNMT nurse retired. On 10/15/11, a new dedicated PNMT Nurse was hired. The two dedicated PNMT members were the PNMT Coordinator (SLP) and Nurse. The PNMT OT, PT, and RD members' responsibilities were shared between two OTs, two PTs and two RDs. As dedicated members, the PNMT Coordinator and PNMT Nurse did not carry caseloads beyond the individuals the PNMT formally followed. The PNMT OTs, PTs, and RDs were assigned a Facility caseload in addition to formally following individuals on the PNMT caseload. The following chart indicates the caseloads of PNMT members at the time of the review:

Core PNMT Members	Current Caseloads and Responsibilities
Speech Language Pathologist	PNMT Coordinator, dedicated member, and supported 12 individuals on PNMT caseload
Physical Therapist #1	Lead PT, shared PT responsibilities for PNMT caseload, and supported an additional 134 individuals
Physical Therapist #2	Shared PT responsibilities for PNMT caseload, and supported an additional 130 individuals
Registered Nurse	Dedicated member, and supported 12 individuals on PNMT caseload
Occupational Therapist #1	Director of HT, shared OT responsibilities for PNMT caseload, and supported an additional 104 individuals
Occupational Therapist #2	Shared OT responsibilities for PNMT caseload, and supported an additional 215 individuals
Registered Dietician #1	Shared RD responsibilities for PNMT caseload, and supported an additional 214 individuals
Registered Dietician #2	Shared RD responsibilities for PNMT caseload, and supported an additional 214 individuals

On 1/6/12, a Facility physician joined the PNMT. The Monitoring Team observed a PNMT meeting in which the physician provided individual-specific recommendations,

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		and provided educational instruction to PNMT members. The appointment of a physician to the PNMT should assist the PNMT members in achieving positive clinical outcomes for individuals supported by the PNMT. Since the last review, the addition of therapists was a positive development. However, the PNMT OTs, PTs, and RDs continued to have significant caseloads in addition to their PNMT responsibilities. At this time, no analysis of staffing caseloads had been completed to measure the acuity of clinicians' caseloads. The HT Director should initiate an analysis of the current clinicians' caseloads. This analysis should take into account the scope and severity of individuals' needs (e.g., individuals' high and medium PNM risk indicators) to determine if the current allocation of staffing resources was adequate or required reallocation of caseloads to better meet individuals' needs. <u>PNMT members attend relevant continuing education courses.</u> PNMT core members attended multiple State-sponsored webinars, including: ▪ Four of eight PNMT members (50%) attended Introduction to PNMT (i.e., PNMT Coordinator, PNMT OT #1, PNMT PT #1, and PNMT PT #2). ▪ Seven of seven PNMT members (100%) attended Issues in Evaluation and Treatment of Individuals with Developmental Disabilities/Texas Annual Habilitation Therapy Conference (i.e., PNMT Coordinator, PNMT Nurse, PNMT OT #1, PNMT PT #1, PNMT PT #2, PNMT RD #1, and PNMT RD #2). The first day of the Habilitation Therapies Conference was dedicated to PNMT members. Multiple continuing education courses were presented during the annual HT Conference. The remaining PNMT member had not been hired at the time of the review. ▪ One of one PNMT nurses (100%) attended PNMT-Nurse Training (i.e., PNMT Nurse). ▪ Five of eight PNMT members (62%) attended PNMT-Dietary (i.e., PNMT OT#1, PNMT PT #1, PNMT PT #2, PNMT RD #1, and PNMT RD #2). As documented above, all PNMT members did not consistently attend State-sponsored webinars. As stated in the previous report, attendance of PNMT members at State-sponsored webinars should be non-negotiable. Additional continuing education included: ▪ Breathing, Digestion and Swallowing: Best Practices in Dysphagia Management (i.e., PNMT Nurse, PNMT Coordinator, PNMT OT #1, PNMT OT #2, PNMT RD #1, and PNMT RD #2). ▪ Laboratory Assessment of Nutritional Status: Bridging Theory - Practice Session 4: Vitamin Mineral Deficiencies (i.e., PNMT PT #2). ▪ Living Well with Cancer (i.e., PNMT Coordinator, PNMT RD #1, and PNMT RD	

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		#2). ▪ Oral Nutrition Supplements: A Solution to a Recurrent Problem (i.e., PNMT Coordinator, PNMT PT #2, PNMT RD #1, and PNMT RD #2). ▪ Ethics and Your Professional Responsibility: What's It to You? (i.e., PNMT PT #2). ▪ One Size Does Not Fit All: Nutrition Solutions for Pressure Ulcers (i.e., PNMT RD #1, and PNMT RD #2). Seven of eight PNMT members (88%) attended community continuing education courses. Attendance rosters, course certificates of completion, and agendas were submitted. The State-sponsored webinars and continuing education courses the staff attended provided relevant and appropriate clinical instruction for PNMT members. Individual-specific continuing education spreadsheets were presented documenting the following information: date of course, course name, hours, and continuing education units. The HT Department was in the process of designing a spreadsheet to comprehensively track continuing education completed by all disciplines. Although this was a needed system to provide the Habilitation Therapies Director with a mechanism to easily determine if staff had completed necessary and appropriate continuing education, the Facility had not yet implemented this tracking system. <u>PNMT meets regularly to address change in status, assessments, clinical data, and monitoring results.</u> During the time period from 8/29/11 to 1/6/11, documentation submitted confirmed the PNMT met 33 times. The draft Facility Physical Nutritional Management Team Supplemental to State Policy Number 012.2 for Physical Nutritional Management documented PNMT meetings "will occur at least once weekly." The PNMT meeting documentation was reviewed and the following summarizes the results: ▪ With regard to attendance at the meetings: o A SLP attended 27 of the 33 PNMT meetings (82%). o An OT attended 27 of the 33 PNMT meetings (82%). Two OTs attended eight of these meetings. o A PT attended 26 of the 33 PNMT meetings (79%). Two PTs attended seven of these meetings. o A RD attended 33 of the 33 PNMT meetings (100%). Two RDs attended twenty-eight of these meetings. o A Nurse attended 16 of the 33 PNMT meetings (48%). o A Facility PCP liaison attended two of the 33 PNMT meetings (6%). o A Respiratory Therapist attended one of the 33 PNMT meetings (3%).	

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		▪ A review of PNMT meeting attendance sheets showed the PNMT met twice a week with the exception of the weeks of September 7th and September 12th. The PNMT met once during these weeks. ▪ None of the attendance sheets for six PNMT individual-specific reviews (0%) (i.e., for Individual #6, Individual #212, Individual #350, Individual #103, Individual #452, and Individual #498) documented IDT attendance and/or representation to inform the IDT of an individual's progress and/or lack of progress for PNMT Action Plan steps. However, a review of the PNMT Follow-Up Logs and Integrated Progress Notes (IPNs) documented PNMT meetings with IDT members. The PNMT Coordinator should ensure documentation of attendance and IDT representation during the individual review meetings. ▪ For five of the 13 individuals in Sample 0.2.a, who were followed formally and/or discharged by the PNMT and who had an admission to the Infirmary, emergency room, and/or hospital (i.e., Individual #350, Individual #212, Individual #498, Individual #103, and Individual #452), documentation was available to show that for one of them (20%), the PNMT consistently re-assessed their status or reviewed their risk ratings after an admission to the Infirmary, emergency room and/or hospital. For example, Individual #452 was admitted to the Infirmary with a diagnosis of aspiration pneumonia. There was no ISPA meeting with the IDT members and the PNMT to re-assess her risk ratings and/or re-assess her PNMT Action Plan due to her change in health status. The following concerns were noted: ▪ The PNMT met on a weekly basis, but multiple PNMT attendance sheets revealed that core PNMT members were not present at PNMT meetings. ▪ The PNMT did not consistently inform IDT members of an individual's progress and the status of the PNMT Action Plan. The PNMT should invite IDT members to attend individual-specific update reviews. ▪ PNMT action plans did not clearly document clinical indicators to identify a change in health status, and define when the PNMT should be alerted. In addition, the PNMT was not consistently completing a re-assessment of individuals who have been admitted to the Infirmary, emergency room and/or hospital, or making revisions, in collaboration with the individual's IDT, to the Integrated Risk Rating form and the PNMT Action Plans, as appropriate. The PNMT did not consistently engage in a problem-solving approach to identify the root cause of why an individual had experienced a change in status. The discovery of these events should identify what behaviors, actions, or conditions need to be changed to prevent a recurrence of the individual's specific health status change (i.e., diagnosis of aspiration pneumonia).	

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		The Facility's projected action plan steps to address the requirements for Section O.1 included the revision of the Facility's PNMT policy based on information received during the Statewide PNMT conference. Based on interview, the HT Department had developed a Facility policy entitled Physical Nutritional Management Team Supplemental to State Policy Number 012.2 for Physical Nutritional Management. It was in the process of being approved and had not been implemented. The development a Facility policy that further defined the roles and responsibilities of the PNMT was a constructive move forward in achieving positive outcomes for individuals at highest risk. The policy addressed: the purpose of the PNMT, membership and member responsibilities; PNMT meetings; PNMT process; documentation of PNMT activities; and distribution of PNMT work products. However, the following concerns with the policy were noted: ▪ The PNMT policy for ongoing training for PNMT members stated: "core team members will participate in continuing education directed toward evaluation and management of high risk conditions at least every two years." The HT Department should re-evaluate the timeline of "at least every two years" which was not adequate. ▪ The PNMT policy stated: "It is recommended that core team members direct part of their professional continuing educations requirements in areas that relate to PNMT responsibilities." The Facility policy should require not "recommend" continuing education in areas related to PNMT responsibilities. The PNMT members should have extensive clinical expertise in their specific area of clinical practice, as well as in the area of physical and nutritional supports. As a result, PNMT members should participate in on-going continuing education opportunities to expand their knowledge and skills and keep abreast of current trends in the field. This is critical to the success of the team and, most importantly, to the individuals they support. ▪ The Facility PNMT policy defined the criteria for when PNMT meetings "may also occur," but did not specifically state that the PNMT should meet after an individual's admission to the Infirmary, emergency room, or hospital. ▪ The section of the PNMT policy addressing the comprehensive assessment phase acknowledged the PNMT would review referral data within five days and determine assessment priority. Four levels of assessment priority were defined. A review of PNMT assessments showed the assessment process could take several months to complete. The Facility PNMT policy should include timelines for completion of an assessment and implementation of a plan as required in the State At-Risk policy. ▪ The Facility PNMT policy should define the PNMT discharge process including the content of a PNMT Discharge Plan. The second action step in process was to initiate PNMPs for individuals who staff assisted to eat. This action step will be addressed with regard to Section O.3. These	

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		action steps were not adequate to address remaining problematic issues related to Section O.1. Prior to the Monitoring Team's next review, the Facility should focus on the following actions: ▪ PNMT core members should attend scheduled PNMT meetings. ▪ The PNMT should consult with the Facility PCP liaison for every individual on its caseload and these consultations should be documented. ▪ The PNMT should invite IDT members to attend individual-specific update reviews. ▪ When individuals on the PNMT caseload are admitted to the Infirmary, emergency room, and/or hospital, the PNMT should initiate a problem-solving approach, in collaboration with the IDT, to analyze what past events might have contributed to the individual's change in health status. This should lead to the identification of behaviors, actions, or conditions that the team should change to prevent a recurrence of the event. The Facility's Self-Assessment indicated that it was not in compliance with this requirement of the Settlement Agreement. This was consistent with the Monitoring Team's findings.	
O2	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall identify each individual who cannot feed himself or herself, who requires positioning assistance associated with swallowing activities, who has difficulty swallowing, or who is at risk of choking or aspiration (collectively, "individuals having physical or nutritional management problems"), and provide such individuals with physical and nutritional interventions and supports sufficient to meet the individual's needs. The physical and nutritional management team shall assess each individual having physical and nutritional	<u>A process is in place that identifies individuals with PNM concerns.</u> The Monitoring Team reviewed the Facility's Infirmary, emergency room, and hospitalization databases from late August to December 2011. These database printouts identified multiple individuals who had been diagnosed with aspiration pneumonia, pneumonia, respiratory distress, and vomiting. Individuals in Sample O.1 had been admitted to the hospital and/or Infirmary with PNM-related diagnoses, but the PNMT had not reviewed them, nor had their IDTs referred them to the PNMT. No formal process was in place to track and trend individuals who had been hospitalized and/or had received a new PNM-related diagnosis. PNMT members should critically review individuals who have been admitted to the Infirmary, emergency room, or hospital with diagnoses related to PNM concerns and make self-referrals, as appropriate. For example, Individual #212's PNMT assessment stated: "[Individual #212] was referred to the PNMT by her PST in 10/11 following her diagnosis of aspiration pneumonia. However, a formal consult was not received until 12/19/11." Her PNMT assessment, dated 12/21/11, documented the completion of her assessment approximately two and a half months after the IDT referral. The Facility draft PNMT policy defined the referral process but this policy had not been finalized. Consequently, IDTs had not received training on the PNMT referral process. Consequently, individuals that should have been referred to the PNMT may have not	Noncompliance

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	management problems to identify the causes of such problems.	been referred. The PNM Team provides individuals identified as being at an increased risk level with a comprehensive assessment 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. According to the Facility in its Self-Assessment for Section O.1: "PNMT evaluation shells and final reports/action plans have been updated to include: a. Review of Integrated Risk Forms and Aspiration Pneumonia Enteral Nutrition evaluation (APENs) including identification of high and medium risk areas with recommendations for modifications/additional rationales for risk areas identified as needing further intervention; b. Date of initial referral; c. Reason for referral; d. Results of Head Above Bed Evaluation (HOBE) evaluation; e. Identification of individual triggers and integration into action plans and trigger sheets; f. Comprehensive review of Physical Nutritional Management Plan (PNMP); g. Collaborative hands-on assessment with the individual; h. Detailed analysis of evaluation/clinical data supporting recommendations made by the team; i. Integration of PNMT Action Plans into other Departmental Action/Care/Support Plans, Monitoring, etc., as appropriate; j. Action Plans include individualized monitoring schedule; k. Action Plans identify who, what, when, where, and how." The integration of these components into the PNMT assessment and action plan was a positive step forward in moving toward compliance within this section. The self-assessment should have documented the implementation date of PNMT assessments and action plan revisions. A review of the individuals in Sample O.2.a did not show that these revisions had been consistently implemented for individuals within this sample. An audit of PNMT assessments and action plans should be completed to ensure compliance with these revisions. The ABSSLC PNMT Roster, dated 1/2011, listed 17 individuals including: Individual #23, Individual #429, Individual #6, Individual #452, Individual #212, Individual #457, Individual #337, Individual #350, Individual #226, Individual #407, Individual #117, Individual #498, Individual #59, Individual #80, Individual #414, Individual #100 and Individual #103. Since the Monitoring Team's last review, the PNMT had added seven of these 13 individuals to their caseload (i.e., Individual #429, Individual #6, Individual #212, Individual #457, Individual #350, Individual #80, and Individual #414). Four of these individuals had been discharged from the PNMT including: Individual #429, Individual #226, Individual #407, and Individual #117. The current caseload of the PNMT at the time of the review was 13 individuals. The ABSSLC PNMT Roster, dated 1/2011, documented that three of these seven individuals' PNMT assessments (i.e., Individual #457, Individual #80, and Individual	

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		#414) were "in progress." On a positive note, on 1/5/12, Individual #80 was referred to the PNMT due to his risk for having a feeding tube placed, and on 1/6/12, his PNMT assessment was completed. However, the PNMT did not complete PNMT assessments for two other individuals within an adequate timeframe, which resulted in a failure to timely address their risk status: ▪ On 11/16/11, Individual #457's IDT referred him to the PNMT. The IDT requested an evaluation "secondary to his recent diagnosis of aspiration pneumonia." The PNMT Roster identified the date of the evaluation as "in progress," although a PNMT assessment was submitted with a date of 1/23/12. It was concerning that over two months had expired from the date of his referral to the completion of his assessment. In addition, the PNMT did not reassess his risk ratings, but relied upon his risk ratings from 5/16/11. ▪ On 12/13/11, Individual #414's IDT referred him to the PNMT "due to his high risk for aspiration and history of multiple pneumonias." A draft PNMT assessment dated 2/13/12 was submitted as part of the document request. Two months had elapsed since the IDT referral, and the PNMT assessment had not been finalized. The PNMT should adhere to the State's At Risk policy timelines for the completion of a PNMT assessment and implementation of an action plan. The State At-Risk Individuals policy stated: "PNMT will begin assessment within 5 working days," and "the plan will be implemented for the individual within 14 working days of the completion of the plan, or sooner if indicate by risk status." The Monitoring Team reviewed Integrated Risk Rating Forms, PNMT assessments, PNMT Risk Action Plans, and additional supporting documentation for six individuals of the 13 (46%) individuals on the PNMT caseload in Sample O.2a. The following observations were noted: ▪ In three of the six individual records reviewed (50%) documentation was present of a PNMT and/or IDT referral date. PNMT assessment documentation for Individual #212, Individual #350 and Individual #452 included referral dates. The PNMT assessment document should confirm the IDT referral date to the PNMT or the PNMT self-referral date. ▪ In none of the six individual records reviewed (0%) was there documentation of adequate PNMT review of an individual's risk levels during the comprehensive PNMT assessment process, and updating them, as appropriate. PNMT assessments did not consistently complete a re-assessment of the individual's risk rating form to determine if the individual's risk rating status had changed as a result of the health event that led to the PNMT referral. The individual's high and related medium risk indictors should form the foundation of a PNMT assessment. The PNMT assessment should present the findings of a re-assessment of the individual's risk ratings, in collaboration with the IDT. The	

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		PNMT assessment document should include the revision date of an individual's Integrated Risk Rating form, and it should coincide with the PNMT assessment date. ▪ In none of the six individual records reviewed (0%) was documentation of an adequate PNMT assessment present. ▪ In none of the six individual records reviewed (0%) did the PNMT assessments reflect a comprehensive review/assessment of identified high and related medium risk levels. ▪ In none of the six individual records reviewed (0%) was individual-specific clinical baseline data established to recognize changes in health status. On a positive note, one individual's nursing care plan for aspiration (i.e., Individual #6) identified criteria for notification of the PNMT. However, PNMT assessments did not consistently define clinical indicators of a potential health status change to be monitored by the PNMT and nursing staff. The clinical indictors should define the individual's stable and unstable health status. These alert criteria should be integrated into nursing care plans, and define when nursing staff should contact the PNMT. ▪ In none of the six individual records reviewed (0%) was an adequate PNMP found to provide strategies to minimize high and medium risk indicators. The PNMT assessments did not adequately document re-assessment of an individual's PNMP strategies to determine if current strategies were adequate to address high and medium risk indicators as appropriate. PNMPs did not consistently identify individual-specific triggers to alert staff to a potential change in status, identify risk indicator status, provide identification of what positioning options were acceptable for individuals who required a position change every two hours, safe elevation ranges in daily activities, and time to remain upright after a meal. HOBE assessments were not consistently completed for individuals at high risk or medium risk of aspiration pneumonia, respiratory compromise and/or gastrointestinal problems. Some PNMT assessments documented the completion of a HOBE assessment, but these assessments were not submitted for individuals at high risk of aspiration and respiratory concerns. ▪ In none of the six individual records reviewed (0%) was an adequate PNMT action plan found that outlined specific interventions to address high and related medium risk factors. PNMT Action Plans did not document the specific interventions to minimize an individual's high and related medium-risk indicators. In addition, PNMT Action Plans were not updated when an individual experienced a change in status. There should be adequate documentation to confirm the efficacy of PNMT interventions and simply answer the question is the individual better or worse as a result of PNMT interventions.	

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		▪ For none of the six individuals (0%), a PNMT/ISPA meeting had been conducted within established timeframes to discuss the Integrated Risk Rating Form, PNMT Assessment, and action plan. PNMT Follow-Up Logs documented contact with IDT members, but no ISPAs were submitted to show that the PNMT had met with IDT members to present their findings to the IDT, and to review the assessment, recommendations, and action plan. <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> It should be noted that this heading previously was discussed under Section O.6. However, it was moved to this section because it is more relevant here. At the time of the Monitoring Team's review, the Facility had not developed efficient information systems to provide current and accurate information to the PNMT. Specifically: ▪ Based on interview, the At-Risk Coordinator was responsible for maintaining the database for individuals' risk indicators. She was experiencing difficulties in having QDDPs provide timely Integrated Risk Rating results to enable the production of an accurate database. The Facility had developed a Change of Status Process, dated 12/11. The process included notification of the At-Risk Coordinator upon completion of the Integrated Risk Rating form, but did not provide a timeline for notification. Consequently, the PNMT was not able to assess the current status of individuals with PNM high-risk indicators and related medium risk indicators. ▪ Based on document review, IDTs were not consistently referring individuals to the PNMT who were at risk of receiving a feeding tube. The HT Department had developed a draft Facility PNMT policy that defined the PNMT referral process. It stated: "an individual <u>must</u> be referred to the PNMT whenever the PST is giving consideration to initiation of enteral feeding." At the time of the Monitoring Team's review, the draft policy had been submitted for approval. Once the policy is finalized, the IDTs should receive training on the PNMT policy to understand the PNMT referral process and their responsibilities in working collaboratively with the PNMT. In addition, the HT Director, in collaboration with Quality Assurance staff and the QDDP Coordinator, should work to ensure PNMT referrals are forwarded to the PNMT in timely manner. ▪ There was no formal system to notify the PNMT when individuals experienced a change in health status. The PNMT Nurse, in collaboration with Facility medical personnel, should establish guidelines to ensure the PNMT is immediately informed of an individual's related changes in status, including an Infirmary, emergency room, and/or hospitalization admissions. Prior to the Monitoring Team's next review, the Facility should focus on the following actions:	

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		▪ The HT Director and PNMT members should implement the recommendations within this section to improve the PNMT process. ▪ Although the PNMT continued to revise their processes for the PNMT assessment format and action plan documentation, these processes only recently been had implemented. To facilitate progress in addressing this requirement, the HT Director, in collaboration with State PNM consultants, should implement an auditing process of PNMT assessments, action plans, and related documents to assess the quality of PNMT work products and to determine if progress is being made. The audits should identify strengths and weakness with the PNMT process to enable the structured implementation of changes to move the PNMT toward compliance with the requirements of this section. ▪ The Facility's policy should define the timelines for submission to the Facility At-Risk Coordinator of individuals' risk ratings completed during the annual ISP meeting or an ISPA meeting. These established timelines should enable the completion of an accurate individual at-risk list for distribution to appropriate Facility representatives. ▪ The PNMT Nurse, in collaboration with Facility medical personnel, should establish guidelines to ensure the PNMT is immediately informed of an individual's related changes in status, including an Infirmary, emergency room, and/or hospitalization admissions. The Facility's Self-Assessment indicated that it was not in compliance with this requirement of the Settlement Agreement. This was consistent with the Monitoring Team's findings.	
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.	The Facility's Self-Assessment for Section O.3 indicated that the HT Department had reviewed current PNMP documentation. However, there was no description of what had been reviewed or the number of PNMPs that had been reviewed. One of the results of the self-assessment was a finding that individuals received medication in alignment with their prescribed diet texture. No evidence of auditing activities, including, for example, the number of individuals' MARS audited was presented to confirm that individuals received medication in alignment with their prescribed diet texture. <u>All persons identified as being at risk (requiring PNM supports) are provided with a comprehensive Physical and Nutritional Management Plan (PNMP).</u> At the time of the onsite review, the current census of ABSSLC was 428 individuals. The Facility submitted a list of 178 individuals who did not have PNM needs and subsequently, did not have a PNMP. The Monitoring Team reviewed the ABSSLC At-Risk Individuals list. It identified many individuals with PNM high-risk indicators (e.g., choking, aspiration, falls, and skin integrity). However, many of these individuals were identified as having "no PNM needs." In addition, the Monitoring Team's observation of	Noncompliance

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		an individual in the Infirmary did not support the Facility's designation that Individual #194 had "no PNM needs." The Monitoring Team reviewed individuals who were ranked at high risk for some PNM risk indicators and the following concerns were noted: ▪ The Facility had listed individuals ranked at high risk for aspiration as not having PNM needs (i.e., Individual #323 and Individual #103). If individuals were at high and/or medium risk for aspiration, this also meant that they had significant PNM concerns. These individuals needed a PNMP to provide staff with strategies to minimize their risk of aspiration throughout the 24-hour day. ▪ Individuals evaluated as being at high risk for choking were identified as not having PNM needs (i.e., Individual #242, Individual #22, Individual #323, Individual #165, Individual #150, and Individual #179). Individuals at high and/or medium risk for choking required a PNMP to minimize their risk of choking. ▪ Individuals were identified as not having PNM needs, but were rated at high risk for falls (i.e., Individual #126, Individual #89, Individual #153, Individual #442, Individual #462, Individual #533, Individual #8, Individual #94, and Individual #439). If individuals were at high and/or medium risk for falls, this meant that they needed a PNMP. ▪ Individuals were identified with "no PNM needs," but were ranked at high risk for skin integrity (i.e., Individual #439, Individual #252, and Individual #146). Individuals at high and/or medium risk for skin integrity required a PNMP. Based on the examples above, individuals who had been identified with "no PNM needs" did, in fact, have PNM needs. The HT Department should define the PNM criteria for individuals who require a physical and nutritional management plan, including the PNM risk indicators that fall into this category. The PNM criteria should be utilized to review the list of 178 individuals with "no PNM needs" to determine which of these individuals meet the PNM criteria and should be provided with an adequate PNMP. State Consultants had recommended the HT Department staff create standards of practice and core competencies to streamline information provided on PNMPs. Based on interview and document review, the HT Department staff designated Residence 6480 as a pilot home to initiate revisions to individuals' PNMPs. Therapists were divided into two teams and each team developed a revised PNMP format. The HT Key Staff Meeting minutes, dated 1/30/12, documented a review of the two PNMP revised formats. On 2/13/12, during the on-site review, the Monitoring Team observed a HT weekly staff meeting during which therapy and clinical staff (OTs, PTs, SLPs, and RDs) worked to reconcile the two draft PNMP formats for six individuals living in residence 6480. The therapy teams' two formats were merged into a draft PNMP template. The draft PNMP template reflected significant positive changes from the previous PNMP	

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		template. The revised PNMP format incorporated the individual's triggers, high and medium risk factors, and outcomes. The revised PNMP format included the following sections: medication administration, dining plan, reflux precautions, oral care/dental care, positioning, transfer, mobility, movement, communication, and hearing/vision. Adaptive/assistive equipment and the reason for the equipment would be addressed at the beginning of each section. Draft PNMPs for these six individuals were to be revised to incorporate the changes agreed upon during the meeting. On 2/16/12, the Monitoring Team also attended the meeting in Residence 6480 during which therapists presented the six draft PNMPs. The meeting participants included two PTs, an OT/PT Tech, QDDP, QDDP Educator, Registered Nurse II, two Active Treatment Coordinators, RD, PNMP Coordinator, OT, SLP, Home Supervisor, and Home Activities Specialist. These IDT members reviewed each individual's PNMP and made suggestions for changes to the PNMPs. The meeting was a positive example of IDT members working collaboratively to produce a PNMP that was meaningful for the individual and easily understood by other team members. HT Department personnel should continue collaboration with IDT members as they work to revise individuals' PNMPs across the campus. Procedures/guidelines should be developed to support consistency in the development and implementation of PNMPs. These procedures should define the process for competency-based training and performance check-offs for PNMP core competencies and individual-specific PNMP strategies. In addition, a PNMP audit tool should be developed to track compliance with the Facility PNMP procedures. The PNMPs for the 15 individuals in Sample O.1 were reviewed. These were individuals who had experienced a health status change, and/or had been identified at high risk for aspiration. All of these individuals had a PNMP, however, some essential components were missing: ▪ In nine of 15 records (60%) the PNMPs included adequate positioning instructions for wheelchair and alternate positioning, including strategies for safe elevation ranges. Individuals that did not have adequate instructions for alternate positioning included: Individual #511, Individual #311, Individual #395, Individual #407, Individual #385, and Individual #492. Various concerns were noted with regard to these plans. For example, the PNMP should provide more specific instructions for staff beyond "ensure reposition change every 2 hours." The PNMP should define the variety of positioning options and/or provide a positioning schedule (i.e., Individual #407, Individual #395, Individual #311, Individual #511, and Individual #492). Furthermore, Individual #385's PNMP did not provide an elevation range for his alternate positioning options. ▪ In 15 of 15 records (100%), the PNMPs included adequate transfer instructions. ▪ In four of four records (100%), for individuals who ate orally and/or had recreational feedings (i.e., Individual #42, Individual #471, Individual #311, and	

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		Individual #492), the PNMPs had adequate mealtime/dining plans that included written and/or pictorial instructions for positioning, food texture, fluid consistency, and staff presentation techniques. ▪ In three of 15 records (20%), the PNMP included the time an individual needed to remain upright after eating and/or receiving enteral nutrition (i.e., for Individual #283, Individual #385, and Individual #492). ▪ In 10 of 15 records (67%), the PNMPs included adequate strategies for medication administration. For five individuals (i.e., Individual #297, Individual #42, Individual #471, Individual #385, and Individual #492), the missing PNMP components included no wheelchair positioning instructions (Individual #297); lack of elevation range for right sidelying (Individual #385); instructions for medication administration in wheelchair, but no staff instructions for alternate positioning and/or statement that medication was only to be presented in wheelchairs (i.e., Individual 492 and Individual #42). ▪ In 13 of 15 records (87%), the PNMPs included adequate strategies for oral hygiene. Individual #42 and Individual #471's PNMPs did not have staff instructions for oral care. ▪ In 15 of 15 records (100%), the PNMPs included a listing of individual adaptive equipment. ▪ In 11 of 15 records (73%), the PNMPs included adequate bathing/showering positioning and related instructions. The PNMPs for Individual #42, Individual #471, Individual #385, and Individual #492 did not have adequate instructions for staff to achieve the prescribed range of elevation in bathing/showering equipment. ▪ In 13 of 15 records (87%), the PNMPs included adequate personal care instructions, with elevation strategies during checking and changing. Individual #385 and Individual #492's PNMPs did not have adequate staff instructions to achieve a safe elevation range while receiving personal care. ▪ In 15 of 15 records (100%), the PNMPs included communication strategies. The HT staff had not begun the process of auditing PNMPs to track compliance with the revised PNMP format. The Monitoring Team's review of PNMPs for individuals in Sample O.1 found concerns related to staff instructions for alternate positioning throughout the day including mealtimes, time to remain upright after a meal and/or receiving enteral nutrition, medication administration, oral hygiene, bathing/showering, and personal care. <u>People who receive enteral nutrition and/or therapeutic/pleasure feedings are provided with PNMPs that include the Settlement Agreement components.</u> It should be noted that in previous reports, this heading was addressed in Section O.8, but has been moved here due to its greater relevance with Section O.3. The PNMPs for	

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		the 11 individuals who received enteral nutrition in Sample 0.3 were reviewed and some PNMP components were not adequate. More specifically: ▪ In three of 11 records (27%), individual PNMPs had adequate positioning instructions for wheelchair and alternate positioning, including strategies to achieve an appropriate elevation range. Various concerns were noted for the remaining eight individuals. For example, the PNMP should provide more specific instructions for staff beyond "ensure position change every 2 hours." The PNMP should define the variety of positioning options and/or provide a positioning schedule (i.e., Individual #429, Individual #285, Individual #122, Individual #366, Individual #184, and Individual #49). Individual #373's PNMP instructions directed staff to "change tilt [in wheelchair] every 2 hours." Individual #403's PNMP stated: "please offer alternative seating in the recliner." There were no staff instructions given to ensure staff achieved a safe degree of tilt in the individual's wheelchair or recliner. ▪ In 11 of 11 records (100%), individual PNMPs had adequate transfer instructions. ▪ In six of 11 records (55%), individuals' PNMPs had adequate staff instructions to identify the prescribed time an individual was to remain upright after completing a meal or receiving enteral nutrition. The PNMPs for Individual #49, Individual #122, Individual #373, Individual #265, and Individual #21 did not specify the time an individual was to remain upright after a meal. ▪ In six of 11 records (55%), individuals' PNMPs had adequate instructions for nurses to support safety during medication administration. Individual #429, Individual #366, Individual #49, and Individual #403's PNMPs included instructions for presentation of medication in only one position (i.e., wheelchair, recliner). The PNMPs did not present alternate positions or document that medication was only to be presented in one position. Positioning instructions did not provide the safe range of elevation in bed for Individual #122. ▪ In 11 of 11 records (100%), individuals' PNMPs had adequate strategies for oral hygiene. ▪ In 11 of 11 records (100%), individuals' PNMPs listed individual adaptive equipment. ▪ In six of 11 records reviewed (55%), individuals' PNMPs had adequate bathing/showering positioning instructions. Staff instructions to achieve safe bathing/showering equipment elevations were not present for Individual #184, Individual #101, Individual #122, Individual #366, and Individual #403. ▪ In nine of 11 records (82%), individuals' PNMPs listed adequate personal care instructions to achieve elevation range during checking and changing. Individual #122 and Individual #366's PNMPs did not provide staff instructions to achieve a safe elevation range when individuals received personal care. ▪ In 11 of 11 records reviewed (100%), individuals' PNMPs recommended	

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		communication strategies. As documented above, essential components were missing from PNMPs for the individuals in Sample O.1 and Sample O.3. <u>PNM plans were incorporated into individuals' ISPs.</u> None of the 15 individuals' PNMPs in Sample O.1 were incorporated and/or integrated into individuals' ISPs. Information from the PNMP should be integrated within the ISP and other supporting documents (e.g., health management plans, Positive Behavior Support Plans, skill acquisition programs, etc.), not simply referenced and/or listed. Another important component of integration of PNM plans into ISPs involves the discharge planning process for individuals the PNMT has supported. According to the Facility's Self-Assessment: "PNMT Policy and Procedures draft includes addresses (sic) steps to be completed when the PNMT discharges an individual including meeting with PST to discuss the PNMT Discharge Plan." Since the Monitoring Team's last review, the PNMT had four individuals whom they formally followed. The Monitoring Team reviewed the following three individuals who had been discharged from the PNMT: Individual #429, Individuals #117, and Individual #407 in Sample O.2.b. The following summarizes the findings based on this review: ▪ The PNMT Follow-Up Log, dated 12/9/11, documented that the PNMT Nurse, SLP, and RD attended Individual #117's annual ISP. "Individual #117 is currently stable and PNMT will discharge from formal follow-up at this time." His annual ISP did not discuss his discharge from the PNMT, nor did the PNMT develop a discharge plan. ▪ The ABSSLC PNMT Roster indicated that Individual #407 had been discharged from the PNMT. The PNMT Follow-Up Log stated: "The PST will meet with staff and nursing to identify possible triggers exhibited when she is ill or not feeling well that will alert staff/nursing to intervene/watch more closely." It was unclear why the PNMT had not previously developed these triggers to alert staff to a change in status, and why she was discharged before these triggers had been established for nursing and direct support professionals. The PNMT had not developed a discharge plan. ▪ Individual #429 was referred to the PNMT after her gastrostomy tube placement. She also subsequently received a tracheostomy. The PNMT did not re-assess her risk ratings, complete a comprehensive PNMT assessment, develop an action, and/or provide a discharge plan. The PNMT Discharge Plan should provide specific, detailed recommendations to the IDT to support an individual's stable health status. Specifically, the Discharge Plan should	

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		identify the detailed action steps that the IDT should continue to implement, and these action steps should be integrated into the ISP Risk Action Plan. <u>PNMPs are developed with input from the IDT, home staff, medical and nursing staff.</u> Review of 15 individuals in Sample O.1 revealed that none of the PNMPs (0%) were developed with adequate input from the IDT, with an emphasis on direct support professionals, medical/nursing staff, and behavioral staff (if appropriate). Individual's PNMPs were not adequately discussed in annual ISP and/or ISPA documentation. As a result, evidence was not available to substantiate that teams provided input into their development and/or revision. <u>PNMPs are reviewed annually at the ISP meetings, and updated as needed.</u> Review of individuals in Sample O.1 revealed that none of their PNMPs were integrated annually at the ISP meeting, and updated as needed. Evidence was found that that PNMP was listed, but PNMP strategies were not integrated, as appropriate, into skill acquisition programs, PBSPs, nursing/health management care plans, and/or daily schedules. The ISPs did not incorporate measurable, functional outcomes in relation to an individual's PNMP. <u>PNMPs are reviewed and updated as indicated by a change in the person's status, transition (change in setting), or as dictated by monitoring results.</u> Based on review of the eight individuals' ISPAs in Sample O.1 who had experienced a change in status: ▪ For none of the eight individuals reviewed (0%) (i.e., for Individual #458, Individual #253, Individual #283, Individual #468, Individual #297, Individual #91, Individuals #42, and Individual #511) did the IDT conduct an adequate ISPA meeting to address the individual's change in status. The ISPA meeting should document a review of the individual's risk rating in reference to their change in status and revise the risk rating(s), if appropriate; revision of the risk action plan to address the change in status; and consideration of the need for a revision and/or update to the individual's PNMP as a result of the individual's change in status. Therapists also should be involved in these meetings. A number of issues were identified for the individuals reviewed. For example: o Individual #283's IDT met on 11/17/11 to address her change in status. However, based on the documentation provided, it could not be determined if the IDT interventions were adequate. The ISPA stated her positioning during feedings was changed, PNMP updated, and she was to remain upright for one and a half hours after feeding. However, no therapists attended the ISPA meeting. It was unclear how her PNMP was modified without input and/or assessment from her therapists. o Some members of Individual #42's IDT completed an ISPA on 1/18/12	

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		to address ongoing medical issues for the past three months, including vomiting and blood in her brief. The ISPA stated: "PNMP dated 7/13/2011 was reviewed with no changes deemed warranted." No therapists were in attendance for this ISPA meeting. The Facility's projected action plan steps addressing the requirements for Section O.3 are discussed below: ▪ The HT Department planned to "incorporate relevant HOBE evaluations findings/recommendations into PNMP." The status of this action step was "completed/ongoing." However, none of the individuals in Sample O.1 and Sample O.3 had received a HOBE assessment to assess and confirm if the current recommended PNMP elevation ranges for the individual in his/her wheelchair, alternate positioning, bathing, oral care, personal care, and medication administration was optimal. The Facility's Self-Assessment indicated that it was not in compliance with this requirement of the Settlement Agreement. This was consistent with the Monitoring Team's finding.	
O4	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall ensure staff engage in mealtime practices that do not pose an undue risk of harm to any individual. Individuals shall be in proper alignment during and after meals or snacks, and during enteral feedings, medication administration, oral hygiene care, and other activities that are likely to provoke swallowing difficulties.	<u>Staff implements interventions and recommendations outlined in the PNMP and/or Dining Plan.</u> The Monitoring Team observed staff implementation of PNMPs and dining plans in the Infirmary and the following residences, including dining rooms in 6480, 5961, 5962, 6521, 5971 and 5972. The Monitoring Team also observed a nurse completing two individuals' medication passes. During these observations, multiple examples were noted of staff noncompliance with PNMPs and dining plan strategies. The Monitoring Team observed the 41 individuals identified above as being in Sample O.4 in their residences and dining rooms. The following summarizes the results of observations for these individuals: ▪ In none of three observations (0%) were individuals seated in optimal alignment in their wheelchairs. ▪ In ten of the 33 observations of individuals during mealtimes (30%), staff was compliant with dining plans instructions for positioning, food texture/fluid consistency, use of adaptive equipment, and/or presentation techniques. ▪ In none of three observations (0%) did staff complete a pivot transfer correctly. ▪ In one of one observation, (100%) staff used a mechanical lift correctly. ▪ In one of two observations for medication administration (50%), a nurse followed the PNMP instructions for medication administration. Of further concern, PNMP Coordinators and OT/PT Techs did not intervene during	Noncompliance

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		mealtimes to correct staff non-compliance with dining plan strategies. As recommended in the Monitoring Team's last report, the Facility should implement an interdisciplinary mealtime safety initiative to enforce staff compliance with mealtime plans for those individuals who eat orally and/or receive enteral nutrition. This should include the following: ▪ For residences for which implementation of PNMPs during mealtimes is an issue, identification of a mealtime supervisor/coordinator to provide oversight before, during, and after the meal; ▪ Implementation of competency-based training for mealtime supervisors/coordinators and monitors, including 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: o Mealtime position and alignment; o Diet texture and fluid consistency; o Presentation techniques to enhance nutritional intake and hydration; o Care and use of adaptive equipment; o Aspiration and choking precautions and rationale; o Understanding a swallow study; o Risk indicators and problem solving; and o Techniques to promote optimal levels of independence and skill acquisition during mealtimes. ▪ Development and implementation of competency-based performance check-offs for mealtime supervisors and monitors to ensure competency with mealtime learner objectives. ▪ Establishment of a validation and re-revalidation process for mealtime supervisors and monitors, including auditing mealtimes to ensure competency with mealtime indicators. ▪ 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. ▪ 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. ▪ A heightened mealtime monitoring schedule for individuals identified at high risk, such as individuals at risk for aspiration pneumonia, respiratory concerns,	

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		choking, weight, fluid imbalance, etc. Although there was acknowledgment of non-compliance within this section, the Facility's HT Department had not developed an action plan for Section O.5. Prior to the Monitoring Team's next review, the Facility should focus on the following actions: ▪ Therapists should audit PNMP Coordinators and OT/PT Techs during mealtimes to validate their competency in coaching and mentoring staff to support compliance with prescribed dining plan techniques. ▪ The Facility should implement an interdisciplinary mealtime safety initiative to enforce staff compliance with mealtime plans for those individuals who eat orally and/or receive enteral nutrition. The Facility's Self-Assessment indicated that it was not in compliance with this requirement of the Settlement Agreement. This was consistent with the Monitoring Team's findings.	
O5	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall ensure that all direct care staff responsible for individuals with physical or nutritional management problems have successfully completed competency-based training in how to implement the mealtime and positioning plans that they are responsible for implementing.	<u>Staff are provided with general competency-based foundational training related to all aspects of PNM by the relevant clinical staff.</u> New employees completed physical management performance check-offs, including stand/pivot transfers, two-person assist from the floor, rolling and repositioning in bed, two-person manual lift, three-person side-by-side lift, mechanical lift, bathing trolley, and concerto bathing table safety. Based on interview, the HT Department had developed mealtime core competencies, but these competencies had not been integrated into New Employee Pre-Service Training (NEPT). The HT Department was still in the process of developing and implementing PNM mealtime core competencies performance check-offs for NEPT. The HT Department had integrated the training course for aspiration pneumonia into the NEPT. As stated in the Monitoring Team's last report, no learner objectives were presented for the course. Learner objectives should define the content for staff competency-based performance check-offs. Staff only were required to complete a written test. This did not meet the standard of competency-based training. PNMP Coordinators and OT/PT Techs had completed performance check-offs for stand/pivot transfers, two-person assist from the floor, rolling and repositioning in bed, two-person manual lift, three-person side-by-side lift, mechanical lift, bathing trolley, concerto bathing table safety, palm protectors, wrist/hand splint, mealtime, adaptive dining equipment, bed positioning, and general communication.	Noncompliance

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		The Monitoring Team did not agree with the Facility's Self-Assessment results in Section O.3. The Self-Assessment stated new staff was "consistently competency-trained." However, the Facility had not presented data to support this statement. As part of the evaluation of compliance with staff competency-based training requirements for individuals with PNM concerns, the data should include the total staff population to be trained (i.e., those providing PNM supports to an individual) (N) and the number of staff who have completed core competency PNM training (n) to yield a percent of completion for staff training for PNM core competencies. In addition, as a baseline measure, the Facility should assess quality of its competency measures in this area. The ABSSLC Nursing Services Policy: P-02A Section IV - Nursing Management of Medications stated: "Special instructions for medication or treatment administration will be included on the MAR and/or treatment record. An example is crushed medication that must be given in a specific food consistency per the Dining Plan or utilization of positioning or adaptive equipment." However, this policy did not specifically address how the PNMP was to be an integral component of medication administration. For example, the policy did not address how licensed and registered nurses would complete competency-based training and performance check-offs on wheelchair positioning, alternate positioning, use of adaptive equipment, food/fluid textures, and presentation techniques. The HT Department should finalize and implement PNM core competencies performance check-offs with new employees and current staff. Nursing staff should be required to complete competency-based training on PNM as well. <u>All foundational trainings are updated annually</u>. Based on documentation provided, no Annual Refresher classes were completed for physical and nutritional supports. <u>Staff are provided individual-specific training on the PNMP by the appropriately trained personnel.</u> PNMPs for individuals in Sample O.1 included individual-specific staff instructions necessitating that staff complete competency-based training and testing of staff competency. However, none of the 15 individuals' staff (0%) in Sample O.1 had completed competency-based training and performance check-offs for individual-specific PNMP strategies. The following concerns were noted: ▪ The PNMP Training Form check sheet were presented as evidence for competency-based training and performance check-offs. This form was not adequate to meet the standard for completion of an individual-specific staff competency-based performance check-off. The training form presented 16 areas of competency. However, 15 of these indicators would require staff to	

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		complete multiple demonstration steps to test competency. These various steps were not detailed on the check sheet. ▪ Training rosters with individual-specific PNMP topics were not adequate for the completion of an individual-specific staff competency-based performance check-offs. These rosters did not demonstrate that each staff member had successfully completed each of the steps necessary to confirm that they were competent in the various areas. The results of the Facility Self-Assessment indicated that staff received competency-based training when changes were made to an individual's PNMP. However, a review of individuals in Sample 0.1 showed the presence of PNMP training forms and/or training rosters, but this documentation did not confirm that staff's competency for PNMP changes had been adequately tested. The PNMP training forms did not include adequate steps to document staff performance. Training rosters with staff signatures included a competency legend (i.e., test, verbalized back, and demonstrated). The trainer was to circle one of these three choices. On multiple forms, trainers had not circled any of these choices. On other forms, the trainer circled "verbalized," which did not meet the standard to test staff competency. On training rosters on which the trainer circled "demonstrated," a performance check sheet was not provided to document staff performance. The HT Department should formalize procedures to meet the standard for the provision and documentation of competency-based training and performance check-offs for revisions to an individual's PNMP. <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> As discussed above, direct support professionals responsible for providing PNM supports to the individuals had not completed competency-based training and performance check-offs for individual-specific PNMP strategies. Although there was acknowledgment of non-compliance within this section, the Facility's HT Department had not developed an action plan for Section 0.6. Prior to the Monitoring Team's next review, the Facility should focus on the following actions: ▪ The provision of competency-based training and staff performance check-offs for PNM mealtime core competencies for new employees should be implemented. In addition, the process to complete competency-based training and performance check-offs for PNM core competencies should be implemented for current staff. ▪ The implementation of competency-based individual-specific training and	

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		performance check-offs for PNMP strategies should be initiated. The Facility's Self-Assessment indicated that it was not in compliance with this requirement of the Settlement Agreement. This was consistent with the findings of the Monitoring Team.	
O6	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall monitor the implementation of mealtime and positioning plans to ensure that the staff demonstrates competence in safely and appropriately implementing such plans.	<u>A policy/protocol addresses the monitoring process and provides clear direction regarding its implementation and action steps to take should issues be noted.</u> The Facility did not have policies and/or procedures developed or implemented for the following monitoring forms: PNMP Monitoring-Routine, HT Monitoring Form, ABSSLC Mealtime Observation, Steridient Monitoring Log, and Compliance Monitoring. As stated in previous reports, the HT Department should develop a monitoring policy to define the monitoring system to test staff compliance with PNMPs and dining plans. At a minimum, such a policy should include: ▪ Definition of a monitoring process to cover staff providing care in all aspects in which an individual is determined to be at risk (i.e., bathing, oral care, personal care, wheelchair and alternate positioning, transfers, medication administration, etc.); ▪ Training and validation process for monitors to achieve accurate scoring and a high level of inter-rater agreement; ▪ Identification of PNM risk factors requiring enhanced PNMP and mealtime monitoring; ▪ Formal schedule for monitoring to occur; ▪ Requirement that all monitoring forms provide instructions for individual monitoring indicators to support scoring consistency and inter-rater agreement; ▪ Auditing process of completed monitoring forms to ensure compliance with Facility policy; ▪ Development and implementation of a system to track and trend monitoring results to resolve individual-specific and systemic issues; and ▪ Establishment of a threshold for staff re-training for monitoring results that illustrate repeated staff non-compliance with PNMPs and therapy programs. <u>Monitoring covers staff providing care in all aspects in which the person is determined to be at an increased risk (all PNM activities).</u> An excel spreadsheet tracked the dates of individuals' mealtime and PNMP monitoring completed in September, October, November, and December 2011. The Monitoring Team analyzed the frequency of monitoring dates for individuals with significant PNM needs. For example, the ABSSLC At-Risk Individuals list, dated 2/13/12, included 32 individuals at high risk for aspiration. These 32 individuals comprised Sample O.5.	Noncompliance

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		Individuals at high risk of aspiration were at a heighted risk level for a variety of daily activities (e.g., wheelchair and alternate positioning, mealtimes, tooth brushing, bathing, medication administration, personal care, etc.). This group of individuals should have received enhanced monitoring to ensure staff compliance with dining plans and PNMPs. However, the Monitoring Team's review of these individuals' mealtime and PNMP monitoring dates did not show that enhanced monitoring had occurred: ▪ Thirteen of the 32 individuals' staff (41%) in Sample O.5 was monitored during mealtimes. Nineteen of the 32 individuals' staff were not monitored during mealtime to test their compliance with prescribed dining plans. Individuals at high risk for aspiration should received enhanced monitoring. The Facility should define the frequency of monitoring for individuals at high risk for aspiration and related PNM risk indicators. The individual's monitoring schedule should be documented in their risk action plan. ▪ A review of these individuals' mealtime monitoring dates spanning a four-month time period from September to December 2011 did not support a methodical approach to mealtime monitoring. For example, an individual's staff received one mealtime monitoring, while another individual's staff was monitored 21 times within the same time period. ▪ Eight of these 32 individuals were on the PNMT caseload and/or had been discharged by the PNMT including: Individual #429 (discharged by PNMT), Individual #6, Individual #452, Individual #212, Individual #457, Individual #498, Individual #100, and Individual #103. Three of these eight individuals' staff (38%) received mealtime monitoring. ▪ The ABSSLC At-Risk Individuals list, dated 2/13/12, included 34 individuals with no current Integrated Risk Rating form, and three individuals with a discrepancy between the Integrated Risk Rating form and the ISP. Consequently, no accurate, updated list was available to identify individuals at highest risk, who should receive enhanced PNMP and mealtime monitoring. As stated above, the HT Department should develop procedures to ensure individuals with PNM high and/or medium risk indicators receive enhance monitoring. Monitoring forms for the 15 individuals in Sample O.1 were reviewed, and the following was found: ▪ None of 15 individual records (0%) documented adequate PNMP monitoring. The PNMP monitoring frequency (i.e., once a month) was not adequate for the individuals within this sample who were at high risk for aspiration, and/or had experienced a health status change. As stated in previous reports, recurrent individual-specific concerns were identified, but no resolution was documented on monitoring forms. There was no evidence of inter-rater agreement between therapists and the monitors (i.e., PNMP Coordinators and OT/PT Techs) to	

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		validate their competency and ensure accuracy of monitoring results. ▪ None of these 15 individuals received individual-specific monitoring to document staff compliance with risk action plan steps related to PNM risk factors. Based on interview, the State Consultants had not submitted a written report to the HT Department from their November 2011 visit. The Monitoring Team requested therapists' notes from the consultant visits. Based on a review of therapists' written notes, the State consultants recommended the HT Department "utilize one monitoring tool for effectiveness and compliance to eliminate the HT, PNMP, meal and PNMP monitoring separately." The HT Director discussed the implementation of a new universal monitoring form. At the time of the Monitoring Team's visit, only HT therapists were using the universal Compliance Monitoring form. The form had four observation indicators, including PNMP/Dining Plan was present/easily located; equipment was present, working, and utilized; plan being performed as written/instructed; and staff communicated with individual before and during activities. Six indicators were for staff drills, including explaining the plan rationale, goal(s), and outcome(s); explaining risk associated with not performing program; identifying individual triggers; whether or not staff reported being trained on program; whether or not staff entered data correctly in appropriate location; and identifying who to contact, if there was a problem. The form could be utilized for individual-specific monitoring, random competency checks, and corrective action competency re-checks. The compliance threshold was 80% and above. If the compliance score was below 80%, a plan would be initiated, which could include notification to a Home Supervisor or Unit Director, follow-up meal observation, staff competency re-drill, and/or other plan to be identified on the form. Staff with a second non-compliance score needed to complete program implementation monitoring by supervisory staff. The form included a section for reliability checks to be completed by the PNMP Coordinator and therapist. Based on the Monitoring Team's review of the Compliance Monitoring form, the instructions for the four observation indicators identified multiple areas that the monitor would be responsible for checking for meals, medication administration, oral care, bathing, lifting/transferring, and communication that were not present on the monitoring form itself. In the instructions, the staff drill indicators also listed multiple areas to monitor for compliance. A monitor would be challenged to remember multiple compliance indicators for each of the four observation questions. These areas were not present on the monitoring form. If an indicator was marked "no," the monitor was to document noncompliance in the form's comment section. The one-page form did not provide sufficient space to address multiple areas of noncompliance. In addition, the form and instructions addressed the implementation of reliability checks to be conducted by therapists. The therapy content expert(s) will have to be diligent during	

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		the reliability checks to determine if the form's indicators require revision, while testing the monitor's competency with areas requiring assessment. The results of the Facility's Self-Assessment for Section O.7 stated: "New monitoring tool has been developed that will enable tracking/trending of program changes due to efficacy of individuals' programs." At the time of the review, as noted above, only therapists had recently implemented the new Compliance Monitoring tool. The monitoring results had not been tracked and/or trended to provide an analysis of the monitoring data. Consequently, the HT Department did not have monitoring data available. By the next review, the HT Department should have developed and implemented a system to analyze the results of the new universal monitoring form. Part of this analysis should assess if the monitoring activities produced adequate data to determine staff competence and compliance in safely and appropriately implementing PNMPs and dining plans. If not, revisions should be made to the form(s) and/or instructions, and/or additional training should be provided to those implementing the forms. On a positive note, the ABSSLC Medication Administration Observation form included six questions related to the individual's PNMP that were to be audited during a medication pass. The auditor was to monitor for the presence of the PNMP in the medication administration record book, whether or not the nurse referred to the PNMP prior to presenting medication, if assistive and positioning equipment were present, identification of who to contact if problems with equipment were noted, and if the nurse was able to verbalize the rationale between the medical diagnosis and the PNMP. However based on interview, auditors had not been provided PNM core competency-based training and performance check-offs to test their competency in auditing these indicators. <u>All members of the PNM team conduct monitoring.</u> The review phase section of the draft Facility PNMT policy identified the following PNMT monitoring requirements: ▪ Focus monitoring on identified clinical indicators and measurable outcomes as stated in the action plan; and ▪ Monitor issues identified during the assessment and developed in the action plan until all issues have been resolved and the risk has been lowered according to the risk rating. Individual-specific PNMT monitoring documentation for six individuals followed by the PNMT in Sample O.2.a was reviewed. Since the Monitoring Team's last review, the PNMT had initiated monitoring. Monitoring was documented in Integrated Progress Notes	

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		and/or on Compliance Monitoring forms. A review of IPNs revealed the PNMT had conducted monitoring, but unfortunately, the monitoring was not directly tied to assessing compliance with PNMT action plan steps. The action plan steps for these individuals did not adequately define what interventions the PNMT had put in place to minimize identified risk factors. This led to ineffective monitoring results that did not assist the team to determine if the plan was being implemented. PNMT monitoring should address staff compliance with action plan interventions designed to minimize an individual's health risks. In December 2011, the PNMT members implemented the use of the Compliance Monitoring form. At the time of the onsite review, the PNMT had not completed an analysis of the monitoring data to determine if revisions needed to be made to the form to provide sufficient data to document the compliance with PNMT interventions. The following was found: ▪ None of the six individuals' PNMT Action Plans (0%) (i.e., Individual #6, Individual #350, Individual #212, Individual #498, Individual #103 and Individual #452) adequately defined individual-specific monitoring to document staff compliance with PNMT Action Plan steps. Although there was acknowledgment of non-compliance within this section, the Facility's HT Department had not developed an action plan for Section O.6. The Facility's Self-Assessment indicated that it was not in compliance with this requirement of the Settlement Agreement. This was consistent with the Monitoring Team's findings.	
O7	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement a system to monitor the progress of individuals with physical or nutritional management difficulties, and revise interventions as appropriate.	<u>Person-specific monitoring is conducted that focuses on plan effectiveness and how the plan addresses and minimizes PNM risk indicators.</u> Individual-specific monitoring form documentation was reviewed for the 15 individuals in Sample O.1: ▪ None of the 15 individuals' records (0%) documented the completion of monitoring to address the implementation status of risk action plan steps. No monitoring documentation was presented to verify that monitoring had been implemented for risk action plan steps for PNM high-risk indicators and related medium-risk indicators. ▪ None of the 15 individual records (0%) documented adequate monitoring to determine the efficacy of the plan's interventions to minimize high and medium-risk indicators. No monitoring documentation was presented to enable staff to analyze if the current interventions were adequate and/or required modification.	Noncompliance

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		Individual-specific monitoring form documentation was reviewed for the six individuals in Sample O.2.a, who the PNMT formally followed: ▪ None of the six individual records (0%)) documented the consistent completion of adequate individual-specific monitoring. This was complicated by inadequate PNMT risk action plans that did not identify specific interventions to be implemented to minimize high and related medium risk indicators. The Facility acknowledged that it was not in compliance with this subsection. However, the Facility's HT Department had not developed action plan steps for Section O.7. Prior to the Monitoring Team's next review, the Facility should focus on the following actions: ▪ The Facility should develop and implement a monitoring system to track and trend the progress of individuals with physical or nutritional management difficulties, and revise interventions as appropriate. The Facility's Self-Assessment indicated that it was not in compliance with this requirement of the Settlement Agreement. This was consistent with the Monitoring Team's findings.	
O8	Commencing within six months of the Effective Date hereof and with full implementation within 18 months or within 30 days of an individual's admission, each Facility shall evaluate each individual fed by a tube to ensure that the continued use of the tube is medically necessary. Where appropriate, the Facility shall implement a plan to return the individual to oral feeding.	<u>All individuals receiving enteral nutrition receive annual assessments that address the medical necessity of the tube and potential pathways to by mouth (PO) status.</u> The Facility Self-Assessment indicated that it had conducted a review of APEN assessments completed within the past six months. However, the Facility did not present evidence, such as the number of APEN assessments reviewed, a copy of the audit tool used to assess the quality of the APEN assessments, or an analysis of the audit results. The Facility's Self-Assessment indicated that APEN assessments had not "consistently proven to be well documented." The HT Department should provide additional data to explain what led them to the conclusion that APEN assessments were not "well-documented." The Self-Assessment indicated that the Facility had developed guidelines for the completion of APEN assessments. These guidelines stated: "in case of definitive diagnosis of aspiration pneumonia, an Aspiration Pneumonia/Enteral Nutritional Evaluation will be initiated (new one will be completed even if APEN previously initiated with[in] past 12 months)(refer to APEN practice.)." Unfortunately, these guidelines did not provide additional direction to IDT members related to the content or analysis needed to complete an adequate APEN assessment. As illustrated below, the individual APEN assessments reviewed did not meet the intent of this provision.	Noncompliance

#	Provision	Assessment of Status	Compliance
		According to State policy, all individuals who received enteral nutrition would receive an annual APEN assessment, which had an established format. The assessment was to be completed with input from the Primary Care Practitioner, RN, Habilitation Therapists, Dietician, Pharmacist, and other IDT members. The Nurse Case Manager was to compile the APEN assessment. The APEN assessments for 11 individuals in Sample O.3 were reviewed, and the following was found: ▪ None of the 11 individuals' APEN assessments reviewed (0%) were found to be adequate. This was because they did not address the medical necessity for the continued use of a feeding tube, provide justification for the continued need to receive enteral nutrition, and/or address the individual's potential to transition to a less restrictive form of enteral nutrition, which might lead to the development of a plan to return an individual to oral eating. ▪ None of the 11 individual APEN assessments (0%) indicated that there was input from appropriate IDT members. <u>Individuals who are at an increased PNM risk are provided with interventions to promote continued oral intake.</u> One (i.e., Individual #80) of the three individuals (33%) (i.e., Individual #80, Individual #429, and Individual #407) who were at risk of receiving a feeding tube were referred to the PNMT prior to placement of the tube. Individual #429 and Individual #407 were referred to the PNMT after they received a feeding tube. The PNMT did not have the opportunity to complete a comprehensive assessment to determine what strategies could have been implemented to promote Individual #429 and Individual #407's continued oral intake. Specifically: ▪ The ISPA for Individual #429, dated 9/20/11, documented her risk for the placement of a feeding tube. No discussion occurred during the ISPA meeting of a referral to the PNMT. She received a gastrostomy tube in September 2011 (documentation presented conflicting dates of tube placement as 9/19/11 or 9/27/11), and a tracheostomy on 10/22/11. Individual #429's PNMT assessment did not occur until 10/5/11. This did not provide the PNMT with the opportunity to assess her ability for continued oral intake prior to the placement of her feeding tube. The draft Facility PNMT policy stated "an individual must be referred to the PNMT whenever the PST is giving consideration to initiation of enteral feeding (i.e., G-tube or J-tube placement). The PNMT must assess and determine that all avenues have been pursued and enteral feeding is the most appropriate means for provision of nutritional before the PSTA proceeds with recommendations for initiation of enteral nutrition."	

#	Provision	Assessment of Status	Compliance
		When the Facility PNMT policy is finalized it will not guarantee that IDTs will refer an individual who is at risk of receiving a feeding tube to the PNMT. Consequently, the PNMT should establish Facility procedures to ensure they are alerted when an individual is being considered for feeding tube placement. If the IDT does not make a referral to the PNMT, the PNMT should immediately initiate a self-referral. <u>The need for continued enteral nutrition is integrated into the ISP.</u> Based on a review of the 11 individuals' ISPs in Sample O.3, none of the 11 individuals' ISPs (0%) documented the rationale for the continued need for enteral nutrition, transition to a less restrictive method of receiving nutrition, and/or attempts to return the individual to full or partial oral intake. <u>A policy exists that clearly defines the frequency and depth of assessments (Nursing, MD, SLP or OT).</u> The DADS At-Risk Individuals policy, dated 11/2/10, required "a comprehensive integrated assessment performed at least annually and as indicated for individuals who have a long history of/or recent hospitalization for aspiration pneumonia and for individuals who receive enteral nutrition." However, as discussed in this section, the Facility had not met the intent of this policy. The Facility's HT Department had not developed action plan steps for Section O.8. Prior to the Monitoring Team's next review, the Facility should focus on the following actions: ▪ Training should be provided for IDT members required to provide discipline-specific clinical assessments and collaborate with IDT members in the completion of an APEN assessment. ▪ The Facility, in collaboration with the HT Department, should formalize a monitoring tool to audit the APEN assessments. The monitoring tool should include criteria that will accurately reflect the strengths and weaknesses in the quality of the APEN assessments. The Facility's Self-Assessment indicated that it was not in compliance with this requirement of the Settlement Agreement. This was consistent with the Monitoring Team's findings.	

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

1. The HT Director should initiate an analysis of the current clinicians' caseloads. This analysis should take into account the scope and severity of individuals' needs (e.g., individuals' high and medium PNM risk indicators) to determine if the current allocation of staffing resources was adequate or required reallocation of caseloads to better meet individuals' needs. (Section O.1)

2. The HT Director should finalize the continuing education tracking system for PNMT members and other therapists 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)
3. The PNMT Coordinator should facilitate PNMT core members' attendance at scheduled PNMT meetings. (Section O.1)
4. The PNMT should consult with the Facility PCP liaison for every individual on its caseload, and these consultations should be documented. (Section O.1)
5. The PNMT should invite IDT members to attend individual-specific update reviews. (Section O.1)
6. When individuals on the PNMT caseload are admitted to the Infirmary, emergency room, and/or hospital, the PNMT should initiate a problem-solving approach, in collaboration with the IDT, to analyze what past events might have contributed to the individual's change in health status. This should lead to the identification of behaviors, actions, or conditions that the team should change to prevent a recurrence of the event. (Section O.1)
7. The HT Department should revise the Facility's draft PNMT policy to further define continuing education requirements for the PNMT, the PNMT assessment and action plan development and implementation timelines, and further discussion of the PNMT discharge process, including a description of a PNMT Discharge Plan. (Section O.1)
8. To support successful development and implementation of adequate and effective comprehensive PNMT assessments and action plans, the following is recommended:
    a. PNMT assessments and action plans should be completed in alignment with the State's At-Risk policy timelines.
    b. The PNMT assessment document should identify the IDT referral date to the PNMT, or the PNMT self-referral date.
    c. The PNMT assessment should include the findings of a re-assessment of the individual's risk ratings, in collaboration with the IDT, in order to determine if the individual's risk ratings have changed as a result of the health event that resulted in a PNMT referral. The individual's high and related medium-risk indicators should form the foundation of a PNMT assessment.
    d. The PNMT assessment should include re-assessment of an individual's PNMP strategies to determine if current strategies are adequate to address high and medium-risk indicators.
    e. As a part of the PNMT assessment, the HOBE assessments should be completed for individuals at high risk of aspiration, respiratory concerns, gastrointestinal problems, and related risks. Such assessments should identify safe elevation ranges for daily activities, and these should be incorporated into PNMP strategies.
    f. The PNMT assessment should define clinical indicators for the PNMT and nursing staff to monitor. These clinical indicators should define stable health status and unstable health status.
    g. The PNMT assessment and risk action plan should define the criteria for when nursing is to alert the PNMT to a health status change. These PNMT alert criteria should be integrated into nursing care plans.
    h. The PNMT assessments and risk action plans should include the interventions that will be implemented to minimize high and related medium-risk factors.
    i. The PNMT Action Plan steps should be implemented in a timely manner.
    j. The PNMT Action Plans should be updated when an individual experiences a change in status, which would also include an Infirmary, emergency room, and/or hospital admission.
    k. There should be adequate documentation to confirm the efficacy of PNMT interventions, and answer the question regarding whether the individual is better or worse.
    l. There should be an ISPA meeting to document the integration of the PNMT Action Plan into the ISP. (Section O.2)
9. To facilitate progress in addressing the requirements for Section O.2, the HT Director, in collaboration with State PNM consultants, should implement an auditing process of PNMT assessments, action plans, and related documents to assess the quality of PNMT work products and determine if progress is being made. The audits should identify strengths and weakness with the PNMT process to enable the structured implementation of changes to move the PNMT forward toward compliance. (Section O.2)

10. The Facility should define the timelines for submission of individuals' risk ratings to the Facility At-Risk Coordinator to enable the completion of an accurate individual at-risk list to be distributed to appropriate Facility representatives. (Section O.2)
11. The PNMT Nurse, in collaboration with Facility medical personnel, should establish guidelines to ensure the PNMT is immediately informed of an individual's related changes in status, including an Infirmary, emergency room, and/or hospitalization admissions. (Section O.2)
12. The Facility should provide adequate justification on the Medication Administration Record if medication presented is not in alignment with an individual's prescribed diet texture. (Section O.3)
13. The revised PNMP format should be formalized through the development of Facility procedures to provide guidelines for therapists in the development of PNMPs. (Section O.3)
14. The Facility should define the PNM criteria for individuals who require a physical and nutritional management plan. Based on these criteria, the list of 178 individuals with "no PNM needs" should be reviewed to determine which of these individuals meet the PNM criteria, and as appropriate, they should be provided with an adequate PNMP to meet their needs. (Section O.3)
15. The Facility should develop guidelines to support consistency in the development and implementation of PNMPs. These procedures should define the process for competency-based training and performance check-offs for PNMP core competencies and individual-specific PNMP strategies. (Section O.3)
16. The Facility should continue the revision of individual PNMPs campus wide. (Section O.3)
17. The Facility should develop and implement a PNMP audit tool to assess compliance with written PNMP procedures. (Section O.3)
18. The PNMT Discharge Plan should provide specific, detailed recommendations to the IDT to support an individual's stable health status. Specifically, the Discharge Plan should identify the detailed action steps that the IDT should continue to implement, and these action steps should be integrated into the ISP Risk Action Plan. (Section O.3)
19. The Facility should define the criteria for individuals who will receive a HOBE assessment. (Section O.3)
20. A timeline should be developed to track the implementation of HOBE assessments for the identified universe of individuals who meet the criteria for a HOBE assessment. (Section O.3)
21. For residence for which mealtime issues exist, the Facility should implement an interdisciplinary mealtime safety initiative to enforce staff compliance with mealtime plans for those individuals who eat orally and/or receive enteral nutrition. This should include the following:
    a. 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 mealtimes 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, actions to correct the issues should be identified and implemented, such as staff re-training and/or an administrative directive to correct deficiencies that appear to be systemic.
g. 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)

22. Therapists should audit PNMP Coordinators and OT/PT Techs during mealtimes to validate their competency in coaching and mentoring staff to support compliance with prescribed dining plans. (Section O.4)
23. The provision of competency-based training and staff performance check-offs for PNM mealtime core competencies for new employees as well as current staff should be implemented. In addition, a process should be implemented to provide competency-based training and performance check-offs in PNMP core competencies to current staff. (Section O.5)
24. The implementation of competency-based individual-specific training and performance check-offs for PNMP strategies and other related therapy programs should be initiated. (Section O.5)
25. As one measure of staff competency-based training compliance, data should include the total number of staff who will require training (N) and the number of staff who have completed foundational PNM training (n) to yield a compliance percentage. (Section O.5)
26. As stated in previous reports, the Facility should develop a monitoring policy to define the monitoring system to test staff compliance with PNMPs and dining plans. At a minimum, such a policy should include:
    a. Definition of a monitoring process to cover staff providing care in all aspects in which an individual is determined to be at risk (i.e., bathing, oral care, personal care, wheelchair and alternate positioning, transfers, medication administration, etc.);
    b. Training and validation process for monitors to achieve accurate scoring and a high level of inter-rater agreement.
    c. Identification of PNM risk factors which require enhanced PNMP and mealtime monitoring;
    d. Formal schedule for monitoring to occur;
    e. Requirement that all monitoring forms provide instructions for individual monitoring indicators to support scoring consistency and inter-rater agreement;
    f. Auditing process of completed monitoring forms to ensure compliance with Facility policy;
    g. Development and implementation of a system to track and trend monitoring results to resolve individual-specific and systemic issues; and
    h. Establishment of a threshold for staff re-training for monitoring results that illustrate repeated staff non-compliance with PNMPs therapy programs. (Section O.6)
27. The Facility should develop and implement a system to analyze the results of the new universal monitoring form. Part of this analysis should assess if the monitoring activities produce adequate data to determine staff competence and compliance in safely and appropriately implementing PNMPs and dining plans. If not, revisions should be made to the form(s) and/or instructions, and/or additional training should be provided to those implementing the forms. (Section O.6)
28. The Facility, in collaboration with the HT Department, should formalize a monitoring tool to audit the APEN assessments. The monitoring tool should include criteria that will accurately reflect the strengths and weaknesses in the quality of the APEN assessments. (Section O.8)
29. Training should be provided for IDT members required to provide discipline-specific clinical assessments and collaborate in the completion of an APEN assessment. (Section O.8)
30. The Facility should develop a unified system to present data from the monitoring tools in a meaningful way to enable the monitoring results to be easily analyzed and trends identified. The presentation of data should include the total population being reviewed (N), and the sample of the population (n) to produce a percent sample to indicate the relevance of compliance scores. (Facility Self-Assessment)

SECTION P: Physical and Occupational Therapy	
Each Facility shall provide individuals in need of physical therapy and occupational therapy with services that are consistent with current, generally accepted professional standards of care, to enhance their functional abilities, as set forth below:	**Steps Taken to Assess Compliance:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o Presentation Book for Section P; o ABSSLC Presentation for 2/13/12 for Section P; o The following documents: Occupational Therapy assessment, Physical Therapy assessment, HOBE assessment, supporting documentation for implementation of PT programs, OT/PT Consultations for the past year, ISP and ISPAs for the past year, PNMP, Dining Plan, Diet Card, PNMP Clinic documentation for the past year, individual-specific monitoring for past six months, PNM competency-based training for staff and performance check-offs, Community Living Discharge Plan, Integrated Risk Rating Form, and Risk Action Plan, and Modified Barium Swallow study, as available for 22 individuals, including: Individual #377, Individual #418, Individual #231, Individual #150, Individual #22, Individual #92, Individual #26, Individual #88, Individual #504, Individual #83, Individual #335, Individual #514, Individual #315, Individual #220, Individual #485, Individual #199, Individual #21, Individual #102, Individual #188, Individual #389, Individual #402, and Individual #67; o Habilitation Therapy Organizational Chart, dated 1/12; o List of OT, Certified Occupational Therapy Assistant (COTA), PT, Physical Therapy Assistant (PTA), and Assistive Technology (AT) Staff, undated; o List of Continuing education courses completed by OT/PT Staff, from 1/11 through 11/11; o List of Individuals who Use Wheelchair as Primary Mobility, undated; o List of Individuals with Transport Wheelchairs, undated; o List of Individuals with Other Ambulation Assistive Devices, undated; o List of Individuals with Orthotics and/or Braces, undated; o OT/PT Annual Evaluation (template), undated; o Seating System Assessment (template), undated; o Eating Evaluation/Nutritional Management Plan, revised 2/10; o Head of Bed Elevation Evaluation (template), undated; o Tracking Log of Completed Evaluations, from 7/11 through 1/12; o Wheelchair Seating and PNMP Clinic Assessments (templates), undated; o OT/PT-related Spreadsheets, from 3/11 through 7/11; o Monitoring Forms used by OTs, COTAs, PTs, PTAs, and PNMP Coordinators since last on-site review (templates), from 6/11 through 11/11; o Competency-based Performance Check-off Sheets related to OT/PT and foundational/core competencies for Physical/Nutritional Supports implemented since last on-site review (templates), undated; o QA/QI Data - sections O, P, and R, dated 1/13/12; and o List of Individuals Receiving Direct OT and/or PT Services and Focus of Intervention, undated.

	▪ **Interviews with**: o Bobbie Holden, Director of Habilitation Services; o Karen Mayfield, Lead PT; o Amy Gleaton, OT; and o Leslie Riggins, BBS, Speech Language Assistant. ▪ **Observations of**: o Observations in Infirmary and the following residences, including dining rooms: 6480, 5961, 5962, 6521, 5971, and 5972.
	Facility Self-Assessment: Based on a review of the Facility's Self-Assessment, with regard to Section P of the Settlement Agreement, the Facility found it was in noncompliance with any of the subsections of Section P. This was consistent with the Monitoring Team's findings. The Facility submitted three documents, including: ABSSLC Self-Assessment, Action Plans, and Provision Action Information. The ABSSLC Self-Assessment listed the steps the Facility staff conducted to complete the self-assessment, and the subsequent results for the completion of these tasks. The Action Plans documented the status of action steps that had been completed, were in process, and/or had not been started. The ABSSLC Provision Action Information listed actions completed since the previous compliance visit. As compared to the previous Plan of Implementation, these three documents provided a more focused presentation of what had been accomplished, and future plans for moving forward in meeting the requirements of the Settlement Agreement. Based on interview with the HT Director and therapists, Section P monitoring tools had been completed, but the three documents did not present the data or findings from these monitoring activities. QA/QI Data Section R data summary stated; "For the 4th Quarter of Fiscal Year 2011 (June thru August), the QA Monitoring overall compliance score was 81%. Department monitoring for June, July and August were not completed; consequently the department's overall compliance for the 4th quarter is not available. The indicators are not weighted. Inter-rater reliability scores are not available at this time." These cumulative compliance scores did not provide sufficient information and/or data to analyze the Facility's compliance with individual indicators. Specific compliance scores for each indicator will be required for the Facility to accurately interpret and analyze their progress with compliance. The Facility should develop a unified system to present data from the monitoring tools in a meaningful way to enable the monitoring results to be easily analyzed and trends identified. As discussed below in subsections of the report, the presentation of data should include the total population being reviewed (N), and the sample of the population (n) to produce a percent sample to indicate the relevance of compliance scores.
	Summary of Monitor's Assessment: The Director of Habilitation Services was to be commended for her success in recruiting and hiring two OTs and three PTs since the Monitoring Team's last review. The HT Director continued to recruit to fill three OT vacancies. The HT Department had not adopted the State-established OT/PT assessment format. At the time of the on-site review, therapists were reviewing the format.

	The HT Department personnel had adopted the "rolling assessment" process to provide an update to an OT/PT assessment when an individual experienced a change in status. This required a therapist to go back to the original assessment and update relevant sections, as appropriate. Although this process had just been initiated, the "rolling assessment" concept appeared to be a logical approach to providing adequate assessment information when an individual experienced a change in status. Based on documentation submitted, none of the 428 individuals living at ABSSLC received direct OT service programs. Forty-six individuals (11%) received direct PT service programs. Upon review of their risk indicators, it was not clear why some of these individuals received direct therapy. In fact, some of these individuals received direct therapy and had not been ranked at high risk in any risk category, including in the focus areas for which they received direct PT therapy (i.e., skin integrity, falls). Therapists did not appear to be taking into account an individual's risk rankings, as well as conducting an analysis of assessment data to justify a recommendation for the provision of direct PT therapy. In addition, individuals who were at high risk and might have had a need for direct therapy were not receiving direct therapy. The PNMP Clinic process did not document a number of important elements. These included: medium and high-risk indicators that might impact therapeutic interventions; a comprehensive list of individual-specific prescribed PNMP adaptive, mealtime and communication/hearing equipment; an appropriate therapist evaluation/review of prescribed equipment for fit, availability, function, condition, and effectiveness; signatures for therapists in attendance; recommendations, identifying the responsible therapist; date of work order and delivery of equipment; and frequency of equipment monitoring. In addition, the PNMP Clinic did not include an interdisciplinary assessment of the function, condition and effectiveness of individuals' bedrails. The assessment should assess the relative risk of using the bed rail compared with not using the bed rail, and thoroughly consider if other options would provide the same benefit while reducing the risk. The use of bed rails should be based on an individual's needs and should be documented clearly and approved by the IDT team. No standard wheelchair cleaning and maintenance protocols were in place. Home staff should clean wheelchairs regularly, and Assistive Technology (AT) staff should provide routine maintenance. Protocols should identify the steps involved in cleaning wheelchairs, which typically occurs during third shift. In addition, AT staff should develop and implement a regular maintenance schedule for individual's wheelchairs. Based on interview and observation, multiple individuals' seating systems were not adequate, because they did not provide optimal alignment and support. In addition, individuals' seating systems had not been re-assessed in a timely manner.

#	Provision	Assessment of Status	Compliance
P1	By the later of two years of the Effective Date hereof or 30 days from an individual's admission, the Facility shall conduct occupational and physical therapy screening of each individual residing at the Facility. The Facility shall ensure that individuals identified with therapy needs, including functional mobility, receive a comprehensive integrated occupational and physical therapy assessment, within 30 days of the need's identification, including wheelchair mobility assessment as needed, that shall consider significant medical issues and health risk indicators in a clinically justified manner.	The Monitoring Team's individual samples for Section P included: ▪ Sample P.1 – thirteen individuals who were identified at high risk and/or experienced a change in status, including: Individual #377 (dehydration), Individual #418 (fracture), Individual #231 (overweight), Individual #150 (choking), Individual #22 (choking), Individual #92 (skin integrity), Individual #26 (skin integrity), Individual #88 (fracture), Individual #102 (community placement), Individual #188 (community placement), Individual #389 (community placement), Individual #402 (community placement), and Individual #67 (liquid diet only); ▪ Sample P.2 – three of three individuals (100%) who were newly admitted to ABSSLC including: Individual #137, Individual #197, and Individual #142; ▪ Sample P.3 – nine of 46 individuals (20%), who were receiving formal PT Service programs, including: Individual #504, Individual #83, Individual #335, Individual #514, Individual #315, Individual #220, Individual #485, Individual #199, and Individual #21; and ▪ Sample P.4 – 22 of 428 individuals' OT/PT assessments (5%) including: Individual #377, Individual #418, Individual #231, Individual #150, Individual # 22, Individual #92, Individual #26, Individual #88, Individual #504, Individual #83, Individual #335, Individual #514, Individual #315, Individual #220, Individual #485, Individual #199, Individual #21, Individual #102, Individual #188, Individual #389, Individual #402, and Individual #67. Each indicator of compliance is underlined, and the narrative that follows summarizes the Monitoring Team's findings. <u>The Facility provides an adequate number of physical and occupational therapists, mobility specialists, or other professionals with specialized training or experience.</u> The Director of Habilitation Services was to be commended for her success in recruiting and hiring two OTs and three PTs since the Monitoring Team's last review. Based on interview, the HT Director continued to recruit to fill three OT vacancies. The Facility had six OT and five PT positions allocated. At the time of the onsite review, the HT Department had four OTs, which was the equivalent of three full-time positions due to some OTs working part-time on a contracted basis. There were three OT vacancies and no PT vacancies. The current census for ABSSLC was 428 individuals. The list the Facility provided of the caseloads for OTs and PTs totaled to 431 individuals, which exceeded the current census by three individuals. Based on this list, the following chart represents the caseload and responsibilities of OTs and PTs:	Noncompliance

#	Provision	Assessment of Status	Compliance

Occupational Therapist	Current Caseload and Responsibilities
Habilitation Therapies Director, OT	Director of Habilitation Therapies, PNMT member, supported 12 members on the PNMT caseload and supported 104 individuals in residences 6350, 6360, 6400, 6450, and 6521
OT #1	Began employment on 11/3/11, Contract OT for 35 hours per week, PNMT OT, supported 12 individuals on the PNMT caseload, and supported 215 individuals in residences 5961, 5962, 5971, 5972, 6330, 6370, 6480, 6500, and 6510
OT #2	Began employment on 11/8/11, contract OT for 40 hours per week, supported 112 individuals in residences 5390, 6690, 6710, 6720, 6730, 6740, 6750, and 6760
OT #3	Contract OT for 30 hours per week, no assigned caseload, primary responsibility completion of OT assessments
OT #3	Contract OT for 2.5 hours per week (Note: based on documentation two contract OTs averaged 1 full-time OT position.)
OT #4	Vacant
OT #5	Vacant
OT #6	Vacant
Physical Therapist	**Current Caseload and Responsibilities**
PT #1	Lead PT, PNMT member, supported 12 individuals on the PNMT caseload, and supported 134 individuals in residences 5971, 5972, 6360, 6370, 6390, 6400, and 6710
PT #2	PNMT member, supported 12 individuals on the PNMT caseload and supported 130 individuals in residences 5961, 6330, 6510, 6730, 6740, 6750, and 6760
PT #3	Supported 119 individuals in residences 5962, 6350, 6450, 6521, 6690, and 6720
PT #4	Began employment on 11/7/11 and supported 48 individuals on 6500 and 6480
PT #5	New graduate and will be assigned caseload when he is licensed

#	Provision	Assessment of Status	Compliance
		Continuing Education OTs and PTs attended multiple state-sponsored webinars, including: ▪ One of five OTs (20%) and two of five PTs (40%) attended Introduction to PNMT (9/14/11) Director of Habilitation Therapy, PT #1, and PT #2). ▪ One of five OTs (20%) and two of five PTs (40%) attended PNMT-Dietary (9/28/11) (OT#1, PT #1, and PT #2). ▪ Three of five OTs (60%) and three of five PTs (60%) attended Issues in Evaluation and Treatment of Individuals with Developmental Disabilities/Texas Annual Habilitation Therapy Conference (10/12/11 to 10/14/11) (OT #1, OT #3, OT #4, PT #1, PT #2, and PT#3). Multiple continuing education courses were presented during the annual HT Conference. Additional continuing education included: ▪ Breathing, Digestion and Swallowing: Best Practices in Dysphagia Management (Director of HT and OT #1), ▪ Don't Get All Puffed Up! It is Edema or Lymphedema? (OT #3) ▪ Oral Nutrition Supplements (PT #2) ▪ Ethics and Your Professional Responsibility: What's Is It to You? (PT #2), Facility OTs, and PTs had attended State-sponsored webinars and community continuing education. It should be noted that two OTs and three PTs were hired during the past six months. Consequently, these therapists might not have been employed when the State-sponsored webinars were presented. All individuals have received an OT/PT screening. If newly admitted, this occurred within 30 days of admission. Since the last onsite review, three individuals in Sample P.2 had been admitted to ABSSLC. ▪ None of the three newly admitted individuals (0%) had received a timely OT/PT assessment within 30 days of admission. OT/PT assessments had been completed, but the assessment dates exceeded the timeline of 30 days. ▪ None of the three individuals' OT/PT assessments (0%) followed the State-established OT/PT assessment format. ▪ None of the three individuals (0%) had received an adequate OT/PT assessment to assess significant medical issues and health risk indicators, as they related to the PNM risk areas, in a clinically justified manner. Within 30 days of admission, IDT members were responsible for completing a risk assessment to determine areas of risk. The OT/PT assessment should provide an assessment of risk factors following the content of the State-established OT/PT format risk level guidelines. These guidelines included services and supports for identified risks, rationale, efficacy, and individual triggers. The OT/PT assessment information should assist the IDT in the completion of an	

#	Provision	Assessment of Status	Compliance
		individual's Integrated Risk Rating Form, and the development of the Risk Action Plan(s). As discussed below, ABSSLC had not yet started using the new State Office format. <u>All people identified with therapy needs have received a comprehensive OT and PT assessment within 30 days of identification.</u> As noted above, based on interview, the Habilitation Therapies Director, OTs and PTs were reviewing the State-established OT/PT assessment format. However, at the time of the review, ABSSLC had not adopted the format. Based on interview, the HT Department had adopted the "rolling assessment" process to provide an update to an OT/PT assessment when an individual experienced a change in status. This required a therapist to go back to the original assessment and update relevant sections, as appropriate. Although this process had just been initiated, the "rolling assessment" concept appeared to be a logical approach. A review of 13 individuals' OT/PT assessments in Sample P.1 found: ▪ OT/PT assessments for four of the 13 individuals (31%) (Individual #188, Individual #402, Individual #418, and Individual #26) documented the completion of an OT/PT assessment prior to the annual ISP. The remaining individuals' OT/PT assessments were not completed prior to the ISP. ▪ None of the 13 individuals' OT/PT assessments (0%) were adequate. The OT/PT assessments reviewed did not follow the State-established OT/PT format. For example, the OT/PT assessments did not adequately address medium and high-risk areas that required supports from OTs and PTs. Moreover, the assessments should describe services and supports provided to minimize risks, provide rationale for current services and supports, present evidence that supports were effective and document individual triggers that will alert direct support professionals and nursing staff to a change in status. ▪ None of the four individuals (0%) (Individual #398, Individual #402, Individual #102 and Individual #188), who had transitioned to the community, received an adequate OT/PT assessment and/or discharge summary. The OT/PT assessment and/or discharge summary should provide a description of essential supports necessary for a successful transition for community placement to assist the community provider in providing adequate services to promote the individual's successful transition. When the HT Department has finalizes the OT/PT assessment format, audits should be conducted to assess the quality of the assessment and therapists' compliance with the State-established OT/PT assessment format and Facility assessment content guidelines.	

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		<u>If receiving services, direct or indirect, the individual is provided a comprehensive OT and/or PT assessment every three years, with annual interim updates or as indicated by a change in status.</u> A review of nine individuals' OT/PT assessments in Sample P.3, who received direct PT, therapy found: ▪ None of the nine individuals' OT/PT assessments (0%) presented an adequate analysis of assessment data to justify the PT program. In addition, individual's risk factors were not adequately assessed in the OT/PT assessments to support the initiation of a direct therapy plan. <u>Evidence of communication and/or collaboration is present in the OT/PT assessments.</u> A review of 13 OT/PT assessments for individuals in Sample P.1 found: ▪ Thirteen of the 13 individuals' (100%) OT/PT assessment included OT/PT signatures and dates. The Facility's HT Department had not developed an action plan for Section P.1. Although the Facility had made progress in increasing the OT and PT staffing, significant work was needed to provide individuals with timely and adequate OT/PT assessments. The Facility's Self-Assessment indicated that it was not in compliance with this provision of the Settlement Agreement. This was consistent with the Monitoring Team's findings.	
P2	Within 30 days of the integrated occupational and physical therapy assessment the Facility shall develop, as part of the ISP, a plan to address the recommendations of the integrated occupational therapy and physical therapy assessment and shall implement the plan within 30 days of the plan's creation, or sooner as required by the individual's health or safety. As indicated by the individual's needs, the plans shall include: individualized interventions aimed at minimizing regression and enhancing movement and mobility, range of motion, and independent movement; objective, measurable outcomes; positioning devices	<u>Within 30 days of the annual ISP, or sooner as required for health or safety, a plan has been developed as part of the ISP. Within 30 days of development of the plan, it is implemented.</u> Based on documentation submitted, none of the 428 individuals living at ABSSLC (0%) received direct OT service programs. Forty-six individuals (11%) received direct PT service programs. The following nine individuals in Sample P.3 participated in the following "formal PT Service Programs": ▪ Individual #504's formal PT program was "to promote strengthening, functional independence and weight loss." Her high-risk indicators were weight and osteoporosis. ▪ Individual #83's formal PT positioning program was "to promote healthy skin integrity;" home exercise programs "to maintain/improve ambulation skills while minimizing risk associated with osteoporosis through weight bearing activities" and "to promote joint movement and active leg movement to minimize regression." He did not have any high-risk indicators. ▪ Individual #335's formal PT program was "to maintain/improve ambulation	Noncompliance

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	and/or other adaptive equipment; and, for individuals who have regressed, interventions to minimize further regression.	skills." Her high-risk indicators were falls and seizures. ▪ Individual #514's formal PT programs were to "to promote joint movement and minimize regression;" and a formal positioning program "to promote healthy skin integrity." His high-risk indicator was osteoporosis. ▪ Individual #315's formal programs were range of motion, positioning, and home exercise "to promote skin integrity and reduce the risk of further contractures." She had no high-risk indicators. ▪ Individual #220's formal PT program was "to improve/maintain balance, coordination and ambulation skills and minimize regression in these areas." His only high-risk indicator was acne. ▪ Individual #485's formal PT program was "to increase visual acuity, fine motor skills and maintain ambulation skills." Her high-risk indicators were fractures, urinary tract infections, and seizures. ▪ Individual #199's formal PT programs were "to maintain/improve her balance, ambulation skills, overall strengthening and endurance." Her formal positioning program was "to promote healthy skin integrity." Her high-risk indicators were choking, gastrointestinal problems, weight, and urinary tract infections. ▪ The focus of Individual #21's formal PT programs for joint movement and positioning was "to maintain range of motion to help reduce further contractures, promote healthy skin integrity and to reduce the risk of skin breakdown." His high-risk indicator was osteoporosis. Individuals for whom their risk categories indicated might have benefitted from direct and/or indirect PT services were not included on the list of individuals receiving direct therapy. For example: ▪ The ABSSLC At-Risk Individuals list identified 15 individuals at high risk for skin integrity. However, none of these individuals received direct PT supports. It was unclear why these individuals were not provided direct PT supports to minimize their high-risk status for skin integrity. ▪ The Facility IDT members had identified 32 individuals at high risk for falls. However, only three of these 32 individuals (i.e., Individual #306, Individual #335, and Individual #117) received direct PT therapy. A review of the nine individuals' PT therapy plans/programs established: ▪ None of the nine individuals' OT/PT assessments reviewed (0%) documented an analysis of assessment findings to justify the initiation and/or continuation of direct PT plans. Three individuals' OT/PT assessments were significantly outdated (i.e., Individual #315, dated 2/8/05; Individual #220, dated 11/15/01, and Individual #335, dated 6/1/01). Individuals receiving direct therapy should receive a comprehensive OT/PT assessment to provide	

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		justification for the provision of direct therapy. The remaining six individuals' OT/PT assessments (i.e., Individual #504, Individual #83, Individual #514, Individual #485, Individual #199 and Individual #21) did not provide an adequate analysis of assessment data to support the initiation and/or continuation of direct PT programs. ▪ None of the nine individuals' PT Service Plan's goals and objectives (0%) were functional and measurable. For example, an individual PT Service Plan objective stated: "[Individual #335] will be provided with an ambulation program to maintain/improve ambulation skills." This objective did not define how her ambulation skill progress would be measured. <u>Appropriate intervention plans are: integrated into the ISP, individualized, based on objective findings of the comprehensive assessment with effective analysis to justify identified strategies, and contain objective, measurable and functional outcomes.</u> A review of the nine individuals' PT programs and ISPs found the following: ▪ PTs for four of nine individuals (44%) attended the individuals' annual ISP meetings. PTs did not attend the annual ISP meetings for Individual #315, Individual #220, Individual #485, Individual #21, and Individual #335. ▪ None of the nine individuals' (0%) PT Service Plans were adequately integrated into the ISP. Individuals' ISPs did not address the purpose and objective(s) of an individual's direct therapy plans, or discuss how therapy plan objectives would be integrated into other daily activities and/or skill acquisition programs to reinforce therapy plan objectives, as appropriate. ▪ Eight of the nine individual's (89%) PT therapy plans were developed within 30 days from the annual ISP date. Individual #335's PT plan's implementation date was prior to the ISP. ▪ Seven of the nine individuals' (78%) PT therapy plans were implemented within 30 days of their development. However, no development dates were documented for Individual #315 and Individual #21's PT programs. Consequently, the Monitoring Team was not able to discern if the plan was implemented within 30 days of the plan's development. As a result, these were found to be not in compliance with this indicator. Individual #335's PT plan was implemented on 2/21/12 prior to the annual ISP meeting on 3/1/12. The Adaptive Equipment Program Review Objective Data Sheets documented adaptive and mealtime equipment. Individual #220 did not have a PNMP. However, he was at medium risk for falls and osteoporosis. His PNM needs, as documented by his risk factors and prescribed adaptive and mealtime equipment, should have led to the development and implementation of a PNMP. Individual #220 did not have a PNMP. A review of the remaining eight individuals'	

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		PNMPs who received direct PT found: ▪ One of eight individuals' PNMPs (i.e., Individual #335) (13%) were current within the last 12 months. Individual #504, Individual #83, Individual #514, Individual #315, Individual #485, Individual #199, and Individual #21's PNMPs did not have an effective date. ▪ Four of eight individuals (50%) had an ISPA meeting as indicated to address necessary changes in PNMPs (i.e., Individual #514, Individual #315, Individual #199, and Individual #21). Individual #199's ISPA, dated 2/2/12, addressed changes to her PNMP, but her PNMP did not incorporate recommended changes from her eating assessment addendum. ▪ None of the four individuals' with ISPA meeting documentation showed that PNMPs had been updated in a timely manner to address changes in status. ▪ None of eight individuals' PNMPs (0%) were appropriately addressed in the ISPs. OTs and PTs did not consistently attend annual ISP and/or ISPA meetings to discuss PNMP strategies, and evidence was not found in ISPs of integration of PNMP strategies into action plans, nursing care plans, and Positive Behavior Support Plans. <u>On at least a monthly basis or more often as needed, the individual's OT/PT status is reviewed and plans updated as indicated by a change in the person's status, transition (change in setting), or as dictated by monitoring results.</u> Based on review of the nine individuals' direct PT therapy programs: ▪ None of the nine individual's (0%) PTs completed adequate monthly progress notes to document an individual's progress and/or lack of progress. The monthly progress notes documented a review of PT program review objective data sheet, but no analysis of the monthly data was included, or a comparison to the previous month's data to determine if the individual had made progress or if there was a lack of progress. The monthly progress note should provide justification for the continuation and/or discuss recommendations for modification to a program, if progress has not bee made. If a therapy plan had been modified, an ISPA meeting should have been conducted to address the necessary changes in the plan and/or the addition of a new plan. The HT Director and therapists should further define the expectations for the development and implementation of direct and indirect therapy programs. These protocols should include, at a minimum, the following: ▪ Timeframes for development and implementation of direct and indirect therapy plans; ▪ Format for direct and indirect therapy plans, including functional and measurable outcomes, development of consecutive steps to be followed by the	

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		staff responsible for plan implementation, program frequency, and method of data collection; ▪ Inclusion in direct and indirect therapy plans of recommendations from the annual and/or rolling assessment; ▪ Integration of direct and indirect therapy plans into an individual's ISP; ▪ Embedding of skills learned in direct and indirect therapy in skill acquisition programs and daily schedules, as appropriate, to provide additional learning opportunities to practice new skills; ▪ Format for monthly progress notes that documents an individual's progress and/or lack of progress and justification for the initiation, continuation or discontinuation of direct therapy plans; and ▪ Format for quarterly progress notes for provision of indirect supports. The Facility's HT Department had not developed an action plan for Section P.2. The Facility's Self-Assessment indicated that it was not in compliance with this provision of the Settlement Agreement. This was consistent with the Monitoring Team's findings.	
P3	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that staff responsible for implementing the plans identified in Section P.2 have successfully completed competency-based training in implementing such plans.	<u>Staff implements direct/indirect therapy plans identified by OT/PT.</u> Of the nine individuals' PT programs reviewed: ▪ Nine of the nine individuals' (100%) records reviewed provided data to substantiate implementation of PT programs. <u>Staff successfully complete general and person-specific competency-based training related to the implementation of OT/PT direct/indirect therapy plans.</u> ▪ None of the nine individuals' (0%) records reviewed provided documentation of competency-based staff training and performance check-offs for individual-specific PT programs for Habilitation Technicians, PNMP Coordinators or Facility staff. The HT Department should produce data in the future to document individual-specific competency-based training and performance check-offs for PNMP and/or OT/PT programs. The data should identify the number of staff to be trained (N) for the implementation of individual-specific OT/PT programs, and the number of staff who have successfully completed individual-specific training and performance check-offs for OT/PT programs (n). The Facility's projected action plan steps to address the requirements for Section R.3 included: quarterly observation and audits to ensure PNMP Coordinators and Habilitation Technicians were competent to perform their duties; re-training or other	Noncompliance

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		appropriate follow-up, if problems areas were identified; and compilation, trending, and reporting of quarterly audit data to identify systemic issues. Although these action steps were "not started," they were found to be appropriate steps in addressing some of the requirements for this section of the Settlement Agreement. The Facility's Self-Assessment indicated that it was not in compliance with this provision of the Settlement Agreement. New employees had been provided competency-based training and performance check-offs for mechanical lifts, stand-pivot transfers, rolling and repositioning in bed, and three person side-by-side lift. Mealtime competencies had been developed, but had not been implemented in NEPT. Competency-based training needed to be implemented with current staff. Although the Facility had made progress with the provision of foundational training for staff, the Facility remained out of compliance with this provision.	
P4	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall develop and implement a system to monitor and address: the status of individuals with identified occupational and physical therapy needs; the condition, availability, and effectiveness of physical supports and adaptive equipment; the treatment interventions that address the occupational therapy, physical therapy, and physical and nutritional management needs of each individual; and the implementation by direct care staff of these interventions.	<u>System exists to routinely evaluate: fit, availability, function, condition, and effectiveness of all adaptive equipment/assistive technology.</u> Seven of the individuals in Sample P.4 (Individual #220, Individual #150, Individual #22, Individual #102, Individual #188, Individual #231, and Individual #389) had dining plans, but no PNMPs. Four of these seven individuals had prescribed mealtime adaptive equipment (Individual #389, Individual #150, Individual #220, and Individual #22). Four of these four individuals' (100%) mealtime equipment had been monitored on a monthly basis. A review of a subset of the PNMP Clinic Meeting Minutes for 15 individuals' in Sample P.4 (Individual #335, Individual #199, Individual #21, Individual #504, Individual #315, Individual #514, Individual #83, Individual #485, Individual #92, Individual #88, Individual #26, Individual #67, Individual #377, Individual #418, and Individual #402) found: ▪ Thirteen of 15 individuals (87%) had Adaptive Equipment Reviews for prescribed PNMP equipment conducted on a monthly basis by a PNMP Coordinator and/or Habilitation Therapy Technician. Individual #504 and Individual #88's Adaptive Equipment Review forms did not list all PNMP prescribed equipment. The Adaptive Equipment Review form listed the individual's prescribed PNMP equipment and monitored the usage, condition, fit and function of the equipment. In addition, the individual's skin condition was monitored. However, the Monitoring Team was unclear how a PNMP Coordinator or Habilitation Therapy Technician had the clinical skills to adequately assess the fit and function of prescribed equipment. The HT Director and therapists should re-evaluate the appropriateness of PNMP Coordinators and Habilitation	Noncompliance

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		Technicians monitoring the fit and function of adaptive and mealtime equipment. ▪ None of the 15 individuals' PNMP Clinic minutes (0%) documented an adequate annual review of PNMP prescribed adaptive/assistive equipment. Concerns related to these reviews are detailed below. The HT Department should develop procedures for the PNMP Clinic. As stated in the Monitoring Team's previous report, the following concerns with the PNMP Clinic process were noted: ▪ The PNMP Clinic documentation format did not identify medium and high risk indicators that may impact therapeutic interventions; ▪ The PNMP Clinic did not provide a comprehensive list of individual-specific prescribed PNMP adaptive, mealtime and communication/hearing equipment; ▪ The PNMP Clinic format did not document appropriate therapist evaluation/review of prescribed equipment for fit, availability, function, condition, and effectiveness; ▪ The PNMP Clinic form did not have signatures for therapists in attendance; and ▪ Recommendations should identify the responsible therapist, date of work order and delivery of equipment, and frequency of equipment monitoring. In addition, the PNMP Clinic should incorporate an interdisciplinary assessment of the function, condition, and effectiveness of individuals' bedrails. The assessment should assess the relative risk of using the bed rail compared with not using the bed rail, and thoroughly consider if other options would provide the same benefit while reducing the risk. The use of bed rails should be based on an individual's needs, and should be documented clearly and approved by the IDT team. Based on interview, no standard wheelchair cleaning and maintenance protocol was in place. Home staff should clean wheelchairs, and Assistive Technology (AT) staff should provide routine maintenance. Protocols should be developed and should identify the steps home staff should take in cleaning wheelchairs, which typically occurs during third shift. AT staff should develop and implement a regular maintenance schedule for individuals' wheelchairs. Based on interview and observation, multiple individuals' seating systems were not adequate, because they did not provide optimal alignment and support. In addition, individuals' seating systems had not been re-assessed in a timely manner. For example, a review of seating assessments for individuals in Sample P.4 identified outdated and/or no seating assessment for some individuals:	

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Individual	Date of Seating Assessment
Individual #67	No seating assessment
Individual #315	2/1/05
Individual #504	10/20/08
Individual #335	6/6/01
Individual #21	2/9/04

The therapists and AT staff should conduct a screening to prioritize individuals without an adequate seating system and needing a comprehensive seating assessment. The screening results should prioritize individuals needing a new seating system and/or modifications to their current system. The protocol should define these priority levels. The screening process should take into account an individual's risk factors, which should impact an individual's priority level. The screening results should enable the therapists and AT staff to develop a schedule for the completion of seating assessments and the delivery of wheelchairs.

A policy/protocol addresses the monitoring process and provides clear direction regarding its implementation and action steps to take should issues be noted.
Systemic issues related to monitoring are discussed with regard to Section O.6 of the Settlement Agreement. In addition, the HT Department should develop procedures defining the completion of a comprehensive review of prescribed PNMP adaptive, mealtime and communication equipment to occur during the annual PNMP Clinic.

On a regular basis, all staff are monitored for their continued competence in implementing the OT/PT programs.
Systemic issues related to monitoring are discussed with regard to Section O.6 of the Settlement Agreement.

Responses to monitoring findings are clearly documented from identification to resolution of any issues identified (as discussed further with regard to Section O.5 of the Settlement Agreement).
Systemic and individual-specific issues related to monitoring are discussed with regard to Section O.6 of the Settlement Agreement.

Safeguards are provided to ensure each individual has appropriate adaptive equipment and assistive technology supports immediately available.
As discussed above, the Adaptive Equipment Program Review Objective Data Sheet was completed monthly to monitor individuals' prescribed PNMP adaptive and dining plan equipment. The HT Department should develop protocols to further define the

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		implementation of this form, as well as the roles and responsibilities of the PNMP Coordinators and Habilitation Technicians. The protocols also should outline a process to "close the loop" for equipment problems identified in monitoring. The Facility's HT Department had not developed an action plan for Section P.4. The Facility's Self-Assessment indicated that it was not in compliance with this provision of the Settlement Agreement. This was consistent with the findings of the Monitoring Team.	

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

1. The HT Department should make any necessary Facility-specific adaptations and adopt the State-established OT/PT assessment format, and develop a schedule for the completion of OT/P T assessments that adhere to this format. (Section P.1)
2. When the HT Department has finalized the OT/PT assessment format, audits should be conducted to assess the quality of the assessments and therapists' compliance with the State-established OT/PT assessment format and Facility assessment content guidelines. (Section P.1)
3. The HT Director and therapists should further define the expectations for the development and implementation of direct and indirect therapy programs. These protocols should include, at a minimum, the following:
    a. Timeframes for development and implementation of direct and indirect therapy plans;
    b. Format for direct and indirect therapy plans, including functional and measurable outcomes, development of consecutive steps to be followed by the staff responsible for plan implementation, program frequency, and method of data collection;
    c. Inclusion in direct and indirect therapy plans of recommendations from the annual and/or rolling assessment;
    d. Integration of direct and indirect therapy plans into an individual's ISP;
    e. Embedding of skills learned in direct and indirect therapy in skill acquisition programs and daily schedules, as appropriate, to provide additional learning opportunities to practice new skills;
    f. Format for monthly progress notes that documents an individual's progress and/or lack of progress and justification for the initiation, continuation or discontinuation of direct therapy plans; and
    g. Format for quarterly progress notes for provision of indirect supports. (Section P.2)
4. The PTs should complete competency-based training and performance check-offs for individual-specific PT programs with PNMP Coordinators, Habilitation Technicians, and direct support professionals responsible for their implementation. (Section P.3)
5. The HT Director and therapists should re-evaluate the appropriateness of PNMP Coordinators and Habilitation Technicians monitoring the fit and function of PNMP adaptive and mealtime equipment. (Section P.4)
6. The HT Department personnel should develop procedures for the PNMP Clinic to document an individual's medium and high-risk indicators that might impact therapeutic interventions; present a comprehensive list of an individual's PNMP adaptive, mealtime, and communication/hearing equipment; document the appropriate therapist's assessment of prescribed equipment for fit, availability, function, condition, and effectiveness; document attendance by therapist signature and date; and document the date of recommendation for new and/or modified equipment, date of work order, delivery of equipment, and frequency of equipment monitoring. (Section P.4)
7. The PNMP Clinic should incorporate an interdisciplinary assessment of the function, condition, and effectiveness of an individual's bedrails. The assessment should assess the relative risk of using the bed rail compared with not using the bed rail, and thoroughly consider if other options would provide the same benefit while reducing the risk. The use of bed rails should be based on an individual's needs, and should be documented clearly and approved by the IDT team. (Section P.4)

8. Wheelchair cleaning and maintenance protocols should be developed for home staff and AT staff. These protocols should identify the steps involved in cleaning wheelchairs by home staff, which typically occurs during third shift. AT staff should develop and implement a regular maintenance schedule for individuals' wheelchairs. (Section P.4)
9. The therapists and AT staff should conduct a screening to prioritize individuals without adequate seating systems and in need of a comprehensive seating assessment. (Section P.4)
10. The Facility should develop a unified system to present data from the monitoring tools in a meaningful way to enable the monitoring results to be easily analyzed and trends identified. As discussed below in subsections of the report, the presentation of data should include the total population being reviewed (N), and the sample of the population (n) to produce a percent sample to indicate the relevance of compliance scores. (Facility Self-Assessment)

SECTION Q: Dental Services	
	Steps Taken to Assess Compliance: The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o For the past six months, minutes from the Dental Peer Review Committee; o Lists of individuals who within the past six months: • For newly admitted individuals, were seen for dental services, including date of admission and date of initial evaluation; • Were seen for dental services during the past six months other than for the annual exam, date of visit, and reason or type of visit; • Have refused dental services; • Have missed an appointment (other than refusals), the date of the missed appointment, the reason for the missed appointment, and the date of the completed make-up appointment; • Have had a tooth/teeth extraction; • Have been seen for dental emergencies; • Have had preventive dental care; • Have had restorative dental care; and • Were due for annual dental exams, whether they have had exams, and whether the dentist was able to complete those exams; o Most recent comprehensive exams for one individual from each residence, including copy from dental office's record of visit and copy from active record of same visit, with identification of source of documentation for each record provided for: Individual #178, Individual #321, Individual #61, Individual #184, Individual #437, Individual #479, Individual #76, Individual #217, Individual #81, Individual #266, Individual #318, Individual #82, Individual #313, Individual #412, Individual #435, Individual #159, Individual #83, Individual #54, Individual #193, Individual #80, Individual #297, and Individual #14; o Copy of five most recent oral surgery consults and progress notes past six months; o List of abbreviations used in all dental records/reports; o For the past six months, any data summaries used by the Facility related to dental services, and/or quality assurance/enhancement reports, including subsequent corrective action plans; o Attendance tracking sheet for dental appointments for the past six months; o List of refusals for the past six months per date of refusal (including reason for appointment – prophylaxis, annual, etc.); o List of those who have not seen dentist in one year and reason; 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 requirement/recommendation; o List of those who were edentulous at time of the last on site visit, and those who have

	become edentulous since that time; o List of other reasons for missed appointments per date for past six months (including reason for appointment – prophylaxis, annual, etc.); o List of no shows/missed appointment per building per month for the last six months; o List of refusals per building per month for the last six months; o List of interventions per individual for missed appointments (follow-up appointment scheduled, whether follow-up completed, any correspondence to QDDP, home manager, team, etc.); o QDDP, IDT minutes that review, assess, develop and implement strategies for dental visit refusals and no shows last six months; 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: Individual #137, Individual #283, Individual #318, Individual #507, and Individual #165; o Appointment schedule for those undergoing general anesthesia/conscious sedation; 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: Individual #440 8/19/11, and 11/18/11, Individual #479 9/23/11, Individual #153 9/23/11, Individual #313 9/23/11, Individual #526 11/29/11, and Individual #168 11/13/11; o For the past six months, copies of any correspondence concerning restraint and sedation use for office visit (to QDDP, team, psychologist, etc.); o Copy of complete dental records for prior three years at SSLC, including all documentation including progress notes (prophylactic, annual, emergency, restorative, etc./forms), completed, x-rays, consult reports, restraint check list, oral surgeon consults, etc. for one individual most recently seen from each residential unit. Dental records for the following individuals were submitted: Individual #451, Individual #543, Individual #483, Individual #480, Individual #26, Individual #105, Individual #478, Individual #509, Individual #308, Individual #283, Individual #145, Individual #455, Individual #286, Individual #56, Individual #226, Individual #149, Individual #547, Individual #273, Individual #136, Individual #9, Individual #326, Individual #409, and Individual #14; o For 10 individuals given dental pre-treatment sedation, copies of progress notes/vital sign logs, other pre-appointment assessments from active record and dental office from start of sedation in residence (if applicable) to release from monitoring, including pre-treatment sedation sheets for: Individual #387 7/29/11, Individual #242 10/18/11, Individual #276 11/9/11, Individual #505 11/16/11, Individual #526 11/29/11, Individual #318 10/12/11, Individual #168 11/17/11, Individual #486 10/19/11, Individual #363 11/14/11, and Individual #527 10/18/11; o Current list of HRC approved dental medical restraint with sedation; o Copy of any restraint and sedation tracking list/system used by the Dental Department, including type of restraint, reason, sedation plan, drug used and dosage, effectiveness of

	restraint, trial of less restrictive approach (e.g., lower dosage, less mechanical restraint duration, etc.); o In past six months, per month, percentage of individuals utilizing general anesthesia/IV sedation for dental exam and treatment; o In past six months, per month, percentage of individuals utilizing oral sedation for dental visits; o In past six months, per month, percentage of individuals utilizing mechanical restraints for dental visits; o For most recent five extractions in past six months, copy of initial evaluation for this, second opinion, and subsequent documentation until closure for following individuals: Individual #95 12/6/11, Individual #455 12/6/11, Individual #125 12/6/11, Individual #405 10/6/11, and Individual #39 9/29/11; o For those completing annual exams in past six months: • Oral hygiene rating in each exam listed per individual and date of exam; • Quarterly oral hygiene ratings, if done; and • Corrective action plans related to oral hygiene ratings; o List of all those who receive suction tooth brushing treatment; o Copy of 10 annual dental assessments completed in last 30 days and for the prior year of these same individuals: Individual #398, Individual #465, Individual #435, Individual #22, Individual #203, Individual #40, Individual #204, Individual #525, and Individual #353; o List of annual assessments completed in last six months, and the date of previous annual assessment; o Copy of ten most recent annual dental summaries provided for the ISP o The most recent/current Facility oral hygiene data (percentage of good, fair, poor ratings); o For those with missed appointments (other than refusals), the date of the missed appointment, the reason for the missed appointment, and the date of the completed make-up appointment; o List of refusals for the past six months per date of refusal, including reason for appointment, and date follow-up appointment completed; o Reasons for outstanding or pending Total Intravenous Anesthesia (TIVA) cases greater than three months; o List of those who have outstanding need for dental x-rays, according to current professional standards, and reasons for outstanding need; o Copy of Dental Policy and Procedures with updates highlighted; o Presentation Book for Section Q; o Section Q: Self-Assessment, updated 2/1/12; o Section Q: Provision Action Information, updated 1/30/12; and o Section Q: Action Plans updated 2/2/12. ▪ **Interviews with**: o Jerry Griffin, DDS, Dental Director; o Pat Smith, QA Director; and o Mary White, QA Nurse.

	Facility Self-Assessment: Since the Monitoring Team's previous review, the Facility had made changes to the way it presented its self-assessment information. Using a new format from State Office, the Facility had identified activities engaged in to conduct the self-assessment, the results of the self-assessment, and a self-rating using the information cited in the section on results. Although a number of concerns continued to exist with the Facility's self-assessment process, over time, this format should be helpful in substantiating the Facility's findings with regard to compliance. Additionally, an updated "Provision Action Information" was submitted. For Section Q.1, the Dental Department had created a number of review processes, some involving the review of primary data (e.g., annual exams), and some through database management (e.g., follow-ups to missed appointments). Self-assessment areas included review of annual exam timeliness, review of completeness of the abbreviations list, review of evaluations for newly admitted individuals, tracking of missed and refused appointments until closure, review of closure notes and timeliness for emergency dental log entries, and a review of the dental procedures in the last six months. For the last review noted, it was not clear if the procedures were sampled (there were 1480 procedures), and if so, how they were sampled. Similarly, it was not clear if the review of annual exams was sampled, or if 100% were reviewed. Results of these endeavors indicated that 24 annual dental exams were completed late, and the Facility determined that seven individuals had not seen the dentist in one year. Compliance rate for completion of annuals was 87.2%, which was similar to the 92% determined by the Monitoring Team. Missed appointments were aggressively researched, and residences with high rates of missed appointments were identified. According to the Facility, 100% of emergency visits had closure notes. For Section Q.2, the Facility's review included a review of QA data, although this reflected information relevant to both subsections of Section Q. Reviews were conducted for restraint use, use of oral sedation, annual dental summaries, and general anesthesia cases, including follow-up for missed appointments for general anesthesia. Individuals for whom desensitization plans were appropriate also were rated by a priority system. For results, the QA data was in the 84 to 85% range of compliance. It covered all areas of dental care, and the findings did not agree with the results of the Dental Department's self monitoring using the same tools. Although annual summaries were completed, the Monitoring Team noted the content to be confusing with categories unexplained, and the dental tooth chart remaining incomplete, indicating need for further review. As the Facility noted, some desensitization plans were being implemented, but there was no consistent data yet available trending several months to determine a level of success. The Facility determined it was compliant with Section Q.1, and not compliant with Section Q.2. The Dental Department's methods for sampling data remained unclear. As is described in detail below, the Monitoring Team's findings showed that the Facility remained out of compliance with both subsections. However, improvement toward compliance was evident in many areas of dental care.
	Summary of Monitor's Assessment: The Dental Department appeared to be improving campus-wide. Restraint use and oral sedation use was low and continued to decrease, and use of mechanical restraints also was decreasing. Oral hygiene ratings were determined to be highly favorable, with most individuals in the good to fair category. This might reflect the diligence of frequent prophylactic care. The system of

	desensitization prioritization and referral to the IDT appeared to be working. Refused and missed appointments were tracked to ensure a follow-up appointment was completed. The Dental Department appeared to work closely with the residences and the IDTs in resolving missed and refused appointments. In addition, a scheduled system was used to ensure timely completion of annual dental exams. An emergency dental log was maintained, and indicated closure to the dental concern. The Facility offered a full spectrum of dental services. Areas of concern/weakness included the large number of edentulous individuals. The Dental Department is challenged to create a database for these individuals, with tracking of whether dentures or other dental options have been offered, and if such options were successful or not. Several individuals had desensitization plans that had been implemented, but data collection and analysis remained in the early stage of development. The annual dental summary included some areas that were confusing to those outside of the Dental Department and required further clarification. Lastly, the QA Department data did not agree with the Dental Department data, indicating the need for further collaborative work in determining improvements and compliance for this section. The Dental Department had developed reliable and complete databases. The Dental Department is encouraged to develop formal quarterly reports with analyses of this data, with cumulative trend data over serial quarters. Analysis should lead to formal improvement plans based on the data. Lastly, these quarterly reports should be shared at Dental Department meetings, as well as morning medical meetings and with Facility Administration through the QA/QI Council.

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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 Director, one additional staff dentist, two dental assistants, two dental hygienists, and one dental clerk staffed the Dental Department. The two staff dentists were current in CPR certification. As of the January 2012 roster, the two dental assistants and two dental hygienists were also current in CPR certification. One dental hygienist was due for renewal as of 2/17/12. <u>Annual Assessments</u> A list of those individuals having annual examination appointments was submitted for the time period from July 1, 2011 through December 2011. A total of 275 individuals completed annual examinations during this time period. Of these, all were listed with prior annual examination dates. Of these, 254 had an annual examination date completed within 365 days of the prior annual exam. This was a compliance rate of 92%. Separately, copies of the annual dental assessments that were completed in the 30 days prior to the Monitoring Team visit along with the prior year's completed assessment	Noncompliance

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		were submitted. A total of nine annual assessments were submitted. For nine out of nine (100%) of these individuals, an annual dental assessment had been completed within 365 days. Of these, two were edentulous. The dental chart/diagram did not appear to be completed in any of the nine. Based on the charts/diagrams, it appeared even the edentulous individuals had 32 teeth without restorative work. It is recommended that if this dental chart/diagram of the teeth is not used that it be marked appropriately in order to not confuse members of the IDT. Many strengths were noted in the "Dental Examination Record" the Facility utilized. It quickly gave the reader information in a computerized format with most entries completed by checking the appropriate box, or brief additional narrative phrases. Concise information was included concerning the extraoral exam, intraoral exam, number of missing and unerupted teeth, information concerning dentures/partials, a completed section on periodontal findings, an oral hygiene rating, behaviors concerning cooperation, oral hygiene instruction positioning information, and an informative treatment plan. Some of these areas were carried over to the annual dental summary (discussed with regard to Section Q.2) for review by the IDT, but many of the confusing aspects of the annual dental summary were not noted in the submitted Dental Examination Record. Copies of the prior three years of the dental records were submitted for one individual from each residence. This was a total of 23 dental records. Of these, 18 of the 23 (78%) had completed the current annual exam within 365 days of the prior annual exam. Dental x-rays were obtained during 2011 for 21 of 22 (95%) applicable individuals (one individual was edentulous). Of these 23 individuals, six were seen for dental emergencies in 2011. Seven individuals underwent dental extractions in 2011. Four individuals underwent additional restorative care. Two underwent oral surgery at a community hospital. Four had general anesthesia at ABSSLC. Additionally, during this time period, three new individuals were admitted to the Facility. Three out of three (100%) had completed an initial dental exam in the first month (from one day to thirteen days following admission). <u>Oral Hygiene</u> An oral hygiene index was completed on each individual at the time of the annual exam. Two separate data sets were submitted. One included the oral hygiene scores for a full year, and was inclusive of almost all individuals residing at ABSSLC. According to this document, for a census of 444 individuals, 73% had a good oral hygiene score, 21% had a fair oral hygiene score, and 6% had a poor oral hygiene score. From a separate list, data was submitted for oral hygiene scores for the time period of July through December 2011. A total of 280 individuals were listed. Of these, 220 out of 280 (79%) had an oral hygiene rating of good, 51 (18%) had an oral hygiene rating of	

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		fair, and eight (3%) had a score of poor. This more recent data indicated a further trend toward improvement in oral hygiene scores. As part of preventive oral care, suction tooth brushing was provided to those meeting identified criteria: risk for aspiration, had a history of aspiration, silently aspirated, individuals that could not manage thin liquids safely, individuals that could not spit, and/or individuals that could not brush independently. A list submitted indicated 154 individuals received suction tooth brushing, which was 154 out of 428 (36%) of the population. The Facility submitted copies of correspondence to other departments as evidence of ongoing initiatives, current findings and challenges/obstacles, and discussion of potential options with the goal of improvement of oral hygiene. Topics included finding lack of toothbrushes and toothpaste in the residence, the need for a personal washable shaving bag to keep personal items separated, the use of a three-sided toothbrush, the use of a multi-tuft toothbrush with covers, evaluation of the need to take a vacuum toothbrush on furlough, flavored toothpastes, and training videos specific to the individual for family members to use when individuals went on furlough. <u>Preventive, Restorative, Emergency Dental Services</u> According to the Dental Department, one individual was overdue for recommended dental x-rays (i.e., bitewing x-rays or peri-apical x-rays or left and right oblique x-rays). However, the information submitted indicated the individual had not been on campus since October 2010, and was not expected to return. Information submitted indicated 168 individuals residing at ABSSLC were edentulous, for a rate of 168 out of 428 (39%). It is recommended that the Dental Department develop a information management system to determine how many edentulous individuals have dentures or dental implants, how many were offered (with location of documentation), and if none, reasons for not having dentures or other dental options. The Dental Department provided the breadth of services required to care for the individuals at ABSSLC. In the prior six months, there were 770 preventive care appointments completed for individuals at ABSSLC. There were 33 appointments completed for restorative care of 27 individuals. There were 61 appointments for dental emergencies. Twelve individuals underwent dental extractions (with one to four teeth extracted during the appointment). According to the Dental Department, there were an average of 246 procedure visits per month. The Facility offered general anesthesia when necessary. Also, there was a listing of 17 consultants. Three individuals had dental procedures completed at the area hospital.	

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		The Dental Department provided an analysis for the years 2010 and 2011 concerning restorations and extractions. The analysis determined that there were fewer extractions in 2011 and more restorations. Although there is not sufficient information for trend analysis, the Dental Department did interpret this result to be due to improved oral hygiene, and use of topical fluoride and fluoride varnish products. Additionally, it appeared the newly admitted individuals over the last year were responsible for half the extractions, suggesting a positive impact from oral hygiene for those residing for several years at ABSSLC. It will be important for the Dental Department to continue to analyze this data each year, and expand the data analysis to other areas of dentistry. However, preliminary information indicated the trend of restorations versus extractions was favorable. Monitoring and evaluation of use of oral sedation was reviewed. Ten active records were submitted for individuals who underwent oral sedation. The following summarizes the results of this review: ▪ 10 out of the 10 (100%) recorded nothing by mouth (NPO) status. (Nine were NPO and one was not NPO). ▪ For 10 out of 10 (100%), the restraint checklist form was completed. ▪ The dental IPN and DPN (dental progress note) were identical, using a computerized template. Although it was clearly indicated whether chemical sedation was utilized, it did not include the actual medication, dosage, and route, which was recorded on the restraint checklist form. However, for completeness, it is suggested that all important information be located on the IPN/DPN, as the reader might not have ready access to the restraint checklist form when reviewing the IPN/DPN. ▪ 10 (100%) restraint checklists listed the medication administered, the dose, and the route. ▪ 10 (100%) listed vital signs. It was not clear if the vital signs were taken before or after the procedure, and it is recommended that this be clarified in the template documents. ▪ Eight (80%) had intra-procedure vital sign monitoring, and nine (90%) had post procedure vital signs recorded on the restraint checklist form. ▪ Adequate documentation regarding effectiveness was found in 10 of the 10 (100%) of the active records. ▪ There was one form that indicated that there had been a drug error prior to the sedation, but that the physician determined the individual was stable for treatment. No information was documented as to the type of error or medication involved in the error. ▪ Oral sedation was given for the following procedures: annual exam, prophylactic visit, and restorations. ▪ Medications prescribed as oral sedation included Chloral hydrate, Halcion,	

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		Ativan, and Valium. The active record was submitted for four individuals who had undergone general anesthesia in 2011 for five appointments. The date range of these procedures was from 8/19/11 through 11/18/11. Two other cases were submitted in the request, but they did not undergo general anesthesia and were excluded. The procedures under general anesthesia included one or more aspects of dental care. The list varied in each case, and included the following: crown lengthening, extractions, restorations, prophylaxis, and annual exam. Review of these submitted records revealed the following: ▪ Consent for the dental procedures/anesthesia was up-to-date in four of five that underwent general anesthesia (80%). ▪ A pre-operative anesthesia record was completed and submitted in one of five (20%). ▪ The operative anesthesia record was completed in five of five (100%). ▪ An operative record was completed in five of five (100%). ▪ An intraoperative record was completed in five of five (100%). ▪ A recovery room record was completed in five of five (100%). ▪ A recovery note was written in three of five (60%). ▪ Postoperative vital signs were recorded in five of five (100%). ▪ An IPN closure note was completed in two of five (40%). Separately, five active records were submitted for those undergoing oral surgery for extractions. All involved one or more extractions. Local anesthesia was used when extraction of one tooth occurred, and general anesthesia was used when there were extractions of multiple teeth. Three underwent general anesthesia and two underwent local anesthesia. Consents were submitted for all five active records. All included a pre-operative second opinion note/consult. For those undergoing general anesthesia, the submitted documents included a completed pre-anesthesia assessment, anesthesia report, an operative record, an intra-operative record, and a recovery room record. For all, there was a post procedure IPN. The appointment schedule was submitted for those that had undergone general anesthesia in the prior six months. There were four appointments for July 2011, five appointments for August 2011 (four appointments were listed in a separate document), three appointments for September 2011, none for October 2011, three for November 2011, and four for December 2011. Emergency treatment was reviewed for five individuals. The reasons for the emergency were as follows: tooth pain following extraction, swelling of the jaw, toothache, and mouth pain. The following findings are made based on this review: ▪ Four records (80%) documented the presence or not of pain.	

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		▪ Follow-up occurred for two individuals (40%). Additionally, the Dental Department kept a "dental emergency log." The log tables for September through December 2011 were submitted. They included information such as date and time emergency occurred, the complaint, who reported the emergency, the date and time the individual was scheduled, notes summarizing the visit findings, and resolution. When completed, this information allowed the Dental Department's responsiveness to be tracked from the time the emergency occurred to the time of the Dental Department responded. From review of submitted documents, there were a number of scheduled emergency visits for which time was omitted. It is recommended that this information be completed and monitored for completeness. Additionally, a resolution column provided evidence of closure. However, for some of the cases, the information appeared to not document the closure step. For instance, for the November 2011 log, there was an entry of "schedule for extraction," but there was no information to determine if this was scheduled or when. Similarly, there was the entry "consult Dr. N.," but no information was provided that an appointment had been made. Given this information was from November 2011, it would be expected that a follow-up entry would have been made regarding when the appointment was scheduled or other action steps completed. The Self-Assessment indicated that closure notes had been completed for 100% of dental emergency visits. It appeared that the information from the dental emergency log was not updated to reflect the completed notes. Closure of all dental procedures/activities was tracked and reviewed by the Dental Department. Reportedly, 350 closure notes were reviewed, and all but 11 had a documented closure date. Through December 2011, eight of these had follow-up appointments. Two required treatment and were to be scheduled at the local hospital. According to the Facility, their analysis indicated that 97% of all dental treatment requiring closure notes in the prior seven months was completed. The Dental Department was tracking the other 3%. Quality improvement review of these aspects of dental care is discussed with regard to Section Q.2. Based on the Monitoring Team's findings, the Facility remained out of compliance with this provision. Although progress was noted in a number of areas, some findings remained problematic. For example, although improved processes were in place to ensure annual dental exams, based on the Monitoring Team's sample, this had not occurred for a number of individuals. Some issues were noted with regard to documentation related to oral sedation, and general anesthesia. Follow-up for individuals experiencing dental emergencies also needed improvement, including updating the emergency log.	

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Q2	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement policies and procedures that require: comprehensive, timely provision of assessments and dental services; provision to the IDT of current dental records sufficient to inform the IDT of the specific condition of the resident's teeth and necessary dental supports and interventions; use of interventions, such as desensitization programs, to minimize use of sedating medications and restraints; interdisciplinary teams to review, assess, develop, and implement strategies to overcome individuals' refusals to participate in dental appointments; and tracking and assessment of the use of sedating medications and dental restraints.	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 IDTs, refusals and missed appointments, tracking of use of sedating medications and restraints, and interventions to minimize the use of sedating medications. <u>Policies and Procedures</u> The Dental Department revised its "Dental Policy and Procedures" twice since the Monitoring Team's last visit, on 11/29/11 and 1/5/12. Updated information included new nomenclature (such as QDDP, IDT, etc.), as well as changes in the "Dental Examination Record" that included an oral hygiene plan, positioning information, desensitization prioritization, and supports required for community placement. It was noted that this policy included expectations regarding dental pre-treatment sedation. The policy indicated that: "at least two or more sets of vital signs will be recorded on the residence when sedation is administered prior to transport to the dental office and two or more sets of vital signs will be recorded when a resident returns home following pre-treatment sedation. All residents administered dental pre-treatment sedation will be accompanied by a licensed staff member (nurse or doctor) during transport to the dental office. This does not apply to sedation administered in the dental office for minors." Additionally, it was noted that there would be a dental order that states: "NPO" for each instance of dental sedation. These directives were important safeguards for care of the individual while being sedated for a dental visit. <u>Provision of Dental Records to IDTs</u> Copies of the ten most recent annual dental summaries provided to the IDTs were submitted. They were completed using a computer software template. The information provided was essential in guiding the teams to review any dental concerns. However, there were a number of concerns noted: ▪ The information stated whether a desensitization program was needed or was implemented. However, there appeared to be no ability to describe any progress in this area. ▪ For two individuals, there was a missed appointment section indicating there had been no missed appointments, but the behavior was marked as poor in this section. However, under the last annual exam section, the individuals' behavior was marked as good. ▪ The periodontal section was listed as high, medium, or low, but the reference point was not described (e.g., it was unclear if this rating was referring to risk, degree of inflammation, or something else). ▪ The present condition section listed the type by Roman numeral (I through IV), but there was no key as to what those numbers meant. Team members might	Noncompliance

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		not be able to understand this section without a key. ▪ The dental diagram/tooth chart showing the teeth appeared to be completed in none of them. Even in the edentulous patient, it appeared the teeth were unblemished and in perfect condition. For no individual, were the remaining teeth numbered or identified on the graph. The form did not appear to clearly indicate how many teeth the individual still had and the location of the teeth. ▪ For Individual #452, the Present Condition Periodontal Type stated none, and the Roman numerals were again left blank. For staff not in dentistry, this might lead to confusion as to meaning. Similarly, the caries section stated none, but the "no" box was left blank. The Dental Department reviewed the content of the Annual Dental Summary, and noted that the "current status" section that would require an immediate exam should be replaced by a chronological report of dental events (operative visits, etc.). This was to be discussed further at the statewide Dental Directors' meeting. The most recent comprehensive exams for one individual from each residence were submitted from both the active record and the dental office. These were compared to determine if all information in the dental office record was available in the active record. For 22 individuals, the annual dental examination records, IPN referring to the annual exam, and DPN referring to the annual exam were submitted. The list of these individuals is provided in the section above identifying documents reviewed. For 22/22 (100%), the information was identical in both records. <u>Refusals/Missed Appointments</u> A review of information from ABSSLC for refusal to attend dental appointments for the prior six months (July through December 2011) indicated that 24 individuals refused 29 appointments. Except for the four most recent refusals, all were rescheduled and the rescheduled appointment was completed. The time span to obtain a completed rescheduled appointment ranged from one to 68 days. The average number of days was 19 days before the rescheduled appointment was completed. The Facility was asked to submit IDT minutes/ISPAs that reviewed, assessed, developed, and implemented strategies to reduce dental appointment refusals and no shows. Of the 29 refusals, there were seven ISPAs submitted addressing refusals. It was not clear if this was a sampling of ISPAs from the 29 refusals, or whether ISPAs were not completed on the other 22 refused appointments, or if all 24 individuals had an action plan in response to the refused appointments. From July through December 2011, there were 49 missed appointments for reasons	

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		other than refusals. Reasons identified included schedule conflicts in seven, the appointment was not scheduled on the calendar for 19, there was a staff shortage in five, there were nine missed appointments for medical reasons, there were missed appointments due to cancellation by the supervisor, and three refused to leave the residence. Some of the reasons given might benefit from improved communication and cooperation between the Dental Department and the residences, such as reducing schedule conflicts, ensuring the residences know the appointment is scheduled, and making sure it is added to the calendar. All appointments were rescheduled and these rescheduled appointments were completed. The time from the missed appointment to the completed appointment varied from one to 73 days. The average length of time before the appointment was rescheduled was 14 days. Of the 49 missed appointments, an ISPA was submitted that addressed two of the missed appointments. Additionally, the Dental Department tracked missed dental appointments according to the residence. From a graph entitled: "percent missed dental appointments," the trend-line indicated a downslope for 2011, indicating improvement in this area. Copies of memos sent to QDDPs for missed appointments were submitted, requesting an IDT meeting concerning the missed appointments. Whether ISPAs were completed but not submitted for the other 47 was not clear. The QDDP and Dental Departments should independently track completion of ISPAs related to missed appointments to ensure follow-through. Information submitted indicated 275 annual exams were completed, and 1194 other appointments, for a total of 1469 appointments completed from July through December 2011. There were 29 refusals, and 49 missed appointments. The total of 1469 completed appointments added to the 29 refusals and 49 missed appointments provided a total of 1547 appointments offered. The refused appointments were 29 out of 1547, resulting in a 2% refusal rate. The missed appointments were 49 out of 1547, resulting in a 3% missed appointment rate. The Dental Department also closely followed any general anesthesia cancellations. From July 2011 through December 2011, there were four cancellations. This involved two individuals. For both, the consultant anesthesiologist determined that the individuals were not good candidates for general anesthesia due to medical conditions and recommended treatment at the local hospital. This indicated the Dental Department had a tracking system that demonstrated the ability to identify missed appointments and reschedule them until the follow-up was completed. The Dental Department was also able to track refusals and other missed appointments by residences. This allowed the Dental Department to focus on the	

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		residences with the highest rate of missed appointments. <u>Interventions to Minimize the Use of Sedating Medications and/or Restraints</u> Information was submitted concerning use of restraints for dental procedures. The total number of appointments completed in this time period was slightly different from the number identified in prior paragraphs. The variation was small, but indicated the need for constant monitoring of accurate and complete database management. For the prior six months, the dental office used mechanical restraints for seven appointments out of 1534 completed appointments (0.45%), from July through December 2011. It was noted that no mechanical restraint was used in November or December 2011. For oral sedation, from July through December 2011, according to the data provided, 1534 appointments were kept. Of these, there were 16 appointments out of 1534 completed appointments in which oral sedation was given (1%), and 18 (1.2%) for which general anesthesia/IV sedation was administered. The Dental Department compared dental restraint use for the years 2010 and 2011. In 2010, 7% of appointments used restraint/anesthesia/sedation. In 2011, this figure was 4.6%. Separately, the HRC met two to three times each month to review and approve dental, medical, and behavioral restraints and restrictions. A medical/dental sedation plan was completed by the team, including the rationale for the request, the procedures for which the sedation was indicated, the strategies to be utilized prior to the use of sedation (such as informal counseling with the person, sending familiar staff, sending a favorite object or possession, etc.), which the PCP signed and dated, and the HRC chair signed and dated. The Dental Department submitted a copy of the "Restraint and sedation log by person" for each individual. This chronologically listed the medication given, the effectiveness, the reason for the medication, and the procedure for which it was intended. The Dental Department appeared to be able to track effectiveness of sedation, and had the knowledgebase to increase sedation to improve effectiveness, or to reduce sedation if there was excessive drowsiness, the individual was less apprehensive over time, or there was an attempt at less restrictive procedures, for example. According to the Self-Assessment, the Dental Department had begun to review reduction of sedation use for dental procedures, especially from a multiple drug regimen to a single dose of medication. A change in multiple drug regimens was being explored. The Dental Director completed training in Level 2 Sedation (Texas Board of Dental Examiners oral sedation rules/regulations describe level 1 and 2 sedation), as well as Advanced Cardiac Life Support (ACLS). The plan was that at ABSSLC, Level 2 sedation would occur only	

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		when a Level 2 permit was issued, along with updates in the consultation form, emergency kit, anesthesia record, and pre and post-sedation instructions. The Facility anticipated starting this Level 2 Sedation in March 2012. Level 1 Sedation remained unchanged, according to the state regulations. With regard to dental desensitization: ▪ Over 100 individuals had been identified as requiring a desensitization or other plan to reduce the need for restraint. Prioritization was assigned, with priority 1 for the most urgent priority, priority 2 less urgent, and priority 3 least urgent. The Dental Department made an initial recommendation. However, the IDT provided the final rating of desensitization priority. ▪ At the time of the review, 36 individuals had desensitization plans developed and implemented, and four were in development phase. From a submitted entitled: "ABSSLC Desensitization Priority List," it appeared most of the individuals with priority 1 determination had a plan in place. ▪ From the Self-Assessment of 2/1/12, the Dental Department noted that not all plans were located in the record. ▪ From the Self-Assessment of 2/1/12, data collection and interpretation appeared to remain a challenge. The Director of Psychology and Dental Director met on 1/4/12 to develop a standardized data collection sheet for documentation of progress of dental desensitization. This was not expected to be completed and implemented until April 2012. ▪ As the current desensitization plans required half of the time of a dental hygienist, the limitations on implementation and eventual completion of plans appeared to be the hours assigned by the Dental Department, because no psychology staff were assigned to assist with dental desensitization. It is anticipated that this will slow the implementation process of desensitization plans. <u>Quality Assurance/Improvement Initiatives</u> Both the Dental Department and the QA Department completed active record audits of dental care. The QA Department sampled 10 individuals, stratified to include three individuals seen for annual assessment, three seen for restorative care, two seen for services off campus, and two that underwent pre-treatment sedation/anesthesia. For FY11 Q4, the QA Department monitored 50% of the departmental sample for the months of July and August. The departmental compliance score for this period of time was 76%, and for the QA Department the compliance score was 91%. In FY11 Q3, the departmental compliance score was 79%, indicating a 3% drop in compliance in FY11 Q4. In FY 11 Q3, the QA Department compliance score was 83%, indicating an 8% improvement in FY 11 Q4. The indicators used in evaluation were not weighted, and	

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		inter-rater reliability was not determined. However, the current scores, along with opposite trends indicated considerable disagreement in interpreting the information. The Self-Assessment indicated that on 1/5/11, a meeting was held between the QA Program Compliance Monitor, and the staff dentist to address the discrepancies. The difference in scoring might have been due to the difficulty in finding the information to correctly answer the monitoring tool clinical indicators. For FY12 Q1, data was assessed for all three months (September through November). From the QA compliance scores, there was improvement each month (September 76%, October 82%, and November 95%). The average for the three months was 84%, which was overall a drop of 7% from the QA score of the prior quarter. The departmental overall scores for FY12 Q1 was 85%, indicating a 6% improvement. The scores between the QA Department and Dental Department were close for this quarter. However, as the Monitoring Team has cautioned in the past, overall scores provide little valuable information within this context. Even the focus on inter-rater reliability should revolve around the scoring of each individual indicator. This is necessary to ensure that the Dental and QA Departments are consistently scoring each question on the tools. In addition, the Facility needed to determine areas of dental services considered essential and non-essential. Compliance thresholds for the essential components also should be determined, similar to the thresholds used by the Medical Department in determining compliance of essential and non-essential areas. The Facility determined that a threshold of 70% met compliance as an internal goal. This was a low threshold. However, at this level, several indicators scored below the low threshold of 70%. These are numbered according to the corresponding indicator listed in the "Settlement Agreement Section: for use with dental monitoring tool rev 12/2/2011," and included the following: 1. Upon admission, a comprehensive dental exam was completed within 30 days of admission. 2. The comprehensive admission exam included a description of the individual's level of cooperation. 6. Preventative care was provided, including but not limited to cleaning, root planning, sealant, and fluoride application. 11. If the missed appointment was due to dental clinic issues (sick call-ins, scheduling issues, etc.). 13. If the appointment was refused, there was documentation that the interdisciplinary team reviewed refusals, assessed and developed strategies to overcome individual's refusals to participate in dental appointments. 15. There was documentation if the individual used pre-treatment sedation or restraints. 16. If pre-treatment sedation or restraints were used, there was a desensitization program and/or strategies to reduce the need for the use of these. 17. There was documentation that the desensitization plans and/or strategies to reduce the need for the use of pre-treatment sedation and/or restraints were being implemented. Some of these areas of concern, such as indicator #1, had been corrected. For many, there was no action plan with	

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		corresponding data collection to determine trends of improvement or not. The QA and Dental Department, according to the PCM, had "significant disagreements" with findings and interpretations related to the following indicators, again numbered according to the Dental Department monitoring tool revised 12/2/2011: 3. The annual date of dental examination was within 365 days of admission and/or the last dental examination. 5. Documentation of routine dental services, including but not limited to review of individual's medications, description of any treatment provided, the use and effectiveness of pre-treatment sedation, and the use of manual or physical restraints. 6. Preventative care was provided, and included but was not limited to cleaning, root planning, sealant, and fluoride application. 7. Oral hygiene instruction was provided to the individual, if appropriate, or to staff accompanying the individual. 8. Restorative care was provided including permanent or temporary restorations (fillings). 10. The individual attended all scheduled dental appointments. 11. A missed appointment was due to dental clinic issues (sick call-ins, scheduling issues, etc.). 12. The individual did not refuse to attend dental appointments. 15. A determination of whether the individual used pre-treatment sedation or restraints. 16. If pre-treatment sedation or restraints were used, documentation that there was a desensitization program and/or strategies to reduce the need for the use of these. 17. There was documentation that the desensitization plan and/or strategies to reduce the need for the use of pre-sedation and/or restraints were being implemented. 18. If the individual was at risk for choking/aspiration, documentation of a physical nutritional support plan addressing and incorporating safe positioning for dental procedures. Steps had been taken by the Dental Department to address these discrepancies. The Dental Department believed some of the discrepancies in the scoring between the departments were due to the lack of information available to the QA department about where to locate the required documentation in the active record. However, this did not appear to address all areas of concern, and the two departments are encouraged to have routine meetings to discuss areas that remain with widely different scores. Ultimately, an external scoring audit, such as by the QA Department, would have more objective interpretation of findings than a departmental self-assessment. Based on the Monitoring Team's review, the Facility remained out of compliance with this provision. A number of concerns were noted, including the thoroughness and understandability of some of the components of the annual dental summary; although some desensitization plans had been developed, implementation was slow, and data had not been consistently collected or analyzed; and a number of individuals requiring desensitization plans or other plans to reduce the need for sedation did not have them.	

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

1. If the dental chart/diagram of the teeth is not used, it should be marked appropriately in order not to confuse members of the IDT. (Section Q.1)
2. For those individuals without teeth, the Dental Department should review and document information for each individual concerning whether they have dentures, dental implants, or other dental options, and if not, whether it was offered, and the reason for not having dentures or other dental option. (Section Q.1)
3. All important information should be located on the IPN/DPN, such as the chemical sedation medication used, including dosage and route. (Section Q.1)
4. When oral sedation occurs, the IPNs should not only provide vital signs recorded in the dental office, but also indicate the time of the vital signs, i.e., whether they occur before or after the oral procedure. (Section Q.1)
5. The Dental Department should review the dental emergency log to ensure completeness of all required entries. (Section Q.1)
6. The annual dental summaries should be reviewed for completeness and accuracy. Any categorization or use of symbols should have an interpretation key for the IDT. For those individuals with a desensitization program, a comment about progress should be included on this summary sheet for the IDT. (Section Q.2)
7. Facility compliance scores for dental internal audits similar to the scores and prioritization used in the medical audits are recommended (i.e., essential and non-essential). (Section Q.2 and Facility Self-Assessment)
8. The Dental Department should create quarterly dental reports based on the many databases used in the Dental Department, along with cumulative trend reports of serial quarters. This should be followed by analysis and improvement plans based on information gained from the analyses. These should be shared at formal Dental Department meetings, morning medical meetings, and with Facility Administration at the QA/QI Council. (Facility Self-Assessment and Sections Q.1, Q.2)

SECTION R: Communication	
Each Facility shall provide adequate and timely speech and communication therapy services, consistent with current, generally accepted professional standards of care, to individuals who require such services, as set forth below:	**Steps Taken to Assess Compliance:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o Presentation Book for Section R; o ABSSLC Presentations for 2/13/12 for Section R; o The following documents: Speech Language Pathology assessment, SLP progress notes for the past six months, supporting documentation for implementation of direct SLP communication programs, ISP and ISPAs for past year, Positive Behavior Support Plan, SLP consultations for the last year, competency-based training for staff, individual-specific monitoring for the past three months, and individual-specific monitoring for past three months for communication equipment for the following 23 individuals: Individual #280, Individual #92, Individual #450, Individual #83, Individual #409, Individual #27, Individual #138, Individual #505, Individual #154, Individual #274, Individual #110, Individual #313, Individual #87, Individual #43, Individual #293, Individual #81, Individual #382, Individual #276, Individual #3, Individual #461, Individual #464, Individual #227, and Individual #455; o Master Plan - SLP Evaluation Tracking, undated; o List of Continuing Education Courses and corresponding Certificates of Attendance, various dates; o List of SLP Staff and corresponding home responsibilities, undated; o Speech Alternative or Augmentative Communication (AAC) and Electronic Aides for Daily Living (EADL) Equipment Spreadsheet and Monitoring List, 1/12; o Tracking Log of Completed Assessments, from 8/11 through 12/11; o PNMP Monitoring Form - Routine (template), dated 12/8/11; o Settlement Agreement Cross Referenced with ICF/MR Standards - Section R (template), revised 12/10; o Competency-based Performance Check-off Sheets related to SLP (templates) implemented since last on-site review, undated; o Analysis of Self-monitoring results for Section R, dated 1/20/11; o AAC-related Spreadsheets, dated 1/12; o List of Individuals receiving Direct Speech Therapy, undated; o Focus of Intervention/Service Plan Revision for Multiple Individuals, from 1/11 through 1/12; o List of Individuals with Behavioral Issues and coexisting Severe Language Deficits and Risk Level/Status for Challenging Behavior, updated 6/11; and o List of Individuals with PBSP's and Replacement Behaviors related to Communication, updated 6/11. ▪ **Interviews with**: o Bobbie Holden, Director of Habilitation Therapies; o David Feemster, MA, CCC/SLP; and o Leslie Riggins, BBS, Speech Language Assistant.

	▪ **Observations of**: o Observations in Infirmary and residences, including dining rooms in 6480, 5961, 5962, 6521, 5971, and 5972.
	Facility Self-Assessment: The Facility submitted three documents, including: ABSSLC Self-Assessment, Action Plans for Section R.4, and Provision Action Information. The ABSSLC Self-Assessment listed the steps the Facility completed to conduct the self-assessment, and the subsequent results. The Action Plans documented the status of action steps that had been completed, were in process, and/or had not been started. The Facility had not developed action plans for Sections R.1 through R.3. The ABSSLC Provision Action Information listed actions completed since the Monitoring Team's previous visit. In comparison with the previous Plan of Implementation, these three documents provided a more focused presentation of what had been accomplished, and future plans for moving forward in meeting the requirements of the Settlement Agreement. Based on interview with the HT Director, Section R monitoring tools had been completed, but the resulting data were not discussed in the three documents presented. The QA/QI Data Summary for Section R stated: "for the 1st quarter of Fiscal year 2012 (September, October, November), the QA monitoring compliance score was 95%. The departments overall compliance score for the same period was 94%. The indicators are not weighted. Inter-rater reliability scores are not available at this time." These cumulative compliance scores did not provide sufficient information and/or data to analyze the Facility's progress with compliance for individual indicators. Individual-specific compliance scores for each indicator will be required for the Facility to accurately interpret and analyze their progress. The Facility should develop a unified system to present data from the monitoring tools in a meaningful way to enable the results to be easily analyzed and trends identified. The presentation of data should include the total population being reviewed (N), and the sample of the population (n) to produce a percent sample to indicate the relevance of compliance scores. In comparison with previous Action Plans, the Action Plan presented provided more information on action steps completed and future action plan steps for Section R.4. However, there were no future action plans presented for Section R.1 through R.3 to address strategies to move the Facility forward in achieving compliance within these sections. In addition, the Presentation Book for Section R should include supporting documentation to validate the results of the Self-Assessment activities and completed Action Steps.
	Summary of Monitor's Assessment: At the time of the review, the Facility had a total of three full-time SLPs and two SLP vacancies. In addition, there was one full-time SLP Assistant. One of the SLP vacancies was the result of a Facility SLP accepting the full-time dedicated PNMT Coordinator position. Based on interview, a SLP was to begin employment on March 1, 2012. On a positive note, a full-time Audiologist began employment in February 2012 and was currently in orientation. In November 2011, the HT Director and the SLPs worked with a State SLP consultant. The State SLP consultant provided consultation to the SLPs on competency-based training, use of the State speech language assessment template, rolling assessments, AAC resources, discussion of completing 276 speech

	assessments within the next year, auditing of completed assessments, and equipment monitoring. These topics were relevant and addressed areas of non-compliance. The SLPs initiated the process of reassessing 276 individuals living at ABSSLC using the State-established SLP assessment template. At the time of the review, the SLPs had reassessed 11 of the 276 individuals (4%). Based on interview, a total of 152 ABSSLC individuals had been assessed since the beginning of the Settlement Agreement and would not be reassessed. However, the Facility should not to assume the SLP assessments for these individuals were adequate. Based on the Monitoring Team's previous reviews, the SLP assessments reviewed were not adequate, and often did not include assessment of an individual's AAC needs. Individuals receiving direct speech therapy did not have adequate plans. In addition, the plans were not integrated into their ISPs. In January 2012, the SLPs had developed communication core competencies. A competency check-off on general communication required staff demonstration for parallel talk; basic use of a communication book and when it should be accessible to an individual; how to plug in, use, and troubleshoot an electronic device; how to attach switches to an adapted device; and how to change batteries in adapted radios and other devices. There was a single check box for demonstration of these skills. These skills would require multiple steps to demonstrate staff competency. The competency check sheet needed revision to further expand and list the individual steps that should be demonstrated to successfully master the skill. In the Facility's Self-Assessment, the Facility noted the inadequacy of the current communication monitoring tool. The Monitoring Team agreed that the current communication equipment monitoring systems was inadequate. On a positive note, the HT Department decided to eliminate multiple monitoring tools, and had initiated the process of transitioning to the use of a universal monitoring tool. A new Compliance Monitoring form was to replace the Speech Alternative Augmentative Communication and Electronic Aids to Daily Living Equipment Spreadsheet and Monitoring List. Therapists had recently implemented the Compliance Monitoring form.

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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	The Monitoring Team's samples for Section R were as follows: ▪ Sample R.1 – 18 of 72 individuals (25%) who had AAC systems including: Individual #280, Individual #92, Individual #450, Individual #83, Individual #409, Individual #27, Individual #138, Individual #505, Individual #154, Individual #274, Individual #110, Individual #382, Individual #276, Individual #3, Individual #461, Individual #464, Individual #227, and Individual #455; ▪ Sample R.2 – three of three individuals (100%) newly admitted to ABSSLC, including: Individual #137, Individual #197, and Individual #142; ▪ Sample R.3 – 18 of individuals of 237 (8%) with Positive Behavior Support Plans	Noncompliance

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>augmentative and alternative communication, to conduct assessments, develop and implement programs, provide staff training, and monitor the implementation of programs.</td><td>with co-existing severe language deficits/replacement behaviors related to communication and risk level for challenging behavior, including: Individual #280, Individual #450, Individual #83, Individual #505, Individual #154, Individual #274, Individual #313, Individual #87, Individual #43, Individual #293, Individual #81, Individual #382, Individual #276, Individual #3, Individual #461, Individual #464, Individual #227 and Individual #455;
▪ Sample R.4 – 23 of the total census of 428 individuals (5%), including: Individual #280, Individual #92, Individual #450, Individual #83, Individual #409, Individual #27, Individual #138, Individual #505, Individual #154, Individual #274, Individual #110, Individual #313, Individual #87, Individual #43, Individual #293, Individual #81, Individual #382, Individual #276, Individual #3, Individual #461, Individual #464, Individual #227, and Individual #455; and
▪ Sample R.5 – seven of nine individuals (78%) who received direct speech therapy including: Individual #280, Individual #92, Individual #450, Individual #83, Individual #274, Individual #455, and Individual #409.

<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>
<u>Staffing</u>
At the time of the review, the Facility had a total of three full-time SLPs and two SLP vacancies. In addition, there was one full-time SLP Assistant. One of the SLP vacancies was the result of a Facility SLP accepting the full-time dedicated PNMT Coordinator position. The Presentation Book for Section R showed the Facility began advertising for a SLP position on 10/26/11. Based on interview, a SLP was to begin employment on March 1, 2012. The HT Director continued to recruit for the vacant SLP position.

On a positive note, a full-time Audiologist began employment in February 2012 and was currently in orientation.

The current census at ABSSLC was 428 individuals. The documentation provided related to SLPs caseloads showed the total number of individuals as 432 individuals, which exceeded the Facility census by four individuals. Based on the documentation provided, the following chart illustrates the caseloads of SLPs:

<table>
<tr><th>Speech Language Pathologists</th><th>Current Caseloads</th></tr>
<tr><td>SLP #1</td><td>Supported 151 individuals in residences 6330, 6370, 6450, 6350, 6360, 6521, and 5971</td></tr>
<tr><td>SLP #2</td><td>Supported 138 individuals in residences 5400, 6730,</td></tr>
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	6740, 6500, 6510, 5962, and 6720
SLP #3	Supported 143 individuals in residences 6480, 5972, 6390, 6750, 6760, 5961, 6690, and 6710
SLP #4	To begin employment 3/1/12
SLP #5	HT Director continued to recruit for this vacancy.

<u>Continuing Education</u>

- Three of three SLPs and the SL Assistant (100%) attended Issues in Evaluation and Treatment of Individuals with Developmental Disabilities/Texas Annual Habilitation Therapy Conference. Multiple continuing education courses were presented during the annual HT Conference. The HT Conference agenda and verification of continuing education units was submitted.
- Two of the three SLPs (67%) completed "Positioning the Client to Optimize Access," an AbleNet webinar one-hour course. The course description and certificates of attendance was submitted.
- The three SLPs and SL Assistant continuing education included the completion of 12 hours of ABSSLC Habilitation Therapies In-Service Training. No documentation (i.e., agenda, curriculum, handouts) was submitted to identify the content of the 12 hours of in-service training.
- One of the three SLPs (33%) completed "Jump Start Interactive Communication for AAC Users," an AbleNet webinar one-hour course. A certificate of attendance was submitted.
- Two of the three SLPs (67%) attended "Psychiatric Medication: Overview" by Dr. John Crowley, Psychiatrist. No documentation was submitted to address the content of the in-service.

Documentation of the content of the continuing education classes or in-service training should be submitted for each course, including the agenda, handouts, and proof of attendance, such as a certificate of completion. As noted above, this documentation was not consistently presented. In addition, the SLPs should increase their participation in continuing education for augmentative and alternative communication to enhance their clinical skills.

<u>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.</u>

In November 2011, the HT Director and the SLPs worked with a State SLP consultant. The Monitoring Team requested a copy of the consultant's report. Based on interview, the HT Director was not in receipt of the consultant report from the November visit. As a

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		result, the Monitoring Team requested therapist's notes from the visit. A document entitled: "Meeting with SLPs and Deann [SLP consultant]," dated 11/18/11, was submitted. The State SLP consultant provided consultation to the SLPs on competency-based training, use of the State speech language assessment template, rolling assessments, AAC resources, discussion of completing 276 speech assessments within the next year, auditing of completed assessments, and equipment monitoring. These topics were relevant and addressed areas of non-compliance. The HT Director should incorporate the State SLP consultant's recommendations into related action plans. In addition, the HT Director should continue to use the expertise of the consultant SLP to audit completed SLP assessments, as well as to provide additional consultation to SLPs on the assessment for, and development and implementation of individual-specific AAC systems. The audits of completed SLP assessments should focus on, but not be limited to, the following: ▪ Description of significant health care issues and risk indicators, including discussion of the impact of health care issues and risk indicators on performance, as well as current or future therapy interventions. ▪ Identification of an individual's functional strengths, preferences, and potentials for functional communication; ▪ Discussion of barriers to functional performance; ▪ Completion of clinical assessment within natural environments (i.e., including the community); ▪ Completion of a comprehensive AAC assessment to identify an individual's AAC needs and recommend an appropriate AAC device(s); and ▪ Inclusion of strategies for the use of an individual's AAC system in a variety of environments (i.e., skill acquisition programs, daily schedule, PNMP, etc.). The SLPs initiated the process of reassessing 276 individuals living at ABSSLC using the State-established SLP assessment template. At the time of the review, the SLPs had assessed 11 of the 276 individuals (4%) using the State SLP assessment template. The Facility reported that the remaining 152 ABSSLC individuals had been assessed since the beginning of the Settlement Agreement and would not be re-assessed. The Facility should not to assume the SLP assessments for these individuals were adequate. As discussed in previous reports, the SLP assessments reviewed were not adequate, and often did not include adequate assessment of an individual's AAC needs. The utilization of the State SLP assessment process and the decision to re-assess 276 individuals should assist the Facility in moving towards compliance with Section R. However, the 152 individual's SLP assessments completed prior to the initiation of the new assessment template should be audited to assess their quality and compliance with the Settlement Agreement requirements. The audit results should determine if SLPs should reassess any of these 152 individuals using the new State-established SLP assessment format.	

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		Although the Facility acknowledged that it was in non-compliance within this section, the Facility's HT Department had not developed an action plan for Section R.1. The Facility Self-Assessment results for Section R.1 documented non-compliance "due to one vacancy." It should be noted the achievement of substantial compliance within this section extends well beyond having filled SLP positions. This section also includes SLPs "demonstrating competency in augmentative and alternative communication, to conduct assessments, develop and implement programs, provide staff training and monitor the implementation of programs." The Facility's Self-Assessment indicated that it was not in compliance with this requirement of the Settlement Agreement. Although progress had been made in revising the assessment process and hiring staff, the Facility remained out of compliance with this provision.	
R2	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall develop and implement a screening and assessment process designed to identify individuals who would benefit from the use of alternative or augmentative communication systems, including systems involving behavioral supports or interventions.	<u>All individuals in need of AAC are identified as being in need of AAC.</u> Twenty-three of the 428 individuals' (5%) SLP assessments in Sample R.4 were reviewed. The review found: ▪ Five of the 23 individuals' SLP assessments (22%) were adequate. Individual #81, Individual #43, Individual #87, Individual #313, and Individual #280 were part of the universe of 276 individuals that were identified for reassessment. Their SLP assessments had been completed using the State-established assessment format. Eighteen of the 23 individual's SLP assessments were not adequate. Their assessments did not follow the State-established assessment format or adequately assess an individual's strengths, preferences, and potentials for a functional AAC system(s). The Facility Self-Assessment results indicated that SLP assessments did not adequately provide an adequate assessment of AAC systems, include adequate risk assessments, or provide a description of collaboration with psychologists. The Monitoring Team concurs with the self-assessment results. However, it was positive to note that at least the initial implementation of the new template and process resulted in adequate assessments of individuals, including their need for alterative or augmentative communication. The Facility is encouraged to continue implementing this process. <u>All people have received a communication screening or assessment within 30 days of admission, readmission or change in status.</u> Since the Monitoring Team's last onsite review, three individuals in Sample R.2 had been admitted to ABSSLC. A review of their SLP assessments found: ▪ Three of the three newly admitted individuals (100%) had received a SLP assessment within 30 days of admission.	Noncompliance

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		▪ None of the three individuals' SLP assessments (0%) were adequate. The assessments did not follow the new State-established assessment template, and had not adequately assessed an individual's AAC needs. ▪ None of the three individuals (0%) had received an adequate SLP assessment to assess significant medical issues and health risk indicators, as they related to the SLP-related risk areas, in a clinically justified manner. Within 30 days of admission, IDT members were responsible for completing a risk assessment to determine areas of risk. The SLP assessment should provide an assessment of risk factors following the content of the SLP risk level guidelines. The SLP assessment information should assist the IDT in the completion of an individual's Integrated Risk Rating Form, and the development of the Risk Action Plan(s). Since the Monitoring Team's last review, the Master Speech Plan's priority levels had been revised: ▪ Priority 1 - Individuals with high risk behaviors who are non-verbal; ▪ Priority 2 - Individuals with high risk behavior who are verbal; and ▪ Priority 3 – Everyone else. In addition, individuals who were newly admitted or experienced a change in status would be assessed immediately. Rolling assessments (i.e., previously called updates) would occur annually for school-aged individuals, individuals who receive direct therapy, individuals with AAC devices, individuals with input communication devices, individuals who were functionally verbal with clarification devices and individuals with electronic aides for daily living pertaining to communication. Therapists completing the rolling assessment would discuss what had changed for the individual since the previous assessment, and provide updates in the analysis section of the previous SLP assessment. The "rolling assessment" process appeared to be constructive, but had just been initiated. The Monitoring Team will review individuals' rolling assessments during the next review. Based on interview, after the Master Speech Plan revision, the SLPs were charged with assessing 276 individuals using the new State SLP assessment template. The projected timeline for the completion of these assessments was December 31, 2012. As discussed above with regard to Section R.1, an additional 152 individuals might require a SLP re-assessment upon completion of assessment audits. <u>If receiving services, direct or indirect, the individual is provided a comprehensive Speech-Language assessment at a frequency that ensures relevance and appropriateness of goals.</u> A review of seven individuals' records in Sample R.5 who received direct speech therapy	

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		found: ▪ Six of the seven individual's (86%) records documented the timely completion of a SLP assessment. Individual #450's SLP assessment was not completed prior to the ISP. ▪ One of the seven individuals' SLP assessments (14%) was adequate. Individual #280's SLP assessment was adequate. The assessment addressed the content of the SLP revised template. The SLP assessments reviewed did not follow the newly approved State SLP assessment template, and consequently, did not provide a comprehensive SLP assessment to adequately assess individuals' communication needs. <u>Programs, goals and objectives related to the acquisition or improvement of speech or language are written by the SLP.</u> Nine of the 428 individuals (2%) living at ABSSLC received direct speech therapy. A review of seven individuals' records in Sample R.5, who received direct speech therapy, found: ▪ Two of the seven individuals' direct therapy Service Plans (29%) reflected recommendations from the SLP assessment. For Individual #450 and Individual #455, SLP assessments recommendations were reflected in their Service Plans. ▪ Two of seven individuals' Service Plan's goals and objectives (29%) were functional and measurable (i.e., Individual #274 and Individual #83). ▪ Five of seven SLPs (71%) attended the individuals' annual ISP meetings. SLPs did not attend the annual ISP meetings for Individual #409 and Individual #92. ▪ None of the seven individuals' Service Plans (0%) were adequately integrated into the ISP. Individuals' direct therapy plans were not discussed in the ISP and/or the ISP documented the individual received direct therapy, but did not include this in action plans, or result in the identification of appropriate skill acquisition or support objectives to ensure what was being learned in therapy was extended to other aspects of the individuals' lives. For the HT Department to move toward substantial compliance for individuals receiving direct and indirect therapy supports additional work was needed. The HT Department should review and revise the ABSSLC Specific Policy/Procedure for Speech-Language Pathology to further define the expectations for the development and implementation of direct and indirect therapy programs. These protocols should include, at a minimum, the following: ▪ Timeframes for development and implementation of direct and indirect therapy plans; ▪ Format for direct and indirect therapy plans; ▪ Integration of direct and indirect therapy plans into an individual's ISP to support multiple opportunities for the practice of new and learned functional	

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		communication skills; ▪ Embedding skills learned in direct therapy in skill acquisition programs and daily schedules, as appropriate; ▪ Format for monthly progress notes that documents justification for initiation, continuation or discontinuation of direct therapy; ▪ Format for quarterly progress notes for provision of indirect supports; and ▪ Process for implementing change in an individual's direct therapy plan. In addition, the HT Director and SLPs should explore ways to increase the number of individuals who receive direct and indirect speech therapy. For example, only nine of the 72 individuals with prescribed AAC devices (13%) received direct support from a SLP. Of further concern, as documented above, the seven individuals reviewed who received direct speech therapy did not receive adequate supports to enhance their functional communication skills. For example, therapy plan goals/objectives were not functional and measurable, therapists did not document progress, therapy plans were not revised to reflect an individual's progress and/or lack of progress, and direct and indirect plans were not integrated into ISPs. Direct and indirect therapy programs should be audited to confirm compliance with the State and Facility policies. <u>For persons receiving behavioral supports or interventions, the Facility has a screening and assessment designed to identify who would benefit from AAC. Note: this may be included in the PBSP. Communication programs are integrated in the PBSP as indicated.</u> A review of 18 individuals with PBSPs in Sample R.3 found: ▪ None of the 18 individuals with PBSPs (0%) had adequate SLP assessments that included a comprehensive assessment of their potential for an AAC system. The SLP assessment did not provide documentation of the individuals' communication functioning in relationship to a variety of activities and environments in which he/she participated. The SLP assessments did not consistently assess and provide the results of testing with a variety of AAC devices. There was no analysis of an individual's strengths, preferences, and potentials to utilize different types of communication methods. ▪ None of the subset of 13 individuals' with PBSPs and prescribed AAC systems (i.e., Individual #505, Individual #154, Individual #382, Individual #276, Individual #3, Individual #461, Individual #464, Individual #227, Individual #83, Individual #450, Individual #274, Individual #455, and Individual #280) (0%) integrated the use of their prescribed AAC systems within the ISP and/or PBSP. ▪ None of the 18 individuals' PBSPs (0%) documented collaboration between the speech language pathologist and psychologist in the development of the PBSP. A review of individuals in Sample R.3 revealed the following:	

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		▪ Multiple SLP assessments for individuals with PBSPs did not discuss collaboration with a psychologist to integrate communication strategies in the PBSP (e.g., replacement behaviors). ▪ Multiple PBSPs highlighted communication strategies, but no documentation was provided to support collaboration with a SLP. For example, PBSPs did not discuss collaboration with a SLP, and PBSPs were not co-signed by the SLP to document collaboration in the development of the PBSP. The ABSSLC Provision Action Information document stated: "increased communication integration with psychology prior and during evaluation." Evidence of this increased integration was not present in the individuals' PBSPs that were reviewed. The HT Director and SLPs should review the current department guidelines for individuals who have a PBSP to further define how collaboration between SLPs and psychologists will be documented. These guidelines also should discuss how SLPs and psychologist could co-author skill acquisition programs to support utilization of an individual's AAC system. <u>Policy exits that outlines assessment schedule and staff responsibilities.</u> The ABSSLC Specific Policy/Procedure for Speech-Language Pathology will require an update to reflect the revisions to the Master Communication Evaluation Plan. Although the Facility acknowledged it was in non-compliance within this section, the Facility's HT Department had not developed an action plan for Section R.2. The Facility remained out of compliance with this provision. Although the Facility had made some progress with the initial implementation of the new assessment template and development of a schedule to complete assessments, this was in the very early stages of implementation. In addition to needing to ensure that assessments completed prior to the introduction of the new format were adequate, the Facility did not have adequate processes in place for the provision and monitoring of direct and indirect therapy, were not providing such supports to individuals who needed them, and had not adequately integrated speech and behavior supports.	
R3	Commencing within six months of the Effective Date hereof and with full implementation within three years, for all individuals who would benefit from the use of alternative or augmentative communication systems, the Facility shall specify in the ISP how the individual communicates, and develop and	<u>Rationales and descriptions of interventions regarding use and benefit from AAC are clearly integrated into the ISP.</u> A review of 18 individuals' ISPs with prescribed AAC systems in Sample R.1 found: ▪ None of the 18 individuals' AAC systems were integrated in ISP skill acquisition programs. ▪ None of the 18 individuals' ISPs recommended the use of their AAC systems in activities throughout the 24-hour day. <u>AAC devices are portable and functional in a variety of settings.</u>	Noncompliance

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	implement assistive communication interventions that are functional and adaptable to a variety of settings.	A review of 18 individuals' records with prescribed AAC systems found: ▪ None of the 18 individuals' ISPs and/or PNMPs directed staff to ensure individuals' AAC systems traveled with them throughout the day. ▪ None of the 18 individuals' ISPs and/or PNMPs provided staff instructions to support individual's AAC systems being used in multiple natural environments. <u>AAC devices are individualized and meaningful to the individual.</u> A review of 18 individuals' records found: ▪ None of the 18 individuals with AAC devices (0%) had individual-specific communication strategies to provide staff with an understanding of how to engage an individual with their AAC device. ▪ None of the 18 individuals with AAC devices (0%) had staff instructions for AAC device(s) on how to operate (e.g., high tech devices) and maintain AAC devices. Additional work needs to be completed on integrating individuals' AAC systems into ISPs, which would include skill acquisition programs, PNMPs, PBSPs, nursing care plans, daily schedules, etc. Individuals' ISPs and PNMPs should provide strategies for individuals' AAC systems to be available and utilized in multiple environments. The SLPs should develop staff instructions for individuals' AAC systems assist staff in engaging individuals as well as using and maintaining the equipment, if appropriate (e.g., high tech devices). <u>Staff are trained in the use of the AAC device.</u> In January 2012, the SLPs had developed communication core competencies. A competency check-off on general communication required staff demonstration for parallel talk; basic use of a communication book and when it should be accessible to an individual; how to plug in, use, and troubleshoot an electronic device; how to attach switches to an adapted device; and how to change batteries in adapted radios and other devices. There was a single check box for demonstration of these skills. These skills would require multiple steps for staff to demonstrate competency. The competency check sheet needed expansion, including the list the individual steps that should be demonstrated to successfully show mastery of the skill. In addition, a PNMP competency checklist for the communication section of the PNMP, including the use of equipment was developed for use with PNMP Coordinators, Habilitation Techs, and Speech/Audiology Techs. This checklist did a better job of identifying the demonstration steps to be observed for staff competency. However, some steps were confusing. For example, one step stated: "if expressive, check to see if the person see it/touch it (is it positioned correctly?)" It included multiple steps, and it was not clear what was being tested. Based on interview, HT staff (i.e., PNMP Coordinators and Habilitation Techs) had	

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		received training on communication core competencies. It was positive that some core communication competencies had been developed. However, these competency check sheets required additional work to meet the standard for competency-based training. A review of individuals' records with AAC systems found: ▪ None of the 18 individuals' staff (0%) had received individual-specific competency-based training and performance check-offs to test staff competency in engaging an individual in the use of an individual's AAC systems and how to operate/maintain an individual's AAC system, if appropriate. In its Self-Assessment, the Facility cited a composite score for Section R.3, when it stated: "Average compliance for the seven equally weighted R.3. probes for the month of December 2011 was 58.92%." As has been discussed in previous reports, composite scores provide little valuable information to the Facility, and although the Facility indicated that the probes all were equally rated, it was unclear how the Facility came to this decision. On a positive note, the self-assessment identified seven areas that required additional work. The Self-Assessment included the following: "Based on the findings from this self-assessment, this provision is not in compliance as only 58.92 % of the persons sampled had 1) rationale and descriptions integrated in the ISP, 2) a description of how individual communicates in the ISP 3) description of equipment that is meaningful, portable and functional 4) evidence that staff are trained in use, strategies and 5) evidence that devices are integrated in the ISP/PNMP 6) evidence that strategies are implemented and used, and 7) general communication equipment is available." Likely, the overall rate of 58.92% did not apply to each of these separate indicators. However, this list provided the Facility with a number of areas in which improvements needed to be made. An action plan for Section R.3 should be developed to address these seven areas of non-compliance. The Facility's Self-Assessment indicated that it was not in compliance with this requirement of the Settlement Agreement. This was consistent with the Monitoring Team's findings. The Facility had identified a number of areas in which work was needed, which generally were consistent with the findings of the monitoring team as outlined in this section.	
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	<u>Monitoring system is in place that tracks the presence of the ACC; working condition of the AAC; the implementation of the device; and effectiveness of the device.</u> The Facility's Self-Assessment indicated that the current communication monitoring tool was inadequate. The Monitoring Team agreed with this assessment. A new Compliance Monitoring form was to replace the Speech Alternative Augmentative Communication and Electronic Aids to Daily Living Equipment Spreadsheet and Monitoring List.	Noncompliance

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	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.	Therapists recently had implemented the Compliance Monitoring form. A review of monitoring form documentation for the 18 individuals with AAC systems in Sample R.1 found: ▪ Eighteen of the 18 individuals' AAC system(s) (100%) were monitored. On a positive note, the monitoring forms documented follow-up to AAC repairs and/or other concerns. However, the monitoring was not adequate, because individuals' AAC systems were not monitored in a variety of environments. The majority of AAC monitoring occurred in the residences, which did not provide data to document that individual's AAC systems were present and available in multiple natural environments. The monitoring form did not address the working condition of the device, device use/implementation, or effectiveness of the device. <u>Monitoring covers the use of the AAC during all aspects of the person's daily life in and out of the home.</u> Two of the 18 individuals' AAC system(s) (11%) were monitored in different environments. Sixteen of these 18 individual's AAC monitoring occurred in the home environment only. The monitoring schedule for AAC systems should be formalized to ensure monitoring occurs in multiple environments to reinforce individuals' utilization of their devices occurring in a variety of environments. <u>Validation checks are built into the monitoring process and conducted by the plan's author.</u> At this time the HT Department was not conducting validity checks. The Facility's projected action plan steps to address the requirements for Section R.4 included training monitors on the use of the new Compliance Monitoring form, establishing a tracking system for communication equipment, establishing new monitoring frequencies, establishing a system to trend and analyze monitoring results, and creating a validity check system for monitors. These were appropriate steps in addressing some of the requirements for this section of the Settlement Agreement. The Facility's Self-Assessment indicated that it was not in compliance with this requirement of the Settlement Agreement. This was consistent with the Monitoring Team's findings. Although it was positive that a universal monitoring tool was replacing multiple monitoring tools, the Facility had not yet developed and implemented a comprehensive monitoring system that could detect and remediate issues related to individuals' communication supports.	

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

1. SLPs should increase their participation in continuing education for augmentative and alternative communication to enhance their clinical skills. (Section R.1)
2. The HT Director should incorporate the State SLP consultant's recommendations into related action plans. (Section R.1)
3. In addition, the HT Director should continue to use the expertise of the consultant SLP to audit completed SLP assessments, as well as to provide additional consultation to SLPs on the assessment of, and development and implementation of individual-specific AAC systems. (Section R.1)
4. As SLPs continue to assess individuals using the State-established assessment template, the HT Director should initiate audits of the SLP assessments to analyze assessments against the State-established format and guidelines. The audit results should identify areas that continue to need improvement to ensure completed SLP assessments meet the established SLP assessments standard. At a minimum, such audits should be designed to ensure that assessments include:
    a. Description of significant health care issues and risk indicators, including discussion of the impact of health care issues and risk indicators on performance, as well as current or future therapy interventions;
    b. Identification of an individual's functional strengths, preference and potentials for functional communication;
    c. Discussion of the barriers to functional performance;
    d. Completion of clinical assessment within natural environments (i.e., including the community);
    e. Completion of a comprehensive AAC assessment to identify an individual's AAC needs and recommend an appropriate AAC device(s); and
    f. Inclusion of strategies for the use of an individual's AAC system in a variety of environments (i.e., skill acquisition programs, daily schedule, PNMP, etc.). (Sections R.1 and R.2)
5. The HT Director and SLPs should review the current department guidelines for individuals who have a PBSP to further define how collaboration between SLPs and psychologists will be documented. These guidelines should also discuss how SLPs and psychologist would co-author skill acquisition programs to support utilization of an individual's AAC system. (Section R.2)
6. The HT Department should review and revise the ABSSLC Specific Policy/Procedure for Speech-Language Pathology to further define the expectations for the development and implementation of direct and indirect therapy programs. These protocols should include, at a minimum, the following:
    a. Timeframes for development and implementation of direct and indirect therapy plans;
    b. Format for direct and indirect therapy plans;
    c. Integration of direct and indirect therapy plans into an individual's ISP to support multiple opportunities for the practice of new and learned functional communication skills;
    d. Embedding skills learned in direct therapy in skill acquisition programs and daily schedules, as appropriate;
    e. Format for monthly progress notes that documents justification for initiation, continuation or discontinuation of direct therapy;
    f. Format for quarterly progress notes for provision of indirect supports. (Section R.2)
7. The HT Director and SLPs should explore ways to increase the number of individuals who receive direct and indirect speech therapy. (Section R.2)
8. The Speech Department staff should develop individual-specific staff instructions for individuals' AAC systems, which should be present in PNMPs. (Section R.3)
9. The communication core competency check sheets should be expanded, and include the individual steps that should be demonstrated to test that staff have successfully mastered the skill. (Section R.3)
10. The Speech Department staff should provide staff with individual-specific competency-based training and performance check-offs for individuals' AAC systems. (Section R.3).
11. The HT Department should audit equipment-monitoring forms to ensure compliance with established guidelines. (Section R.4)

12. The monitoring schedule for AAC systems should be formalized to ensure monitoring occurs in multiple environments to reinforce individuals' utilization of their devices in a variety of environments. (Section R.4)
13. The Facility should develop a unified system to present data from the monitoring tools in a meaningful way to enable the monitoring results to be easily analyzed and trends identified. The presentation of data should include the total population being reviewed (N), and the sample of the population (n) to produce a percent sample to indicate the relevance of compliance scores. (Facility Self-Assessment)

SECTION S: Habilitation, Training, Education, and Skill Acquisition Programs	
Each facility shall provide habilitation, training, education, and skill acquisition programs consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o Presentation for Section S at the entrance meeting, on 2/13/12; o Section S Presentation Book: Self-Assessment, dated 2/1/12, including ABSSLC Provision Action Information, updated 1/30/12; Plan of Improvement, content updated 8/12/11; Skill Acquisition Training including sample Skill Acquisition Programs and Data Sheets; Sample In-service Training Rosters; Sample Skill Acquisition Training Competency Checklists; Functional Skills Assessment including Functional Skills Assessment Summary template; and Vocational Assessment State Supported Living Center; o Active Treatment/Skill Acquisition Training PowerPoint, dated 12/28/11; o Skill Acquisition Training Monitoring; o Personal Support Plans for: Individual #319, Individual #151, Individual #74, Individual #390, Individual #518, Individual #13, Individual #303, Individual #156, Individual #455, Individual #272, Individual #505, Individual #197, Individual #466, Individual #318, Individual #293, Individual #153, Individual #507, Individual #99, Individual #274, Individual #301, Individual #514, Individual #17, Individual #278, Individual #363, Individual #539, Individual #98, Individual #395, Individual #9, Individual #144, Individual #396, Individual #384, Individual #146, Individual #327, Individual #504, Individual #246, and Individual #11; o Individual Support Plans for: Individual #196, Individual #109 (Draft), Individual #142, and Individual #284; o Texas DADS State Supported Living Centers Procedure – Personal Focus Assessment, Policy #004, dated 9/7/11; o Texas DADS State Supported Living Centers Procedure – Instructions for Preferences and Strengths Inventory (draft), Policy #004, dated 2/2/12; o Personal Focus Assessments for: Individual #151, Individual #74, Individual #534, Individual #518, Individual #390, Individual #303, Individual #272, Individual #196, Individual #466, Individual #318, Individual #293, Individual #153, Individual #109, Individual #363, Individual #9, Individual #396, Individual #146, Individual #327, Individual #504, Individual #284, and Individual #246; o Specific Target Behavior and related Skill Acquisition Program Data sheets (new format) for: Individual #427, Individual #228, Individual #351, Individual #108, Individual #166, Individual #71, Individual #34, Individual #214, and Individual #381; o Training Documentation Reports for: Individual #319, Individual #151, Individual #534, Individual #518, Individual #156, Individual #48, Individual #466, Individual #153, Individual #507, Individual #17, Individual #278, Individual #363, Individual #98, Individual #396, and Individual #504; o List of individuals with visual impairment;

	○ ABSSLC Leadership Council/QA/QI Notes for: 12/12/11, 12/19/11, /1/9/12, 1/18/12, and 2/9/12; ○ Consumer Support Engagement Observation Process and accompanying form; ○ Engagement Monitoring forms completed between 12/1/11 and 1/30/12; ○ Functional Skills Assessments for: Individual #151, Individual #74, Individual #390, Individual #196, Individual #197, Individual #153, Individual #24, Individual #109, Individual #17, Individual #98, Individual #395, Individual #9, Individual #284, Individual #246, and Individual #11; ○ Review of last six months progress in vocational program, dated 2/16/12; ○ List of individuals who had a vocational assessment completed in the past year; ○ Vocational Assessment State Supported Living Center for: Individual #267, Individual #115, Individual #74, Individual #478, Individual #422, Individual #505, Individual #89, Individual #201, Individual #293, Individual #453, Individual #109, Individual #332, Individual #461, Individual #444, Individual #323, Individual #527, Individual #542, Individual #146, Individual #327, and Individual #504; and ○ Vocational Services Case Management list, updated 1/11/12. ▪ **Interviews with**: ○ Candia Hallford, Vocational Services Director, on 2/15/12; and ○ Jeff Branch, Active Treatment Coordinator; Ron Manns, Director of Behavioral Services; Jolene Willis, Assistant Director of Programs; and Kristin Wyrick, QDDP Coordinator, on 2/16/12. ▪ **Observations of**: ○ Residence 5961, Residence 5962, Residence 5971, Residence 5972, Residence 6330, Residence 6350, Residence 6360, Residence 6370, Residence 6390, Residence 6400, Residence 6450, Residence 6480, Residence 6500, Residence 6510, Residence 6521, Residence 6690, Residence 6710, Residence 6720, Residence 6730, Residence 6740, Residence 6750, and Residence 6760; ○ Activity Center 5921, Activity Center 5922, Activity Center 5923, Activity Center 6340, and Activity Center 6700; ○ Senior Center; ○ Workshop 1, Workshop 2, and Workshop 3; ○ 5th Street Diner; ○ Weekly IDT Meeting, Residence 6400, on 2/13/12; and ○ Community Discharge Living Plan Meeting for Individual #539, on 2/16/12.
	Facility Self-Assessment: A review of the Facility's Self-Assessment, dated 2/1/12, 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. The Facility reported a review of sill acquisition programs. However, the sample size was not reported, the monitoring tool was not provided, and there was no evidence of inter-rater reliability. While individual engagement was reported based on 143 observations, no description was provided of the environments in

	which observations took place, or evidence offered of inter-rater reliability. As noted previously, 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 in the Facility's Presentation Book, including documents reviewed and reliability measures assessed, will prove helpful in the future. As described in the Facility's Self-Assessment, the sample size for review of Sections S.2 and S.3 was limited to two sets of annual assessments completed for the Individual Support Plan meeting. The Facility reported that only one of 16 assessments (6%) met the requirements of both Sections S.2 and S.3. This reflected a very limited sample size, with poor outcomes. The tool the Facility used to monitor compliance was not provided. As the Facility continues to roll out new assessment requirements, improvements in these two provisions should occur.
	Summary of Monitor's Assessment: A review of habilitation services offered to the individuals residing at ABSSLC revealed skill acquisition programs that were limited in scope, and often not reflective of needs identified in current assessments. Although a new format for guiding skill acquisition programs had been introduced, many of the concerns raised in the past remained relevant. Learning objectives lacked specificity, teaching strategies were not outlined clearly, consequences applied to effect behavior change were often uniform and not specific to the individual's identified preferences, and there were no plans to ensure the maintenance and generalization of newly learned skills. Opportunities for learning remained infrequent. Engagement levels across the individual residences and activity centers were very low, and the observed activities were limited in scope, were often inappropriate for the age of the individuals served, and were clearly not individualized. Training in integrated, community-based settings was severely limited. Although more comprehensive assessments of functional, and specifically vocational skills had been introduced, the use of these completed assessments to guide individual support planning was not evident. While the State had developed a policy recognizing the importance of understanding the individual's preferences, these assessments were often incomplete. Even when individuals clearly had displayed lack of progress, refusal to participate, or disinterest in an activity, no evidence was present to show that teams were working collaboratively to identify and develop alternative learning opportunities.

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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	A total of 36 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 was a review of the Optimistic Living Vision for the individual, summaries from various disciplines, and finally, plans of action for the upcoming year, including training objectives. A summary of Monitoring Team's findings is provided below: ▪ Thirty-four of 35 plans (97%) included a review of the individual's preferences. (One of the 36 plans reviewed was missing the first page, which included this	Noncompliance

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	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.	information, so it was removed from this portion of the review.) The plans for Individual #390 and Individual #156 were more comprehensive than most plans, and offered a listing of dislikes as well. ▪ Twenty-one of 35 plans (60%) noted the assessments that had been used to guide the PSP discussion. (Again, one of the 36 plans reviewed was missing the first page, which included this information, so it was removed from this portion of the review.) In several other plans, a general statement was provided indicating that: "Assessments reflecting (his/her) strengths, preferences, needs, obstacles, supports, and recommendations were used during the PSP discussion." Without a clear indication of the assessment and its date of completion, it was difficult to determine whether current information was utilized in developing the PSP. ▪ In only one of the 36 plans (3%) was the assessment of adaptive behavior with its date of completion identified (i.e., Individual #156). As the PSP serves as the primary document guiding the habilitation services provided to the individual, it is essential for the team to be aware of the individual's current skills and needs. ▪ Risk assessments were reviewed in 20 of the 36 plans (56%). As level of risk is an important consideration in both program planning and community inclusion, it is advisable to include a thorough review of the individual's current level of risk. ▪ A range of one to 12 training objectives had been identified for each of the 36 individuals. This resulted in an average of 5.94 annual objectives per individual. The concerns noted in the previous report remained relevant: o Objectives often were identified in one to two words resulting in an inadequate identification of the observable and measurable skill the individual was expected to learn. o Of the two school-aged individuals for whom plans were reviewed, one to four training objectives were identified. Given that numerous hours were available outside of the school day for learning to occur, the Facility should provide greater emphasis on habilitation training. o Scheduled training opportunities varied from daily to monthly. In the plans for some individuals (e.g., Individual #156 and Individual #539), the schedule of training was identified as "ongoing." This was not measurable. Individual #146 had two objectives that were limited to 10 days (telephone skill) and 30 days (applying lotion). As noted previously, training opportunities should be scheduled frequently to ensure learning. o The plan for Individual #466 included an objective to attend the activity center, although it had been noted that he refused to attend. Staff should consider alternative training objectives, including participation in different activities, when the individual has clearly indicated his	

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		disinterest in participation. o Only the plan for Individual #504 included an objective in which training in the community was specified. As the Facility had introduced a new format for annual planning, four additional Individual Support Plans were reviewed. Preferences and strengths were identified, personal goals were reviewed, assessment recommendations were discussed, and action plans were outlined. Similar to the PSPs reviewed, none of these plans included an identification of an assessment of adaptive behavior and its date of completion. Risk assessments were noted as completed in all of the plans, but were included in only two of the documents provided to the Monitoring Team. The number of annual training objectives ranged from four to eight, with an average of 6.25. None of the plans included specific training in the community. Prior to the PSP/ISP meeting, the Team was expected to complete the Personal Focus Assessment (PFA) for the individual. Twenty-one PFAs were reviewed following this visit. Of these 21, only 14 (67%) were dated. Without a clear understanding of the relationship between the date of assessment and the PSP/ISP meeting, it was difficult to determine the relevance of the information provided. Ten of these 21 assessments (48%) reflected an incomplete review of the information requested. Specific examples are provided below: ▪ Individual #151: Although it was noted on the cover page that this woman preferred a quiet environment, the information provided under leisure/recreation indicated she had no preference regarding quiet versus loud activities. Other sections, including seasonal preferences and relationships, had not been completed. ▪ Individual #390: All of Section II relating to personal goals was blank. This resulted in no information regarding living environment, work activities, relationships, leisure, and other club/group activities. ▪ Individual #303: Similarly, information was missing in several areas marked "N/A" or not applicable. This included the response to a very important section regarding information people need to know about the individual's communication style. ▪ Individual #196: One question addressed on this form was whether the individual was comfortable. Although a negative response was provided, no further information was included, nor were recommendations offered for how this situation could be improved. ▪ Individual #363: Many of the sections of this individual's assessment noted that she did not respond. Unless others who are familiar with the individual provide input in trying to best identify preferences, the usefulness of this tool with individuals with limited communication skills is compromised. Further,	

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		although concerns were noted regarding rights restrictions, health, nutrition, community outings, and diet, no additional information was provided to clarify or address these reported concerns. The PFAs completed for Individual #534 and Individual #518 reflected more complete discussions regarding the individual's preferences and needs. A summary, although brief in many cases, was provided in 14 of the 21 assessments (67%) reviewed. To ensure the utility of this assessment process, staff should provide the date of completion, a thoughtful discussion of all areas outlined with input from the individual and those who know him/her well, and a summary of priority interests and needs with related action plans identified. As noted in the Personal Focus Assessment policy, dated 9/7/11, the PFA "… is the cornerstone of the facility's person-centered process." As described by the Active Treatment Coordinator, a new format for skill acquisition programs had been introduced in January. Supervisory staff had been trained in the process and copies of the *Murdoch Center Program Library* had been purchased to assist in the development of new programs. A request was made for copies of all the programs developed since the new format was introduced. Fifteen programs across nine individuals were provided. Each program consisted of an outline of the training that included the specific target behavior, general instructions, prerequisites, materials needed, and a task analysis where appropriate. Also provided was a copy of the Skill Acquisition Program Data sheet, including the following information: the named teaching strategy, the instruction, the objective, the setting, mastery criterion, prompting sequence/error correction, and information regarding reinforcement. A review of identified components is provided below: ▪ Where appropriate, a task analysis was provided for all but one program (93%). The task analysis included in the program for Individual #166, who was learning to make a purchase, was unclear, because the individual's behavior was not clearly described (e.g., he could point to or state the cost of the item/the amount of money he had in his wallet). Further, the task of actually making a purchase was not included in the training program. ▪ None of the programs (0%) included a clear behavioral objective that described the conditions under which the behavior was to occur and the criterion used to determine skill mastery. Although mastery criteria were identified on the data sheets, these should be included in the behavioral objective. ▪ Observable behavior was clearly described in the method section of the task analyses in 11 of 15 programs (73%). ▪ Although the general instructions indicated which of three teaching strategies (i.e., backward chain, forward chain, or total task) was to be used, specific guidelines for teaching were not included. In two programs, a backward chain variation was the labeled strategy, but it was unclear what methods the instructor was to employ. As chaining only recently had been introduced in New	

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		Employee Orientation, it is highly recommended that all training programs describe teaching strategies in observable terms. In two other programs, a forward chain was the identified strategy, but neither of the skills represented behavioral chains. In one, Individual #34 was to touch/point to named body parts, in the other, Individual #214 was to respond to tactile stimulation. ▪ The scheduling of training reflected a wide range from a low of once weekly to a high of multiple times daily. The actual number of trials completed in each training session remained unclear. ▪ Nine of the 15 programs (60%) included the application of some presumed positive reinforcer in addition to praise. These included a pat on the back or backrub (not defined and questionable in its appropriateness), the item purchased, a preferred drink, or music. Eight programs (53%) included an instruction to deliver the reinforcer(s) regardless of the level of prompting necessary. Because independent performance of a skill may be compromised without applying reinforcement differentially, inclusion of this criterion in plans should be reviewed. Particular concerns were raised in the table setting program for Individual #427. The reinforcer identified in the program was praise and access to her meal. Given that access to meals should never be applied contingent upon specific behavior, staff should re-write this statement. ▪ Although all of the programs included a section entitled: "Prompting Sequence/Error Correction," it was unclear what exactly was to be done if the individual made an error, because the guidelines were "Most to least – FP>PP>G>V." It was unclear whether the discriminative stimulus was to be repeated, what was to occur for behaviors that could not be physically prompted (e.g., verbal responses), and whether repeated correction trials were to be conducted using increasingly less intrusive prompts. As noted above, it also appeared that reinforcement was to be provided regardless of the level of prompting needed. ▪ None of the programs included plans for ensuring maintenance and generalization of the newly learned skill. For example, although the program designed for Individual #351 indicated he could write his name on cards to his family and Individual #166 could make a purchase at Walmart or the Dollar Store, neither of these programs included plans to ensure that the newly learned skills extended to these activities. Other concerns specific to individual programs included the following: ▪ Individual #214 was identified as someone with a severe visual impairment. The program developed for him referred to his responding to tactile stimulation. Without advanced warning of touch, and depending on the materials used, this could be a very startling and disturbing activity for this individual. It also was concerning that the instructions included the following statement: "Avoid use of	

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		things that may be uncomfortable (sharp objects, extremely hot or cold objects)." Such instruction should not be necessary, and raised questions about why the author of the plan felt it necessary to state this specifically. ▪ Individual #351 and Individual #381 both had programs designed to teach them to make a purchase from a vending machine. The instructions indicated that two staff members would be required to conduct the training. This level of staffing might significantly impede the implementation of this objective. While the new format for skill acquisition programs was being introduced, many programs remained using the older template. Therefore, a total of 83 Training Documentation Reports, representing 15 individuals, were reviewed. A summary of findings is provided below: ▪ Behavioral objectives were not provided in any of the reports (0%). ▪ A task analysis was included in 50 of 83 programs (66%). ▪ Training was scheduled to occur at a minimum of five days per week in 61 of 83 programs (73%). The remaining programs identified the training schedule as one to three times each week. As discussed in previous reports, without clinical justification, these were inadequate training schedules to allow meaningful learning to occur. Of concern, Individual #48 was scheduled to learn to state the rules of responsible behavior each day whenever he stated that he wanted to move to the community. Unless stating the rules was a positive experience for this individual, the requirement to verbally recite the rules in response to his stated preference could serve as a punisher, which obviously would be inappropriate. Another example of the schedule of training being made dependent upon the individual's behavior was evident in the nutrition program for Individual #319. Training was to occur whenever he asked to eat at the diner. As the program required the individual to state better food choices if he were to go to the diner, this program might also prove punishing, because his initial request was not being honored. ▪ As noted in the past, the number of trials to be conducted each day of training was not identified. It appeared from the data that only one trial was expected. This severely limited the time spent teaching new skills. ▪ A reinforcer was identified in all but two programs. However, praise or some other positive social feedback (e.g., a pat, a high five) was the only listed reinforcer in 73 programs (88%). As noted previously, praise does not always function as a reinforcer. As psychology staff continue to conduct structured preference assessments, it will be important that the information gained is disseminated to those who develop skill acquisition programs. ▪ None of the plans (0%) identified consequences for incorrect responding. ▪ Additionally, there were no plans for ensuring the maintenance and generalization of newly learned skills.	

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		In sum, it is important that training guidelines provide clear and comprehensive information that includes a 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. For 65 of the 83 programs, three months of data were reviewed. For the remaining programs, only one to two months of data were provided to the Monitoring Team. Review of this data resulted in the same concerns noted previously, including: ▪ Opportunities for the skill to occur were significantly limited. ▪ Measures were not included to ensure that training programs were implemented with a high degree of integrity. ▪ Materials were not always available for the completion of the training program. For example, Individual #518, Individual #153, and Individual #507 had minimal opportunities to practice their money management or purchasing skills due to the "lack of money." Staff must make every effort to ensure that needed program materials are available. ▪ 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. Individual #466 had a total of six training objectives included in his PSP from 2010. All of these had been initiated at least 23 months earlier. Similarly, Individual #396 had six programs, five of which had been initiated 27 to 47 months earlier than the date of her PSP meeting. While some of these skills might be essential for daily living (e.g., hand washing, slow eating) or to promote greater health and independence (e.g., making a purchase, exercise), the lack of progress suggested a needed revision to the program, including, but not limited to a different activity, a change in the teaching methodology, or the introduction of a more powerful reinforcer. ▪ Several individuals exhibited frequent refusal to participate in a training program, yet this did not appear to trigger a review of the program. Individual #466, noted above, demonstrated refusals in five of his six programs for over 50% of the days that data was recorded. Individual #98 had been working on toileting skills for close to one year, yet he was still on the first step of the program. This was likely, in part, due to his frequent refusal to participate (e.g., over three months, his refusal rate was 63%). Individual #396 had an exercise program that she had refused to participate in for three months. The Facility staff should develop a mechanism that will trigger consultation from all disciplines when continued refusal is observed (e.g., the monthly review process required in Section F.2.d). Psychology staff, in particular, should take the initiative to work with direct support and other active treatment providers	

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		(including vocational service staff) whenever refusal to participate impedes an individual's progress, improved quality of life, and/or greater independence. ▪ There was no evidence of measures collected to ensure inter-observer agreement. When individual behavior is clearly defined, with simultaneous observation and recording by two staff members, consistent performance expectations are better ensured. At the time of the Monitoring Team's review, graphic display of skill acquisition was not evident. Graphic display of skill acquisition measures would help to 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. Included in the Section S Presentation Book was a copy of the PowerPoint presentation provided to staff entitled: "Skill Acquisition Training." While this addressed many important areas relevant to providing instruction, two areas of concern were raised when reviewing this material. First on page 9 of the document under "How do you know it's a reinforcer," the trainer was advised to discuss the difference between bribery and reinforcement. Additional advice was provided in the training outline dated 12/28/11. Specifically, staff were advised to describe bribery as something given prior to the desired behavior, with no plan to fade. Facility staff should refrain from discussing reinforcement in the same context as bribery, because the latter refers to inducing someone to do something illegal, wrong, or against his/her wishes. The goal of training is for staff to understand the benefit of thoughtfully applying reinforcement to effect behavior change. Concurrent discussion of bribery could attach a negative connotation to reinforcement as well. Additionally, on page 29, a listing of different types of prompts included environmental manipulation, verbal, gestural, modeling, and physical prompts. Later in the presentation, on page 75, the types of prompts found on data sheets did not match this list. This inconsistency was not addressed in the training outline dated 12/28/11. It should be noted that the introductory material included in the training dated 12/28/11 provided appropriate information related to increasing staff members' understanding and appreciation of the importance of active treatment. In-service training is a good foundation for understanding terms and teaching strategies. However, to ensure that competent staff implement skill acquisition programs, it will be important for the Facility to implement checks of treatment integrity. The Skill Acquisition Training Monitoring tool was a first step in ensuring that instruction was provided as written in each program. This tool consisted of staff interview, observation of a teaching interaction, and review of program data. At the time of the visit, monitoring of skill acquisition training had not been introduced.	

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		Ninety-one of the 428 individuals residing at ABSSLC (21%) were identified with severe visual impairment. As noted in previous reports, the Facility should 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 was taken to address the needs of individuals who experience 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. <u>Engagement Measures</u> 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 the residences, activity centers, Senior Center, and workshop areas. The following summarizes the results: ▪ Thirty-eight PLACHECKS were collected in the residences. The percentage of individuals actively engaged ranged from 0% to 100%, with a mean of 27.8% engagement. ▪ Seventeen PLACHECKS were collected across the activity centers. The range of engagement was 0% to 100%, with a mean of 35.2% engagement. ▪ Only one PLACHECK was conducted in the Senior Center. Sixty-seven percent of the individuals present were engaged. ▪ In the workshop areas, 12 PLACHECKS were collected. As has been reported repeatedly, the workshop areas reflected the highest levels of active engagement, with a range of 0% to 100%, and a mean of 84% engagement. The concerns noted in previous reports remained relevant. Individuals were frequently observed without materials that offered varied and age-appropriate activities. Staff 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 1:15). The following provides some examples of observations made during the visit: ▪ Prior to an evening meal, two individuals were observed yelling at another individual who was crying. One of these same individuals then yelled at a second individual, who was refusing to leave her room to get her medication. Another individual sat down at the designated seat of a peer, and began consuming the peer's meal. ▪ In one residence, 20 individuals were seated in the living room and oriented towards a woman who was playing the guitar and singing children's songs.	

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		While this entertainment might have been pleasurable for some or many of the individuals, children's songs were not age-appropriate for this group of adults. ▪ Upon entering another residence, six individuals were observed situated around a television monitor as two staff members played a Wii game. ▪ A visit to one residence revealed two individuals seated on a couch with their 1:1 staff members. There was no social interaction observed during this visit. ▪ Upon entering one residence just before noon, 12 of 13 individuals were not engaged in any activity as they sat on the couches and floor in the living room. Clothes were piled on the floor near the door. ▪ In this same residence, a recreation therapist was observed reading a children's book to one of the individuals. While this individualized attention and activity might have been positive for the individual, staff should make every effort to use age-appropriate materials to help foster respect for the adults with whom they are working. ▪ In two different residences, staff members were observed helping individuals place calls to family members. These interactions were very supportive and positive. ▪ In three different residences, individuals were observed either helping to set the table or clean up after dinner. This was an appropriate activity that could probably occur in many other environments. Engagement remained very limited in the activity centers. Additionally, these centers appeared to be under-utilized, because often no individuals were present when visits occurred. Specific observations are provided below: ▪ A visit to center 5921 revealed a staff member making a statue as four individuals sat around her. They were not engaged in any activity, nor was there any social interaction between the staff member and the individuals served. ▪ In one room of center 5922, eight individuals were present with three staff members. Two of the individuals were lying on the floor, one individual was sucking on a washcloth, and none of the individuals were engaged. Two staff members were talking with each other about taxes as one repeatedly threw and caught a football, and the third staff member was working on a puzzle. ▪ A visit to the Senior Center revealed an environment with competing loud sounds, because both the television and the radio were on. ▪ While visiting center 6700, several individuals were being assisted as they cut fleece fabric to make pillows. One individual was seated off to the side, looking at a magazine. This represented an attempt to keep the individuals served engaged in more interesting and appropriate activities. ▪ A visit to center 5723 revealed five of six individuals engaged in following a dance program that was playing on the television monitor. The music was appropriate for their ages, and the individuals appeared to be enjoying	

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		themselves. As noted previously, engagement was consistently better in the workshop areas. The work remained limited to sorting, folding, or stacking laundry, or shredding paper. However, the Vocational Services Director reported two new contracts, one from a local cable company and one from a national tire company. Further, one individual was providing materials to staff during New Employee Pre-service Training. During the last visit, the Monitoring Team was informed of a pilot project that had just been introduced. Specifically, vocational services had agreed to change the hours of operation of one workshop to accommodate individuals from one home. These individuals were given the opportunity to work late afternoon and evening hours. The results for several of these individuals were very positive, because they continued to benefit from gainful employment. One promising plan for the future was the designation of one position within the department dedicated to job exploration and situational assessment. Since the Monitoring Team's last visit, the Facility's monitoring tool used to assess engagement had been revised. The Consumer Support Engagement Observation Process was described, and samples of completed forms were provided. Guidelines indicated that the staff member completing the assessment should identify a specific individual and up to four additional individuals situated nearby. Each individual was to be observed for five seconds, following which engagement was recorded (Yes/No). Observations of each individual were to be completed three times unless a person exited the environment. As the Active Treatment Coordinator reported, four Program Compliance Monitors from the Quality Assurance Department were collecting engagement measures. A total of 85 Engagement Monitoring forms completed between 12/1/11 and 1/30/12 were reviewed. These documents reflected consistent completion of engagement ratings. However, the information provided in the "Notes" section varied across observers. As the Facility continues to implement this review of engagement, staff should conduct ongoing training and opportunities for inter-observer agreement to ensure that measures are consistent and reliable across observers. Additionally, it would prove helpful to staff responsible for engaging individuals, if recommendations for improving engagement were included in the feedback.	
S2	Within two years of the Effective Date hereof, each Facility shall conduct annual assessments of individuals' preferences, strengths, skills, needs, and barriers to community integration, in the areas of living, working, and engaging in leisure activities.	As noted in the Monitoring Team's last report, 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 completed Functional Skills Assessment was reviewed for 15 individuals. The Monitoring Team had requested an additional three assessments (for Individual #105, Individual #94, and Individual #245), but the Facility	Noncompliance

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		indicated that "No information" was available. Eleven of the 15 assessments (73%) included the date of completion. While all relevant sections had been completed for all 15 individuals, a summary of the person's strengths and needs was provided in only eight of these assessments (53%). In no case (0%), was the summary complete. Specific information is provided below: ▪ Individual #74: Strengths were noted with one word in three of 13 sections, and needs were briefly noted in nine of 13 sections. ▪ Individual #197: Strengths were noted in 12 of 13 applicable sections (i.e., this person does not use adaptive equipment). Needs were noted in seven of 13 sections. However, inconsistencies were found in the information provided. For example, while the individual reportedly enjoys participating in a variety of activities, she was also noted to refuse to get out of bed and chose to sleep during her leisure time. ▪ Individual #153: Strengths were briefly noted in seven of 13 areas and needs were briefly identified in five of 13 areas. ▪ Individual #109: A more complete review was provided of her strengths in eight of 13 areas and needs in nine of 13 areas. ▪ Individual #9: Strengths and needs were briefly noted in seven of 13 and four of 13 areas, respectively. ▪ Individual #284: There was no review of this individual's strengths. In eight of 13 areas, the phrase "Needs help in this area" was used to note skill deficits. Specific needs were not identified. ▪ Individual #246: The summary of this individual's strengths and needs was fairly comprehensive with limitations possibly resulting from the space allowed. ▪ Individual #11: A summary of the individual's strengths and needs was provided in 11 of 13 areas and nine of 13 areas, respectively. Recommendations for habilitation services were provided in only one of the assessments reviewed (7%). This was limited to a recommendation for Individual #197 to be "…encouraged to attend a day program and outside activities to help her get out of bed and meet new friends, see new places." Assessment of adaptive behavior or functional skills will only be useful if information regarding the individual's strengths and needs is summarized with recommendations for future programming provided. According to the list provided by the Facility, since 9/9/11, the newly introduced Vocational Assessment State Supported Living Center had been completed for 54 individuals. This assessment offered a more comprehensive review of the individual's strengths, preferences, employment history, supports necessary to overcome identified barriers to employment, and plans for the future. A total of 20 vocational assessments were reviewed. In every case, a more complete profile of the individual was provided than had been evident in previous vocational assessments. In all but six of the assessments (70%), comments were included at the end of the document under	

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		vocational exploration. This was an important outcome of the assessment, because it addressed the need for continued efforts to expand the individual's skills and opportunities for meaningful employment. Examples of appropriate plans for the future included the following: ▪ Individual #115: Reported preferences for this individual included assembly jobs or janitorial work. Recommendations were included to address both of these interests. ▪ Individual #422: This individual performed a variety of jobs in several different environments. Recommendations included situational assessment in new jobs as these became available both on and off campus. ▪ Individual #89: The recommendation was for this 75-year-old individual to remain in her current workshop setting due to her clearly stated preference. ▪ Individual #109: There was no recommendation for vocational exploration due to this 78-year-old's stated disinterest in obtaining a job. ▪ Individual #146: As this individual had stated an interest in the food service industry, he was to be offered a tour of the diner on campus to gain a better understanding of what this work entailed. Examples of assessments with no or limited plans for the future included the following: ▪ Individual #267: Due to this individual's long history of work refusal, no recommendations were provided for vocational exploration. Staff should continue to work closely with the individual and members of her team, particularly psychology, to design appropriate supports to increase her motivation to engage in work activities. This was particularly urgent for this individual, because staff reported that movement to the community was contingent, at least in part, on her consistent attendance at work or some other day activity placement. ▪ Individual #332: This individual stated a preference for employment in an office setting, yet her recommended job exploration was to visit different job sites on campus once she was stable. Specific recommendations to explore clerical opportunities would better address her stated preferences. ▪ Individual #461: Although staff reported this individual's preference for work outside of the workshop, no recommendations were included for vocational exploration. Although the majority of the assessments included some statement regarding job exploration, none of them included timelines. Without identified dates of completion, many of these recommended activities might be overlooked or forgotten. As noted above with regard to Section S.1, a new position had been identified to assist with job exploration and situational assessment. This held promise for the future in addressing the recommendations resulting from assessment of the individuals' needs and interests. The task of completing assessments had proven to be very time consuming. During a	

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		discussion with the Vocational Services Director, recommendations were made to prioritize individuals based on their expressed interest in working (e.g., those individuals of retirement age might not be interested in pursuing employment) and their identified risk factors. This should be done cautiously to avoid generalized exclusion of individuals due to age and/or specific risk factors.	
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, 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	Feedback provided in the Monitoring Team's last report is repeated here, because it remains relevant. As noted above with regard to Section S.1 of the Settlement Agreement, the assessment process remained flawed at the time of the visit. Needed assessments often were not identified in the PSP/ISP, full psychological evaluations were quite dated (as discussed with regard to Section K.6), and assessment of adaptive behavior was not included. 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. Actual teaching of skills was not observed during the onsite review of the Facility. Additionally review of skill acquisition data (detailed in Section S.1) reflected inconsistent implementation of training. A review of the activities observed among individuals residing at ABSSLC is 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.	Noncompliance

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		Based upon a review of work assignments, 148 of 428 individuals (35%) residing at ABSSLC were employed. The majority of these individuals (105 or 71%) were not in integrated employment, but were working in one or more of the three workshops. This work consisted primarily of sorting, folding, or bundling different laundry items, or shredding paper. Hours of scheduled work ranged from a low of half an hour per week to a high of 36 hours per week. The average number of scheduled hours of work per week was 19.84. These calculations excluded three individuals whose work hours varied. At the time of the visit, only three community-based work sites were identified. Employment at these Department of Transportation facilities consisted of janitorial work. This reflected no increase in competitive, integrated work options since the Monitoring Team's previous visit. 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. These conditions will severely limit the individuals' ability to integrate within the greater 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.	As noted with regard to Section S.1, a review of annual plans for 40 individuals reflected only one person with a training objective specifically designed to occur in the community. As reported by the Active Treatment Coordinator, training in the community "…was not going well." The Assistant Director of Programs acknowledged the difficulty in providing community training due to transportation and staffing restrictions. Staff should schedule training opportunities whenever individuals travel into the community, and consider use of public transportation, where appropriate. In addition, as noted with regard to Section F, if these are barriers to community integration or training, teams should be identifying them as barriers in individuals' ISPs, and the Facility should take steps to reduce the barriers.	Noncompliance

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

1. As the Personal Support Plan/Individual 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. Assessment of individual risk should be clearly identified and explained in the PSP/ISP. (Section S.1 and S.2).

2. The assessments used to guide the PSP/ISP process should be clearly identified with the date of completion in the individual's annual PSP/ISP. (Section S.1 and S.2).
3. Following completion of the Functional Skills Assessment, summaries of identified strengths and needs should be provided with accompanying recommendations for future programming. The focus should be on developing those identified absent skills that will help the individual become more capable and independent in his/her daily life. (Section S.1 and S.2).
4. 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).
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. Clearly written 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; and
    i. Steps to be taken to ensure maintenance and generalization of newly acquired skills, including data collection. (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. With such ongoing monitoring, program revisions should be 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 of 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. As measures of engagement are collected, the Facility should include steps to ensure inter-observer agreement and ongoing training for all monitors. Specific recommendations regarding steps to improve engagement should be included when giving feedback to direct support professionals. (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. 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).
14. 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 Self-Assessment should include data related to specific indicators of compliance. (Sections S.1, S.2, and S.3).

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	
	Steps Taken to Assess Compliance: The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o DADS Policy Number 018.1, entitled "Most Integrated Setting Practices", dated 3/31/10; o ABSSLC Policy #018.1, entitled "Most Integrated Setting Practices," dated 8/18/11; o Presentation Book for Section T; o List of all individuals referred for community placement, undated; o List of individuals requesting community placement with no recommended movement, undated; o Since the last review, list of all individuals who have not been referred solely due to Legally Authorized Representative (LAR) preference, undated; o List of individuals transferred to community, since 8/22/11; o List of individuals who have had a Community Living Discharge Plan (CLDP) developed since 8/22/11; o In response to request for list of individuals discharged pursuant to an alternate discharge, note stating: "No discharges as defined by DNS and End Respite since last on site review," undated; o List of individuals who have transferred to other SSLCs since the last onsite review, undated; o In response to request for discharge plans for Individual #387, Individual #121, and Individual #160, the response: Discharge Summaries were already provided in the pre-visit request;" o Response to request for list of alleged offenders: "There are no court-ordered offenders at AbSSLC at this time," undated; o Tables listing reasons for individual or LAR reluctance regarding community transition, for August through December 2011; o List of referrals with status, including date of move and any post-move monitoring dates as applicable, undated; 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, and ISP Meeting (Facilitation and Documentation) template, dated 12/3/11; o For the last 12 months, list of individuals who have been assessed for placement, date of assessment, and resulting recommendations, undated; o In response to request for list of all deaths if any that occurred following transition to the community: "No deaths following community placement since the last review"; o Community Placement Report, dated 1/12/12; o In response to the following request: "For the last one year period, a list of individuals who have transitioned to the community indicating whether or not since their transition, they

	have: 1) had police contact, and if so the reason why, the date, and an indication of whether or not they were arrested or otherwise detained; 2) had a psychiatric hospitalization, including the date on which they were hospitalized and the length of stay; 3) had an ER visit or unexpected medical hospitalization, including the reason; 4) had an unauthorized departure, including the date and length of departure; 5) been transferred to different setting from which he/she originally transitioned, including both addresses and reason for transfer; 6) died, including the date of death and cause; 7) returned to the Facility, including the date of individual's transition to the community, date of return, and reason; and/or 8) been restrained. Please also include a brief description of any action the Facility took with regard to any of these occurrences," the following response: "This information is currently not being tracked. Please refer to Post Move Monitoring tools;" o Texas Money Follows the Person Demonstration (MFPD) Project Agreement of Participation blank form, dated 8/11; o Abilene State Supported Living Center Tour Activity, from 11/15/10 to 11/18/11; o List of Community Living Options Information Process (CLOIP) dates per month in 2011; o Self-Advocacy meeting flier, agenda, and attendance roster, related emails, and evaluation form for meeting on 11/8/11; o Provider Fair flier and attendance roster, for event on 9/23/11; o Examples of fliers distributed at Provider Fair; o MRA meeting in-service materials and sign-in sheets, dated 9/23/11; o Family Association Meeting sign-in sheet, dated 10/1/11; o Supporting Visions Tier 1 and Tier 2 Training Workbook, and training roster; o Annual Report: "Obstacles to Transition Statewide Summary, Fiscal Year 2011, data as of 8/31/11; o Annual Report: Obstacles to Transition Abilene State Supported Living Center, Fiscal Year 2011; o Individual Support Plans (ISPs), Sign-in Sheets, Assessments, Individual Support Plan Addenda, (ISPAs), Personal Focus Assessments (PFAs), and skill acquisition and teaching programs for: Individual #284, Individual #202, Individual #463, Individual #414, Individual #498, Individual #46, Individual #126, Individual #139, Individual #181, Individual #527, and Individual #162; o CLDP, any associated assessments, and most recent ISPs for the following: Individual #504, Individual #532, Individual #149, Individual #188, Individual #398; and Individual #402; o Draft Community Living Discharge Plans for Individual #136, Individual #382, Individual #307, Individual #509, and Individual #107; o State Office review of CLDP for Individual #398; o Since 8/22/11, a list of all post-move monitoring visits including the dates for each of the completed visits and due dates for upcoming visits; o Pre- and Post-Move Monitoring Checklists for the following individuals: Individual #357, Individual #132, Individual #102, Individual #243, Individual #106; Individual #188; Individual #402, Individual #398, Individual #149, Individual #532, Individual #504; and

	○ Last 10 Section T quality assurance monitoring tools the QA Department completed, and last six completed the Admissions/Placement Department completed, various dates. ▪ **Interviews with**: ○ Laura Wilford, Admissions/Placement Coordinator; ○ Kerry Loveland, Post-Move Monitor; ○ Kristin Wyrick, QDDP Coordinator; ○ Pat Smith, Quality Assurance Director; and ○ Debbie Burgett, State Office Continuity Services staff member. ▪ **Observations of**: ○ Community Living Discharge Planning Meeting for Individual #539; and ○ Post-Move Monitoring Visit for Individual #398.
	Facility Self-Assessment: Based on a review of the Facility's Self-Assessment with regard to Section T of the Settlement Agreement, the Facility found that it was in compliance with the following subsections: T.1.c.2, which requires specifying staff responsible and timeframes for completion of action steps in CLDPs; T.1.c.3, which requires teams to review CLDPs with individuals and their LARs; T.1.h, which requires the Facility to provide a Community Placement Report; T.2, related to post-move monitoring; and T.4, related to alternate discharges. Not all of these findings were consistent with the Monitoring Team's findings. Specifically, the Monitoring Team did not find the Facility in compliance with T.2, or T.4 for the reasons discussed in the sections of the report that follow. Since the Monitoring Team's previous review, the Facility had made notable improvement in the justification it offered for its findings. Over as short period of time working with a new format from State Office, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating using the information cited in the section on results. Although a number of concerns continued to exist with the Facility's self-assessment process, over time, this format should be helpful in substantiating the Facility's findings with regard to compliance. The following concerns were noted: ▪ The Facility's Self-Assessment did not consistently define how the samples were selected, or give a sense of whether they were representative samples. Sometimes the latter was provided, for example, when talking about the CLDPs reviewed. ▪ In addition, not all requirements of the Settlement Agreement had been reviewed. More specifically, within a sub-section, the Settlement Agreement might have numerous requirements, but only some were included in the Facility's Self-Assessment (e.g., Section T.1.b.1 or T.2). If the Facility was choosing, for example, to prioritize assessing certain areas before others, that would be acceptable, but it should be stated specifically. ▪ For the various monitoring/audit tools, inter-rater reliability needed to be established with the QA and programmatic staff (e.g., Post-Move Monitor and QDDP Coordinator) responsible for conducting audits. ▪ As discussed during the last review, the need still existed to add or revise the guidelines/instructions for the audit tools. This will be essential to improve the accuracy of the monitoring results (validity), as well as the congruence between various auditors (reliability).

	▪ At times, the Facility Self-Assessment presented the findings as the rate of noncompliance [e.g., "26% of the ISPs conducted had potentially inappropriate obstacles identified"]. At other times, the rate of compliance was cited, making it more difficult to interpret results. The Monitoring Team recommends that the rate of compliance be cited. ▪ The data presented clearly identified areas of need. However, the Facility Self-Assessment did not yet provide any analysis of the information, identifying, for example, potential causes for the issues, or connecting the findings to portions of the Facility's Action Plans to illustrate what actions the Facility had put in place to address the negative findings. Even when a formal corrective action plan had been developed to address Section T.1.g, the Facility's Self-Assessment did not describe these efforts. Overall, the Facility had demonstrated some good use of the data it had collected. It was positive that the QA and Admissions Placement Departments had begun to meet regularly to discuss monitoring efforts and results. Ongoing efforts to ensure the validity and reliability of the data will be important, as will further using the data to identify areas in which focused attention is needed. The Facility's progress in developing a quality assurance process for Section T is discussed in further detail below with regard to Section T.1.f.
	Summary of Monitor's Assessment: Individuals' ISPs 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 ISPs provide a comprehensive description of individuals' preferences and strengths, as well as their needs for protections, supports, and services. At the time of the review, although assessments prepared for annual ISP meetings had begun to include the assessor's recommendation regarding transition to the community, individuals' ISPs 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 presented to the entire team, including the individual and LAR, for consideration. Based on team discussion, including any opposition from the individual or his/her LAR, the entire team then should make a decision regarding any potential referral for community transition. The Facility continued to be at the initial stages of identifying obstacles to movement to the most integrated setting appropriate to the individual's needs and preferences, as well as strategies to overcome such obstacles. However, in a limited manner, the Facility had begun to analyze the aggregated data. Although more work was needed with regard to completing a full analysis, including integration of information the Facility had in relation to the community provider network(s) in the local area, the Facility had begun to use some information from the analysis to improve data integrity. Based on the initial analysis, the Facility had developed and implemented a corrective action plan. This involved some creative training for QDDPs, as well as work with specific teams to reconsider obstacles that did not appear to be appropriate, or were not adequately justified. With regard to the Community Living Discharge Plan process:

	▪ The CLDPs reviewed generally included a number of action steps related to the transition of the individuals to the community. However, many of them did not clearly identify the specific steps that the Facility would take to ensure a smooth and safe transition, and were not sufficiently detailed or measurable. ▪ The CLDPs reviewed included essential and non-essential supports. However, it appeared that the Facility continued to be struggling with this process. Teams did not consistently identify all of the essential and non-essential supports that the individual needed to transition safely to the community. Post-move monitoring had been completed in a timely manner for 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.

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T1	**Planning for Movement, Transition, and Discharge**		
T1a	Subject to the limitations of court-ordered confinements for individuals determined incompetent to stand trial in a criminal court proceeding or unfit to proceed in a juvenile court proceeding, the State shall take action to encourage and assist individuals to move to the most integrated settings consistent with the determinations of professionals that community placement is appropriate, that the transfer is not opposed by the individual or the individual's LAR, that the transfer is consistent with the individual's ISP, and the placement can be reasonably accommodated, taking into account the statutory authority of the State, the resources available	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." 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 ISP. During future reviews, the Monitoring Team will continue to evaluate the State and the Facility's implementation of this policy. With regard to the availability for funding 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	Noncompliance

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	to the State, and the needs of others with developmental disabilities.	timeframe. At the time of the review, a total of 13 individuals had been referred, and three individuals had exceeded the 180-day timeframe. All three individuals had been referred in June or July 2011. One of these individuals was scheduled to move to the community during the week of the Monitoring Team's review. Another two individuals, referred in August 2011, would exceed the 180-day time frame the week of the Monitoring Team's review. One of these individuals was scheduled to transition to the community the week after the Monitoring Team's visit. The Monitoring Team reviewed all of these individuals with the Admissions Placement Coordinator. In all cases, their teams were making efforts to identify an appropriate community home to which they could move, as well as appropriate day/vocational supports. For a variety of reasons, the appropriate services and supports had not yet been identified. For example, for one individual, numerous visits had been set up, and although the visits appeared to go well, the individual stated he did not want to move to any of them. Other individuals had complex medical and/or behavioral needs, and it was taking time for their teams to identify providers who could adequately meet their needs. In some cases, teams' efforts were resulting in seemingly good outcomes. For example, although it had taken longer than 180 days, Individual #504's team had eventually identified a provider able to make significant accommodations to meet her physical and nutritional management needs (e.g., obtaining a heavy duty van to accommodate her wheelchair, installing a sprinkler system in the home to address issues related to timely evacuation in the case of a fire, increased nursing involvement, etc.). As the Monitoring Team has stated in the past, it is of utmost importance that individuals transitioning to the community have the protections, supports, and services they need to lead safe, meaningful, and productive lives. Teams are encouraged to continue to thoughtfully assess the options available to individuals, and assist individuals and their guardians to make informed decisions about the community providers they select. However, as is discussed with regard to Section T.1.g, although obstacles to individuals' transition to community settings had not been fully identified and analyzed on a systemic level, anecdotally, the availability of community providers who could support individuals with complex behavioral and/or medical needs appeared to be an issue. The Monitoring Team agrees wholeheartedly with the teams' decisions not to transition individuals until an appropriate configuration of supports and services was identified. However, this likely is an area in which more systemic attention is needed from DADS State Office. 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, individuals' ISPs generally did not include a summary or conclusion	

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		stating the professional team members' determination with regard to whether or not community placement was appropriate. For only two of the 11 ISPs reviewed (18%) (i.e., Individual #284, and Individual #414), teams had documented a determination of the professionals regarding whether or not transition to the community was recommended. For both of these individuals, teams indicated they could be served in a less restrictive setting, but the guardians and/or individuals disagreed. 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 ISP. 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 processes. Such policies, procedures, and practices shall require that:	As noted in the Monitoring Team's last report, the Facility had a 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. 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.	Noncompliance
	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	As noted above with regard to Section F of the Settlement Agreement, ABSSLC had continued to make efforts to improve ISPs. The ISP 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 IDT, and the supports and services the individual needed in various areas. A review was conducted of a sample of 11 ISPs. These are listed in the documents reviewed section. 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 ISP 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. <u>Identification in ISPs of Needed Protections, Services, and Supports</u> As was discussed with regard to Section F of the Settlement Agreement, individuals' ISPs	Noncompliance

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	annually, and shall identify, and implement, strategies intended to overcome such obstacles.	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, psychology, psychiatry, physical and nutritional management, and communication), services and supports were not being adequately integrated with one another (e.g., psychology and psychiatry, nursing and physical and nutritional supports, 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). As has been reiterated since the baseline review, it is essential, as teams plan for individuals to move to community settings, that ISPs provide a comprehensive description of individuals' preferences and strengths, as well as their needs for protections, supports, and services. This is important for three reasons, including: 1) as individuals and their guardians are considering different options in the community, it is important for them, as well as potential providers, to have a clear idea about what protections, supports, and services the individual needs to ensure that perspective provider agencies are able to support the individual appropriately; 2) given the extensive histories of many individuals served by ABSSLC, it is important to have one document that summarizes the most relevant historical and current information about an individual to ensure that none of the important components of treatment are lost in the transition process; and 3) as the process progresses, the ISP 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 ISP, it is much more difficult to ensure the individual's safe transition. Based on a review of 11 ISPs, 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 ISPs. Previous reports have provided detailed examples of concerns related to ISPs. 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 ISPs and	

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		CLDPs. <u>Identification of and Plans to Overcome Obstacles to Transition to Community</u> As noted above, the ISP format included a section on obstacles identified by the IDT. In addition, the State Office has standardized a list of obstacles/barriers to community transition to assist in the analysis of information collected from IDTs throughout the SSLC system. As part of the Facility's efforts to improve the identification of obstacles, the QA/QI Committee developed a corrective action plan based on a presentation in early December 2011, during which aggregate obstacle data was presented with a brief analysis of the data. Since then, the Admissions Placement Coordinator had taken a couple of important steps. These included: ▪ On 12/16/11, the Admissions Placement Coordinator provided an in-depth training with the QDDPs. It specifically addressed obstacles and action plans to address them, as well as the identification of supports during the Living Options discussion. The training included a component designed to assist the QDDPs to identify current weaknesses in the process. A sample of actual ISPs was selected, and identifying information removed. QDDPs that did not work with the individuals whose plans they were assigned were asked to review the plans. They were asked to identify the necessary supports and services, as well as the obstacles to transition. When looking at ISPs that other QDDPs wrote, it became more apparent how difficult this was given the information currently provided. This was a creative approach to address the issues identified. ▪ In addition, the Admissions Placement Coordinator reviewed a sample of ISPs, specifically with regard to the obstacles to transition to the community the teams had identified. In doing so, she identified 19 individuals for whom it was unclear why a specific obstacle was identified, and/or the team had not provided adequate justification for the obstacle. The Admissions Placement Coordinator sent an email explaining the concerns or questions noted, and asked teams to review the obstacles and revise them, as appropriate. She provided technical assistance to teams as needed or requested. Based on interview with the Admissions Placement Coordinator and review of email correspondence, this had resulted in clarifications, in some cases, regarding the definitions of obstacles, as well as changes in the obstacles listed for individuals in their ISPs. ▪ Training also had been provided to the Psychology and Habilitation Therapy Departments on 12/16/11, and 1/2/12, respectively. Although the steps the Facility had taken should result in improved identification of valid obstacles, these steps had been taken only shortly before the Monitoring Team's onsite	

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		review. As a result, the full impact likely was not seen in the documents the Monitoring Team reviewed. In reviewing the sample of 11 ISPs, some obstacles were identified. Of the 11 ISPs reviewed, 11 should have had obstacles defined, because none of the individuals had been referred for transition to the community. Of the 11 remaining plans, five (45%) (i.e., Individual #284, Individual #463, Individual #414, Individual #498, and Individual #527) included an adequate list of obstacles. Of note, for four of these individuals, guardian reluctance was noted as the only obstacle, and for the remaining individual, the obstacle was lack of availability of specialized medical supports. The problems associated with the obstacles in the remaining plans included the following: ▪ Some did not conform with the State Office's standardized list (e.g., Individual #181, and Individual #139); ▪ Some were not adequately justified (e.g., Individual #46's behavioral/ psychiatric needs best met in Facility); ▪ 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 #139 identified as a brittle diabetic requiring daily nursing care); and ▪ At times, the team did not identify any obstacles existed, but the individual was not referred for transition (e.g., Individual #162 for whom funding was mentioned as a potential issue, but not listed as an obstacle, and Individual #202, for whom other discussion indicated possible obstacles related to lack of medical/PNM supports, but these were not identified formally). When guardians or individuals' reluctance was cited, teams sometimes inquired about the reasons, which was a positive step. However, it was not clear that this was well documented in the obstacles section (e.g., Individual #463, whose guardian identified past bad experiences with community providers, and Individual #284, whose guardian cited lack of adequate medical and behavioral supports in the community). This is very important information to collect and analyze, but it did not appear it was being captured. The Facility is encouraged to assess the impact of the training and technical assistance the Admissions Placement Coordinator and QDDP Coordinator were providing to teams. As necessary, additional training and technical assistance will need to be provided to ensure improvements are made in this area. Similarly, based on the Monitoring Team's review of action plans to overcome the obstacles identified, of the 11 ISPs, two (18%) (i.e., Individual #414 and Individual #181) included an action plan to overcome obstacles identified. However, only one (9%) was adequate. More specifically: ▪ The plan for Individual #414 appeared to be appropriate. The guardian would not consider community transition, but the team believed that if she came to	

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		visit, she would see the progress the individual had made. An action plan was developed to try to make this happen. ▪ The action plan for Individual #181 was generic, and not considered an adequate, individualized action plan. 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. ABSSLC remained at the beginning stages of identifying obstacles to community transition, and developing plans to overcome such obstacles. This deficiency, in addition to ISPs 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.	As described in previous reports, ABSSLC had engaged in a number of activities to provide education about community placements to individuals and their families or guardians to enable them to make informed decisions. Based on documentation provided, this had taken a number of forms, including: ▪ On 11/8/11, the Post Move Monitor had been an invited speaker at the Self-Advocacy meeting. During the meeting, she described referrals, expectations of community living, differences between current placement and community living, and options. ▪ On 9/23/11, a provider fair was held. A questionnaire was developed and distributed to residences to assist individuals and staff in asking pertinent questions when interacting with community provider staff during the fair. Attendance rosters showed that a number of individuals and staff attended, and a few families attended. ▪ 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. When the Admissions Placement Coordinator attended the quarterly meeting of the Local Authorities (LAs), the March 2012 fair was discussed, and their participation was encouraged. ▪ On the same day as the provider fair, LAs also provided training on services and supports available in the community. Families, individuals, and staff were invited. ▪ On 10/1/11, the Admissions Placement Coordinator attended the ABSSLC Family Association Meeting, and presented some information about admissions and community placement. ▪ Visits to community group homes and day programs continued to occur. However, based on documentation provided, these had mot been occurring	Noncompliance

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		twice a month, as they had been in the past. Based on documentation between 8/16/11 to 11/18/11, four such visits occurred. None occurred in April 2011. Approximately 17 individuals from approximately 13 residences participated in the visits. Based on review of individuals' ISPs, 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 increase opportunities for individuals to participate in regular visits to community homes and day programs. ▪ Individuals and their guardians also were provided information through the Local Authority Community Living Options Information Plan (CLOIP) process. This was occurring regularly as part of the individual planning process. ▪ In the last report, the Monitoring Team reported that the Facility had featured articles in 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. Although it been challenging to obtain guardian consent for more articles, one was being developed for the next issue of the newsletter. 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 11 ISPs was reviewed. For eight of these individuals, additional education was indicated. Of the eight plans that identified a need for further education (Individual #181, Individual #139, Individual #126, Individual #498, Individual #414, Individual #463, Individual #202, Individual #527, and Individual #284), none (0%) included an adequate written action plan. Generally, the problems included: ▪ Generally, none of the plans were individualized. For the most part, they indicated that the individual and/or guardian would participate in a tour of community programs. ▪ For Individual #284, the plan included the individual and the family, but the action steps were not measurable. ▪ For Individual #139, the team specifically indicated in the narrative that they did not believe she understood the options, but then no plan to increase her knowledge was developed. ▪ The narrative of one plan mentioned exposing an individual and/or his/her guardian or family further to community options, but no corresponding action plan was found to ensure this occurred (e.g., Individual #527). The Facility is encouraged to continue offering a variety of educational options to	

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		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. 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' ISPs. 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 individuals for placement pursuant to its new or revised policies, procedures, and practices related to transition and discharge processes. Within two years of the Effective Date, each Facility shall assess all remaining individuals for placement pursuant to such policies, procedures, and practices.	The 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 for the last year of individuals who had annual ISP meetings, and the recommendation, if any regarding a move. 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 ISPs, and the most recent version of the ISP Meeting (Facilitation and Documentation) template, dated 12/3/11. As is discussed above with regard to Section T.1.a of the Settlement Agreement, the individuals' ISPs (i.e., Individual #284, Individual #202, Individual #463, Individual #414, Individual #498, Individual #46, Individual #126, Individual #139, Individual #181, Individual #527, and Individual #162) reviewed did not include documentation of 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. At the time of the review, although some of the assessments prepared for annual ISP meetings had begun to include the assessor's recommendation regarding transition to the community, individuals' ISPs generally did not include a summary or	Noncompliance

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		conclusion stating the professional team members' determination with regard to whether or not community placement was appropriate. For only two of the 11 ISPs reviewed (18%) (i.e., Individual #284, and Individual #414), teams had documented a determination of the professionals regarding whether or not transition to the community was recommended. For both of these individuals, teams indicated they could be served in a less restrictive setting, but the guardians and/or individuals disagreed. 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. In other cases, the team either had a disagreement about what to recommend with no resolution (e.g., Individual #498), or had discussions, but did not make a specific recommendation (e.g., Individual #463, Individual #162, and Individual #202 for whom teams did not identify obstacles, but did not make a referral or other recommendation). Finally, in a number of cases, no recommendation independent of the individual or guardian was made (e.g., Individual #527, Individual #181, Individual #139, Individual #46, and Individual #126). In addition, as noted above with regard to Section F.1.e, some confusion also appeared to exist with regard to which assessments needed to include such recommendations. Specifically, it had been interpreted that only clinicians needed to include recommendations in their assessments. The professional team members should include all ABSSLC staff on the team, including, for example, residential and day/vocational staff. Assessments such as vocational assessments, and functional assessments should include such recommendations. During ISP meetings, when the team members' opinions are sought, this also should include all ABSSLC staff on the individual's team (e.g., QDDP, residential staff, day vocational staff, direct support professionals, etc.). It is important to note that for some individuals (i.e., Individual #202, Individual #162, and Individual #498), teams seemed to have limited or differing knowledge about community options available. These teams, or at least some members of these teams, seemed to believe the individuals would do well in community settings "if appropriate supports were available" or if they could be funded appropriately (e.g., Individual #162's team that expressed concerns that: "At this time there doesn't appear to be a community option capable of this at the present without capping out their funds"). These would be examples of individuals for whom teams should consider an exploratory phase prior to making a decision about a referral or no referral. During this time, the team could ensure that it had an exhaustive list of protections, supports, and services the individual required, and use this list to determine which community providers might be able to support the individual. The team could support the individual and his/her guardian to explore these different options to determine if they meet the needs as well as the preferences of the individual. To ensure that this process occurred expeditiously, an action plan should be developed with specific action steps and associated timeframes,	

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		and persons responsible. 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 ISP. 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. Based on the Monitoring Team's findings that this was not consistently occurring, the Facility remained out of compliance with this provision.	
T1c	When the IDT identifies a more integrated community setting to meet an individual's needs and the individual is accepted for, and the individual or LAR agrees to service in, that setting, then the IDT, in coordination with the Mental Retardation Authority ("MRA"), shall develop and implement a community living discharge plan in a timely manner. Such a plan shall:	Since the last review, limited progress had been made with regard to teams' development of CLDPs. The CLDPs continued to need significant improvement. Community Living Discharge Plans were reviewed for four of the nine individuals who had transitioned from the Facility to the community since the Monitoring Team's last onsite review, representing 44% of this group of individuals. The CLDPs reviewed were for Individual #188, Individual #402, Individual #504, and Individual #398. In addition, a member of the Monitoring Team observed a planning meeting related to Individual #539's transition, and reviewed a draft of his CLDP. 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. The Facility also had added a header at the top of the document that listed the dates the team had met to revise the plan. This was a helpful addition. 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.	Noncompliance
	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	The Community Living Discharge Plans reviewed included a number of action steps related to the transition of the individuals to the community. Clearly, the Facility was making efforts to include more specific supports and services. 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:	Noncompliance

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	living discharge plan with provider staff.	▪ Many of the plans identified the need for training for community provider staff. However, they only defined in general terms which community provider staff needed to complete the training (e.g., day and residential staff), as opposed to identifying which provider staff from the various agencies supporting the individual in his/her new setting needed training (e.g., direct support professionals, management staff, clinicians, etc.). Similarly, the CLDPs very seldom identified what level of mastery of the information was required (e.g., demonstration of competence). Although the Facility had done this in a few cases for some very specific supports (e.g., texture of food), it was not done as a matter of course. ▪ 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. ▪ Only one of the three plans (i.e., for Individual #504) included an action step for the current PCP to contact the community PCP to discuss the specifics of the individuals medical needs, and help to ensure continuity of care. This individual had complex needs, and such coordination should have occurred between many clinicians (e.g., nurses, therapists, psychologists, etc.), but the PCP was the only one the CLDP identified. This type of collaboration was missing from the three other plans. For many individuals, this would be necessary to ensure ongoing coordination of care. ▪ Similarly, no coordination was specified as needing to occur between current and future residential or day/vocational staff. ▪ 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). As noted during the post-move monitoring visit that a member of the Monitoring Team attended for Individual #398, such site visits have the potential to greatly assist individuals to experience safe and successful transitions, and avoid unnecessary problems. For example, if a psychologist had visited the day program site for Individual #398 before his transition, changes likely could have been made to his BSP to address issues related to access to his peers and staff's drinks. For this individual, failure to plan for the differences in the environment between ABSSLC, where staff were	

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		not allowed to have drinks on their desk and Individual #398 did not bring his lunch to work, and the new day program, where these were the norm, had the potential to cause serious health problems for this individual. ▪ 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. ▪ The monitoring activities were identified in the CLDPs, including the role of the IDD Local Authority, as well as the role of Facility staff in the post-move monitoring and follow-up process. However, no action steps were designed to ensure that the Post-Move Monitor worked together with the Local Authority Service Coordinator to pass on important information or ensure monitoring continued to occur of essential and non-essential supports. 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, four (100%) included documentation that the plans had been reviewed with the individual and/or the LAR, as appropriate. The Facility was found to be in substantial compliance with this provision. As discussed above, the new CLDP format requires that teams meet multiple times to complete various portions of the transition process. This is a positive development. To 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.	Substantial Compliance

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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. 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. However, at times, assessments were missing from the packages of assessments, particularly risk rating assessments and psychiatric assessments. In addition, the quality of these assessments was lacking. None of the four CLDPs reviewed (0%) were based on adequate assessments. In particular: ▪ Of particular concern, a number of assessments discontinued previous recommendations without justification. Although as noted below, some supports or services might need to be modified when they are provided in a different setting, the individual's underlying needs still need to be met. One example that Facility staff provided during onsite interviews was the use of a podiatrist to cut individuals' toenails. For some individuals, this support could be transferred to someone else, and it would result in their needs being met, without compromising the quality of the support. However, review of documentation showed some discontinuation of supports that appeared to be more for the convenience of the community provider, or due to a lack of available supports in the community. This resulted in important supports being left out of the CLDP, and it was very concerning. A couple of a number of examples included, for Individual #504, the following statement in the OT/PT assessment: she "had participated in a formal physical therapy program for therapeutic activities and exercise at the Habilitation Therapy Center twice a week..." However, in the community setting, the therapist recommended instead: "In order to promote increased participation and functional independence, [she] should be encouraged to do as much as she can for herself during daily activities..." For Individual #188 and Individual #402, a number of OT/PT recommendations were discontinued without justification. ▪ 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	Noncompliance

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		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. ▪ 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.). ▪ 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 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. ▪ 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. ▪ 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. In various other sections of this report, the Monitoring Team included transition assessments in their sample of assessments reviewed. Consistently, the Monitoring Team found them to be inadequate to provide the IDTs with adequate information with which to develop an appropriate CLDP or to offer community providers with the information necessary to ensure a safe and successful transition for the individual. Commentary with regard to the adequacy of assessments for these purposes can be	

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		found with regard to Sections L, and M of the Settlement Agreement. 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 ISPs 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 ISPs, 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. 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. 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 concerns noted: ▪ 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 ISPs, 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. ▪ Although some clinical services (e.g., psychology/behavior, psychiatry, therapy, etc.) were sometimes now referenced in the CLDPs, the intensity of the supports generally was not identified, nor were the qualifications or the roles of clinicians	Noncompliance

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		clearly defined. In the most recent plans, occasionally the qualifications for psychologists had been identified, and more definition was provided of what they would do. However, this is necessary for all of the clinicians involved with the individual, and needs to address issues such as staff training, review of data, monitoring of the implementation of programs, etc. 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. ▪ 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, individuals who were receiving habilitation therapies supports at ABSSLC did not have functionally equivalent supports identified in their CLDPs. ▪ Of significant concern, for individuals who had been identified as being at risk through the Facility's at-risk screening process, the risk action plans that the Facility had begun to develop, albeit still inadequate, were not reflected in action plans included in the CLDPs reviewed. As is discussed with regard to Section I of the Settlement Agreement, plans for individuals whose teams identify them as being at-risk should be of adequate clinical intensity to address the level of risk. Similarly, the action plans included in CLDPs for such individuals should include supports and services of adequate intensity to ensure the individuals' wellbeing to the extent possible. ▪ 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. Examples of concerning deletions of clinical services are noted above with regard to assessments. ▪ 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. ▪ 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 outcomes of this training. ▪ 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,	

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		exercise programs, etc.). As discussed during the onsite review, CLDPs often included lists of in-service training that community provider staff needed to complete. At times, this training included plans, such as PNMPs. However, the only requirement in the CLDPs was that staff complete an in-service, not that the plans then be implemented consistently. ▪ 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. ▪ 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. ▪ Direct support staffing ratios and requirements were generally not 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.). ▪ 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.). ▪ Generally, day and vocational supports were not well defined. ▪ 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. ▪ Issues continued to be noted with regard to the measurability of supports identified. Although this had improved significantly, the issue was not completely resolved. It should be noted that the CLDPs were showing some improvements. After each of the Monitoring Team's reviews, it was clear that efforts were made to better define essential	

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		and nonessential supports. However, teams were still working from inadequate ISPs, and the CLDPs continued to be missing many essential and non-essential supports. As noted in previous reports, 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. However, the Post Move Monitor continued to conduct a pre-move site visit designed specifically to determine if the essential supports were in place. A review was conducted of six individuals' pre-move site visit documentation (i.e., Individual #102, Individual #106, Individual #402, Individual #188, Individual #398, and Individual #504). For many of the supports listed, these reviews appeared thorough, and included each essential support listed in the individual's CLDP. However, although it was positive that a number of the CLDPs included more specific lists regarding the content of training for community provider staff (as noted above, these remained inadequate descriptions of who needed the training and the level of training needed), it was unclear how the Post-Move Monitor was confirming that this training occurred. Often, the only evidence cited was a sign-in sheet. The sign-in sheets attached to many of the post-move monitoring reports did not detail the training provided. Occasionally, the Post-Move Monitor had actually witnessed the training, but this was the exception. Although the process of having the Post-Move Monitor complete pre-move site visits showed promise, as noted in previous reports, the process was becoming more complicated as more detailed essential supports are appropriately identified in individuals' CLDPs. 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, concerns were noted with the confirmation of training completion. In addition, substantial work was still needed in adequately delineating the essential and	

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		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: ▪ At the time of the last review, the Facility continued using the monitoring tools that had been modified based on the Monitoring Teams' audit tools. The QA Department conducted reviews of the Living Options Discussion, CLDPs, and the Post Move Monitoring Process. The Post-Move Monitor had begun to conduct some reviews of CLDP meetings. Areas in which continued efforts needed to be made included: ▪ The Admissions Placement Coordinator candidly shared that due to time constraints, she had not completed the monitoring she had been scheduled to complete. In meeting with the Quality Assurance Department, a decision was made to shift some of this responsibility to the QDDP Department. Another concern noted was that the Post-Move Monitor was monitoring CLDP meetings, which essentially meant she was monitoring her supervisor's work, creating an inherent conflict. ▪ 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 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. ▪ 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. ▪ Analysis of the data, and development of appropriate corrective action plans had not yet occurred to the extent necessary. It was positive that one corrective action plan had been developed and implemented for Section T.1.g, related to the Facility's obstacles report. This was an important area in which to focus. However, as identified through the Facility's own monitoring, the Monitoring	Noncompliance

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		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. 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 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	Activities at the Facility and State levels demonstrated progress towards substantial compliance with this provision item. The State issued the Annual Report: Obstacles to Transition Statewide Summary, Fiscal Year 2011, with data current as of 8/31/11. The Facility was beginning to gather data on the obstacles. However, this remained limited: ▪ Data for five fiscal years, 2007 through 2011, were reported in the new annual report. Data included number individuals who moved to the community, deaths, and discharges to other placements. Data also was provided for these timeframes on numbers of individuals referred for community placements, the number of rescinded referrals, community transitions, and numbers of individuals who returned from community transitions. ▪ Limited data were included in the report regarding the types of obstacles identified, and the concerns of LARs and individuals that led to their preference to not be referred. At the time, 446 individuals resided at ABSSLC. However, data was provided on obstacles for only 139 individuals (31%). ▪ The data system only allowed one obstacle to be recorded per individual. This confounded the data. ▪ The data on the 139 individuals indicated that 64 (46%) were not referred due to LAR preference. The data system, however, did not indicate if this was the sole reason for non-referral, or if it was one of a number of obstacles. The ABSSLC report did not yet include an analysis of the data: ▪ As noted, data accuracy and validity needed to be improved.	Noncompliance

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	be necessary, appropriate, and feasible, DADS will seek assistance from other agencies or the legislature.	▪ Assistance from the QA Department and State Office might be helpful in analyzing data once it is collected. For example, graphs of the data could be trended over successive months, and analysis could be completed. ▪ Facility staff's knowledge of the underlying issues could be helpful in identifying potential solutions to existing obstacles. For example, in the introductory section of the current report, the Facility provided some valuable information regarding the characteristics of the community providers in the area, such as the lack of vocational services and the limited availability of residential providers. It should be noted that the Admissions Placement Coordinator presented the First Quarter Obstacle Report (for September to November 2011) to the QA/QI Council on 12/12/11. This report showed the beginnings of an analysis of the data, as well as recommendations based on the limited analysis. The Facility's report that was included in the State's overall report outlined some basic steps designed to ensure data integrity. This included the Admission Placement Coordinator's additional review of obstacles in ISPs, and continuing work with teams to "correct, clarify and educate" as appropriate. As discussed above with regard to Section T.1.b.1, the Admissions Placement Coordinator had begun to implement some creative options to address this issue. DADS took steps to overcome or reduce the obstacles that had been identified, including: ▪ DADS created a report summarizing obstacles across the state, and included the Facility's report as an addendum/attachment to the report. The statewide report was dated October 2011. ▪ The statewide report listed the 13 obstacle areas used in FY11. DADS was planning improvements to the way it categorized and collected (and the way it had the Facilities collect) data regarding obstacles. ▪ DADS indicated actions that it would take to overcome or reduce these obstacles: o Eleven numbered items were listed. Five were related to the IDT process and upcoming changes to this process, three were related to working with local authorities and local agencies, two were related to improving provider capacity and competence, and two were related to funding initiatives regarding slot availability and the new community living specialist positions. In general, these were descriptions of the early steps of activities related to addressing obstacles to each individual living in the most integrated setting. o DADS did not, but should, include a description regarding whether it determined it to be necessary, appropriate, and feasible to seek assistance	

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		from other state agencies (e.g., DARS). Improvements in data collection and analysis, implementation of new ISP processes, and actualization of the planned activities to overcome or reduce obstacles will be necessary for substantial compliance to be obtained.	
T1h	Commencing six months from the Effective Date and at six-month intervals thereafter for the life of this Agreement, each Facility shall issue to the Monitor and DOJ a Community Placement Report listing: those individuals whose IDTs have determined, through the ISP process, that they can be appropriately placed in the community and receive community services; and those individuals who have been placed in the community during the previous six months. For the purposes of these Community Placement Reports, community services refers to the full range of services and supports an individual needs to live independently in the community including, but not limited to, medical, housing, employment, and transportation. Community services do not include services 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.	In response to a document request, the Facility submitted to the Monitoring Team a Community Placement Report. For the time period between 9/1/11 and 1/12/12, the report listed: ▪ Current Referrals: 15 individuals were included on this list. At the time of the review, one of these individuals had transitioned to the community. ▪ Community Placements: Six individuals were included on this list. ▪ Rescinded Referrals: Two individuals were included on this list. The reasons for the referrals being rescinded were "LAR Choice," and "Individual Choice." 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 8/27/11 and 1/12/12, the report listed: ▪ Individual Prefers Community, Not Referred – LAR Choice: This list included one individual. ▪ Individual Prefers Community, Not Referred – Other Reasons: This list included four individuals. For two, the reason was "Behavior/Psychiatric. For one individual the reason was "Medical." For the final individual the reason was "MRA not present." This meeting was held in September 2011. It was not clear why a referral meeting would not have been held since that time. 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.	Substantial Compliance

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T2	**Serving Persons Who Have Moved From the Facility to More Integrated Settings Appropriate to Their Needs**		
T2a	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility, or its designee, shall conduct post-move monitoring visits, within each of three intervals of seven, 45, and 90 days, respectively, following the individual's move to the community, to assess whether supports called for in the individual's community living discharge plan are in place, using a standard assessment tool, consistent with the sample tool attached at Appendix C. Should the Facility monitoring indicate a deficiency in the provision of any support, the Facility shall use its best efforts to ensure such support is implemented, including, if indicated, notifying the appropriate MRA or regulatory agency.	<u>Timeliness of the Checklists</u> Post-move monitoring documentation was reviewed for five of the nine individuals (56%) for whom monitoring had been completed since the last review (i.e., Individual #398, Individual #188, Individual #402, Individual #106, and Individual #102). For these individuals during the time period reviewed, the ABSSLC Post-Move Monitor should have conducted 13 reviews. Of the 13 required visits, 13 (100%) had been documented as having been completed on time. 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. In addition, the Post Move Monitor sometimes noted that a visit had been made to the community provider's office to review paperwork, and/or interview staff. <u>Content of Checklists</u> Each of the items on the checklists reviewed had been addressed. Efforts clearly were being made to add additional information regarding the interviews conducted, the documents reviewed, and the observations made. In the Monitoring Team's last report, concern was noted about the amount of information provided with regard to the review conducted, and the results of the review. Since then, significant narrative was provided in the "Additional Comments" section, and the narrative consistently addressed each essential and nonessential support and described the findings of the review. As a result, it appeared that thorough reviews generally had been completed, and the narrative helped significantly in justifying the Facility's findings. 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: ▪ It was positive that a number of the CLDPs included more specific lists regarding the content of training for community provider staff (as noted above, these remained inadequate descriptions of who needed the training and the level of training needed). However, it was unclear how the Post-Move Monitor was confirming that this training occurred. Often, the only evidence cited was a sign-in sheet. The sign-in sheets attached to many of the post-move monitoring reports did not detail the training provided. ▪ The quality of supports the individuals were provided did not appear to be reviewed in a number of cases. For example, for a few individuals, new BSPs	Noncompliance

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		were developed to replace those developed at ABSSLC (e.g., Individual #188). However, except for the presence of the plan, no review was conducted to determine if it met the individual's needs. This likely would have required the team's review, as opposed to just the Post-Move Monitor's review. <u>Use of Facility's Best Efforts to Ensure Supports Are Implemented</u> 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. It appeared that teams were meeting more regularly to review individuals' post-move monitoring reports. In the sample of post-move monitoring reports reviewed, the Post-Move Monitor identified a fairly limited number of concerns, and many of them were minor in nature. However, there continued to be lapses in teams' efforts to ensure supports were implemented adequately. The following summarizes the general concerns related to the follow-up activities the Facility undertook: ▪ At times, it did not appear that teams addressed questions raised by the community provider agency. For example, for Individual #106, the community provided requested input from the team at the 90-day review regarding ways to increase the individual's compliance with showering. The IDT's review as documented in the ISPA dated 2/1/12 did not address this issue. ▪ The ABSSLC teams did not take an active enough role in reviewing some individuals' supports, and ensuring they adequately met the individuals' needs. For example, for Individual #402, although the team met to discuss whether the provider's delay in obtaining an appointment with a neurologist was an issue, the nurse clearly stated this was outside of her purview, but no physician was present at the meeting, and it did not appear efforts were made to obtain the physician's opinion. In addition, despite problems noted at the 45-day review with this individual's behavior, and a clear statement from the ABSSLC team that the implementation of the BSP was important to assist this individual, at the 90-day review, the team did not review the new BSP, which appeared quite poor, nor did the team ensure that the new BSP incorporated some of the strategies that had been discussed at the 45-day meeting. ▪ In one case, it did not appear the team met to address a concern the Post-Move Monitor identified. Individual #102's psychotropic was about to run out, and he had not yet seen the psychiatrist in the community. In her report, the Post-Move Monitor requested the team review and make recommendations. However, no documentation was submitted to show that the team met or offered any recommendations.	

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		Based on these concerns, although significant progress had been made with regard to the thoroughness of the reviews and Post-Move Monitor's documentation, the Facility was not in compliance with this provision.	
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 #398. Also in attendance were the Admissions Placement Coordinator, the Program Compliance Monitor, and a member of the State Office's Continuity of Services office. The Post-Move Monitor followed the format, asked many good questions, reviewed documentation, and conducted observations. The review for Individual #398 consisted of visits to the individual's day program and home, as well as interviews with residential management staff and an LVN. During the review, the Post-Move Monitor and Admissions Placement Coordinator were helpful in providing ideas to address issues raised, and/or offering to be in touch with other staff at ABSSLC to clarify issues or obtain additional information. For example, issues were noted with regard to communication between the vocational and residential providers. ABSSLC staff recommended the use of a notebook that Individual #398 could carry to address this issue. Likewise, Individual #398, who had a target behavior related to excessive intake of fluid, had been drinking all of the drinks in his lunchbox early in the day, taking others' drinks, and drinking out of the sink and toilet in the vocational site's bathroom. The ABSSLC staff made some recommendations regarding the location of his lunchbox, and some approaches that might help staff to better track his whereabouts, such as having him tell staff before he went to the bathroom. The Monitoring Team appreciates that the Post Move Monitor quickly completed the report for this review. As noted above with regard to Section T.2.a, the post-move monitoring report included information about each of the essential and nonessential supports, and provided narrative information to show what steps the Post-Move Monitor had taken to review the various protections, supports, and services. However, in reviewing the report, the following concerns were noted: ▪ Adequate standards were not applied in the monitoring conducted. One of the nonessential supports required that within 45 days, a Master's level psychologist or behavior analyst would review Individual #398's BSP "in order to determine if the target behavior definitions are accurate, the interventions are effective in reducing the target behavior, and if any changes should be made to address new or emerging behaviors." The Post-Move Monitor rated this as completed based on residential staff's assertion that on 1/31/12, the "Behavior Therapist" had assessed Individual #398, and the "New Behavior Plan is pending." No inquiry	Noncompliance

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		was made with regard to the "Behavior Therapist's" qualification, or evidence provided that the person met the requirements listed in the CLDP. In addition, because the revised BSP was not available, nor were any notes provided summarizing the review the Behavior Therapist conducted, it could not be determined that the specific requirements of this nonessential support had been met. For example, it was unclear if the Behavior Therapist had determined if the current interventions were effective, or if changes needed to be made. This was of significant concern given that numerous issues had occurred at the day program related to the individual's consumption of excessive fluids. Although these were detailed in the report, because residential staff were not aware of the extent of the problem, this likely had not been communicated to the Behavior Therapist, and it was unclear if the Behavior Therapist had visited or been in contact with vocational staff. It was further unclear how the Behavior Therapist had assessed the current interventions, if she had not collected data and/or reviewed the various environments in which the plan was implemented. In fact, the Post-Move Monitor identified a concern related to the failure of the vocational program to document behaviors on the correct form. ▪ Similarly, one of the indicators on the post-move monitoring checklist inquired as to whether any behavioral incidents were managed appropriately. This was rated as "yes." However, particularly at the vocational site, evidence was not presented to show that the numerous behavioral incidents had been handled appropriately. For example, environmental modifications had not been made to reduce their occurrence, proper communication with the residential provider had not occurred, and the vocational provider had not requested a team meeting to address the escalating concerns. ▪ Corrective action plans included in the post-move monitoring report were inadequate. Although as noted above, while onsite, ABSSLC staff provided some specific recommendations to address Individual #398's escalating behavioral issues, only one of these was mentioned in the action plan. Other key follow-up actions were not specifically outlined in the action plans. The action plans generally merely referenced referrals to the larger ABSSLC team for review. Although this is an important step, some immediate action was needed to address the issues identified. For example, the action plans did not require the provider to contact their Behavior Therapist to immediately obtain her recommendations, or to have her assess the environment and/or interventions the vocational site was using. Likewise, given that it was not clear whether or not the individual's health had been compromised as a result of the ingestion of additional fluid, the residential program's LVN mentioned asking the primary care provider to order lab testing. This would have been important follow-up to ensure the individual's health and safety. However, it was not memorialized as	

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		part of the action plans. Based on concerns related to adequate standards not being applied in the monitoring conducted and corrective action plans not being representative of what was discussed during the onsite post-move monitoring review, the Facility was not in compliance with this provision.	
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 individuals: (a) individuals who move out of state; (b) individuals discharged at the expiration of an emergency admission; (c) individuals discharged at the expiration of an order for protective custody when no	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 procedures. Since the previous review, under this revised definition, three individuals had had alternate discharges (i.e., were transferred to other SSLCs). The discharge packages for Individual #387, Individual #160, and Individual #121 were requested for review. Each of the requirements of the CMS-required discharge planning process is discussed below: ▪ If an individual is either transferred or discharged, the Facility has documentation in the individual's record that the individual was transferred or discharged for good cause: Based on the information provided, in three out of	Noncompliance

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	commitment hearing was held during the required 20-day timeframe; (d) individuals receiving respite services at the Facility for a maximum period of 60 days; (e) individuals discharged based on a determination subsequent to admission that the individual is not to be eligible for admission; (f) individuals discharged pursuant to a court order vacating the commitment order.	the three records reviewed (100%), good cause was identified in the discharge summaries (i.e., individual's request to live with peers with similar interests, and two families' requests for the individual to live closer to them). ▪ The Facility provided a reasonable time to prepare the individual and his or her parents or guardian for the transfer or discharge (except in emergencies): Based on the information provided, for two out of three (67%) individuals, reasonable time was given to prepare. For the one individual, the discharge/reassignment date was left blank (i.e., Individual #121). ▪ At the time of the discharge, the Facility develops a final summary of the individual's developmental, behavioral, social, health and nutritional status: Although the final summaries included each of these components, for none of the three individuals (0%) was the information adequate. Concerns included: o Adequate summaries were not provided of the individuals' overall stay at ABSSLC. o Incomplete historical and current status information was provided (e.g., significant lapses in information with regard to medical/nursing and psychiatric information). o Generally, little information was provided about the supports the individuals were receiving, and little analysis was provided regarding what supports had assisted the individuals versus those that had not been effective to assist the receiving facility to develop an appropriate treatment plan. o All three individuals had significant psychiatric issues. However, none of the summaries provided adequate information about their diagnoses, current treatments, or history with successful or unsuccessful treatment. ▪ With the consent of the individual, parents (if the client is a minor) or legal guardian, provides a copy to authorized persons and agencies: For none of the three individuals (0%), ABSSLC provided documentation to show that a copy of the discharge summary and related assessments had been provided to the receiving Facility. In its request for documents, the Monitoring Team requested: "Discharge Plans/documentation and related assessments…" However, the only documentation provided for each individual was a document entitled: Discharge Reassignment Summary." ▪ The Facility provides a post-discharge plan of care that will assist the individual to adjust to the new living environment: Based on the narratives provided in the Referrals and/or Necessary Services Required in New Environment section, the IDTs for none of the three individuals (0%) adequately described the key supports that the individuals would need in their new settings. For example: o Individual #160's appeared to have psychiatric needs, based on the	

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		summary of medical diagnoses, as well as the summary of psychological needs. However, other than seeing a psychiatrist quarterly and coordination with the team, no specific information was provided in this section regarding his psychiatric needs. Similarly, the "summary" section of the discharge plan discussed specific dietary needs. These were not mentioned in the "Referrals and/or Necessary Services" section. Much of this discharge summary appeared to be copied from assessments, but because these were not provided as part of the discharge package, it could not be determined how recently they had been updated, or if the information included was the most up-to-date. For example, the psychology recommendations included fading of one-to-one supervision, but no specific description of what staffing should be provided was included in the necessary services section. Although he had a number of medical diagnoses, other than a list of diagnoses and medications in the summary section, no medical or nursing supports were defined in the list of necessary services. This was not an adequate "post discharge plan of care to assist the individual to adjust to his new environment." o Similarly, for the remaining individuals, a limited list of supports was included in the Referrals and/or Necessary Services section. It was unclear why only certain supports that the individual needed were included, and others were not. Some fairly significant supports were missing from each individual's discharge summary. Due to the inadequacies of the discharge/transfer summaries, ABSSLC was not in compliance with this provision.	

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 ISP. 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 ISP 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' ISPs 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 independent assessments of individuals' ability to transition to a more integrated setting, the professional team members should include all ABSSLC staff on the team, including, for example, residential and day/vocational staff. Assessments such as vocational assessments, and functional assessments should include related recommendations. During ISP meetings, when the team members' opinions are sought, this also should include all ABSSLC staff on the individual's team (e.g., QDDP, residential staff, day vocational staff, direct support professionals, etc.). (Section T.1.b.3)
10. For some individuals, particularly those individuals for whom teams are not sure whether or not appropriate supports exist in the community to meet their needs, teams should consider an exploratory phase prior to making a decision about a referral or no referral. During this time, the team could ensure that it had an exhaustive list of protections, supports, and services the individual required, and use this list to determine which community providers might be able to support the individual. The team could support the individual and his/her guardian to explore these different options to determine if they meet the needs as well as the preferences of the individual. To ensure that this process occurred expeditiously, an action plan should be developed with specific action steps and associated timeframes, and persons responsible. (Section T.1.b.3)
11. 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)
12. 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 ISPs, 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. For individuals whose teams identify them as being at-risk, CLDPs should be of adequate clinical intensity to address the level of risk. Specifically, the action plans included in CLDPs for such individuals should include supports and services of adequate intensity to ensure the individuals' wellbeing to the extent possible;

g. Teams should factor in modifications that need to be made to current programs or plans, and writing such modifications into the essential or nonessential supports;

h. 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;

i. 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;

j. 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;

k. 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.);

l. 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;
m. 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;
n. 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;
o. For individuals with complex behavioral or medical needs, community supports adequate to meet their needs should be available upon their transition (e.g., involvement of the community psychologist, psychiatrist, neurologist, etc.), and teams should include dates that meet the individuals' needs. If the conversion of Medicaid from institutional to community is a barrier to the provision of supports, teams should identify this as an obstacle; and
p. Focused effort should be placed on ensuring each of the supports identified is measurable. (Sections T.1.c.1 and T.1.e)

13. 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)
14. 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)
15. 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 and Facility Self-Assessment)
16. Whenever appropriate, IDTs should identify actions necessary to resolve issues related to the essential and nonessential supports provided to

individuals who have transitioned to the community. The IDTs decisions and activities should be documented through to completion. (Section T.2.a)

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. For individuals undergoing alternate discharges, the discharge/transfer summaries should include:
    a. Clear descriptions of when the referrals were made, when the discharge planning process began and ended, and the level of involvement of the individual and his/her guardian or family;
    b. Summaries of relevant historical and current status information, including as appropriate applicable data;
    c. To assist the receiving Facility to develop an appropriate treatment plan, analysis regarding what supports had assisted the individual versus those that had not been effective;
    d. Medical information, including summaries from specialists (e.g., psychiatry, neurology, etc.); and
    e. Adequate post-discharge plans of care that comprehensively describe the key supports that the individual would need in his/her new setting(s). (Section T.4)

SECTION U: Consent	
	Steps Taken to Assess Compliance: The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o Presentation Book for Section U; 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"; o Client Assignment and Registration System (CARE) blank form, revised 1/10; o ABSSLC Guardianship Priority Tools for Priority I and Priority II, with instructions, undated; o In response for request related to curricula for training on the instruments used to determine competency, the following statement: "The QDDP Educator informs the QDDPs, during initial training, of the process on how to refer someone for a guardian/advocate. o Priority I and Priority II lists of individuals needing guardians, updated 5/5/11, and 9/30/11, respectively; o List of individuals who obtained a guardian and/or advocate since 8/11 and guardianships in process with an attorney, undated; o Guardianship Assistance Committee meeting minutes, dated 9/7/11; o Emails from Shae Butts regarding Guardianship Assistance Program, various dates; o Family Association Meeting Agenda, dated 10/1/11; o Letters (17) mailed explaining the Guardianship Assistance Program and/or applied income funding source, various dates; o Texas Guardianship Statute - Probate Code, Chapter XIII. Guardianship, Sections 601 through 700; o Texas Health and Safety Code, Title 7. Mental Health and Mental Retardation, Subtitle D. Persons with Mental Retardation Act, Chapter 591. General Provisions, Subchapter A. General Provisions, Section 591.006. Consent; o Texas Health and Safety Code, Title 7. Mental Health and Mental Retardation, Subtitle B. State Facilities, Chapter 551. General Provisions, Subchapter C. Powers and Duties Relating to Patient Care, Section 551.041. Medical and Dental Care; and 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. ▪ **Interviews with**: o Shae Butts, Human Rights Officer.
	Facility Self-Assessment: In its Self-Assessment, the Facility recognized that it was not in compliance with the requirements of Section U of the Settlement Agreement. This was based largely on review of existing lists and contact logs. Once State Office issues procedures for formally assessing individuals and pursing guardianship or other decision-making resources, then the self-assessment process will need to be

	implemented. For example, 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 self-assessment should include analyses of the audit results. The Facility also had developed an action plan related to Section U. The action plan revolved around the development and implementation of a Facility policy once the State Office policy was finalized. In the Monitoring Team's opinion, this action plan would be important to implement. 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 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, and, as appropriate, assessing in more detail individuals' functioning in this area. In the meantime, ABSSLC had continued to use tools it had created to attempt to prioritize a list of individuals in need of guardians. Through the individual planning process, for individuals who did not have guardians, teams had reviewed the level of involvement of individuals' families/correspondents, if any existed. In addition, a "Guardianship Priority" tool had been used to review factors related to the need for decision-making (e.g., medical decisions, financial decisions), as well as the use of restrictive procedures, and lists had been developed of individuals with Priority I and Priority II levels of need for guardianship. Using the processes currently in place, a total of 90 individuals had been identified as requiring guardians. However, Facility staff recognized that this likely underestimated the numbers of individuals requiring guardians. Since the last review, four individuals had obtained guardians, and petitions for an additional four individuals were in various stages of the process. In addition to the Guardianship Assistance Program funding, the Human Rights Officer had worked with the finance office, and another alternative for funding had been identified using individuals' social security funds.

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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, and the HROs from the various SSLCs had met to discuss the draft policy. 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, because they should assist the Facilities to move forward with regard to the implementation of the Section U Settlement Agreement requirements. As noted in the Monitoring Team's last report, 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' IDTs 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. As also 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 will be important that assessments of an individual's capacity to provide informed consent detail the areas in which the individual is able to make informed decisions, as well as those areas in which he/she cannot make such decisions. Further, it is important for such assessments to identify if there are supports or resources that could enable an individual to make informed decisions, or increase their capacity to make such decisions. Although during the last review, staff reported that they had begun to look at other options to assist individuals with decision-making, such as the identification and appointment of advocates, little, if any, progress had been made in this area. The Human Rights Officer explained that the draft DADS policy allowed for staff to become individuals' advocates, as long as they did not have responsibilities for supporting the individual. However, according to the HRO, many individuals had been on the list for several years for an advocate, but no efforts currently were underway to more formally identify individuals that would benefit from an advocate, or identify and assign advocates to individuals.	Noncompliance

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		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; 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.). 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." QDDPs 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 included individuals who had family involvement, but needed a guardian, but a priority list had not yet been developed that included these individuals. This was due to the fact that Facility staff recognized that the new State Office policy would modify the processes the Facility was using. This prioritization was then further defined by considering a number of factors including, for example, the need for medical decision-making, use of psychotropic medications and other restrictive procedures, and the need for decisions to be made regarding financial matters. Using the "Guardianship Priority" tool, a numeric score was calculated, and the higher the score (i.e., the more risk factors the individual had related to decision-making), the higher their levels of priority on the guardianship list. At the time of the most recent review, the list individuals needing guardians essentially had remained the same, except for some minor changes related to individuals who had transitioned to the community, died, or been admitted to the Facility. Approximately 37 individuals had been identified as Priority I, and approximately 53 individuals had been identified as Priority II. Each of these individuals had been given a priority score based on the completion of the "Guardianship Priority" tool. The Facility recognized that this might not include all individuals who were in need of assistance with making decisions and/or advocacy supports. The Facility also recognized that once the State policy was issued, modifications to this list might occur, based on the more formalized screening and assessment processes contemplated by the draft State policy. However, based on	

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		these initial projections, approximately 90 out of the 428 individuals residing at ABSSLC (21%) were in need of guardians. 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, four individuals identified as requiring a guardian had been appointed a guardian. Four additional petitions for guardianship were in some stage of being processed. 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 21 letters had been sent to interested parties explaining the availability of funding through the Guardianship Committee, or as appropriate, social security funds. Given that family members or other interested parties often cited the cost of the guardianship proceedings as a potential barrier, this was an important effort. Since the Monitoring Team's last review, the Human Rights Officer had invited members of the Reimbursement Office to attend a Guardianship Assistance Committee meeting. They explained the option of using "applied income" funds through social security to pay for up to $1000.00 every four years for guardianship expenses for individuals who were eligible. It appeared that this would not affect the personal funds to which individuals had access. Some of the letters that the Human Rights Officer had sent to families included this information, as appropriate. Funding using applied income had been approved for two of the individuals, who currently were in the process of obtaining guardians. If this funding continues to be a viable resource, it should be helpful as other guardianships are sought, and will assist in conserving the Guardianship Assistance Program funds for individuals who are not eligible for the applied income funds. Although a nonprofit guardianship program in the area was working with one individual, the Facility had not fully investigated the possibility of referring other individuals to this agency. As the State Office Coordinator recommended to Facility staff during the last onsite review, Facility staff should investigate the resources potentially available through	Noncompliance

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		this local nonprofit guardianship agency. 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. 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 self-assessment should include analyses of the audit results. (Facility Self-Assessment)

SECTION V: Recordkeeping and General Plan Implementation	
	Steps Taken to Assess Compliance: The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o ABSSLC Recordkeeping Policy and Procedures, dated 7/9/10; o List of persons responsible for management of records and for auditing records, including names and titles, dated 12/30/11; o ABSSLC Active Record Order and Maintenance Guidelines, dated 12/29/11; o Master Folder Table of Contents, undated; o Statement that ABSSLC had received information from State Office regarding Individual Notebooks, and was planning to implement them soon; o Completed review tools for last 10 records reviewed; o Plans of correction resulting from records audits for the last three full months prior to the compliance visit, including: ▪ Correspondence or other documentation confirming completion of plans of correction resulting from these records audits, along with documentation of follow-up for corrective actions not completed; and ▪ Documentation of any follow-up checks to confirm completion of these corrective actions o Documentation of follow-up on individual record reviews, various dates; o Description of electronic records used as part of the active record, dated 6/11; o List of ABSSLC policies and procedures implemented or revised since the last Monitoring Team's visit in August 2011, dated 1/6/12; o List of SSLC Policies, dated 1/23/12; o For new or revised policies, documentation of training completed; o Records Committee Notes, dated 10/18/11, and 12/28/11; o State Office Recordkeeping Meeting Agenda, for 1/25/12 and 1/26/12; o Inter-rater reliability data, for June through August 2011; o Graph of monitoring data for Section V for Quarter 4, FY 11; and o Presentation Book for Section V. ▪ **Interviews with**: o Kalana Allen, Records Coordinator; o Vickie Allmand, Unified Records Coordinator; o Gloria Sprecher, Unified Records Coordinator; o Pat Smith, Quality Assurance Director; and o Tracyl Gandee, Settlement Agreement Coordinator.
	Facility Self-Assessment: Based on a review of the Facility's Self-Assessment with regard to Section V of the Settlement Agreement, the Facility found that it was out of compliance with all of the subsections. This was consistent with the Monitoring Team's findings.

	Since the Monitoring Team's previous review, the Facility had made notable improvement in the justification it offered for its findings. Over a short period of time working with a new format from State Office, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating based on the information cited in the section on results. Although a number of concerns continued to exist with the Facility's self assessment process, over time, this format should be helpful in substantiating the Facility's findings with regard to compliance. The following concerns were noted: ▪ The results of the Facility's regular record audits should be included in Section V.1 to provide information about the adequacy of individuals' active and master records, and their individual notebooks, including compliance with the guidelines included in Section D of the Settlement Agreement. The Facility had included some of this information in its assessment of Section V.3. However, Section V.3 does not address the records themselves, but rather the Facility's quality assurances processes. Section V.1 addresses the quality of the records. ▪ With regard to Section V.3, the Facility should assess if it is completing the required record reviews, but also if analyses of the data are being used to improve the system. ▪ Inter-rater reliability will need to be formally established with the QA and programmatic staff responsible for conducting audits. ▪ The data presented clearly identified areas of need. The Self-Assessment also indicated that follow-up reviews were being conducted to ensure that issues in individual records were addressed. However, the Facility Self-Assessment did not yet provide any analysis of the information, identifying, for example, potential causes for the systemic issues, or connecting the findings to portions of the Facility's Action Plans to illustrate what actions the Facility had put in place to address the negative findings. Overall, the Facility had demonstrated that it was beginning to incorporate some of the data it had collected into its self-assessment process. Efforts to ensure the validity and reliability of the data will be important next steps, as will using the data to identify areas in which focused attention is needed. The Facility's progress in developing a quality assurance process for Section V is discussed in further detail below with regard to Section V.3.
	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 was diligent about correcting issues that were identified through audits of individual records. However, continued work was needed to analyze data, identify systemic issues, and develop and implement corrective actions to address them. At the time of the Monitoring Team's last review, the Facility did not have Individual Notebooks. Since then, an interdisciplinary group had met, and made decisions regarding the Individual Notebooks. It appeared that a reasonable table of contents had been devised. It included a combination of information that direct support professionals would need to do their jobs, and data collection forms. The Facility had set forth a plan for implementation, and it was expected that by 3/5/12, use of the Individual Notebooks would begin.

	The Facility was continuing to develop and revise policies to address the requirements of the Settlement Agreement. Further work was needed to clearly identify the staff who required training on policies, as well as the type of training (e.g., classroom training, competency demonstration of skills, etc.), and the timeframes within which training needed to occur. The Unified Records Coordinators had begun to track training. However, given the need for the Facility to have a clear understanding of training compliance for each policy, others, including the Competency Training and Development Office, likely needed to be involved. With regard to auditing records, the Unified Records Coordinators, a Program Compliance Monitor from the QA Department, and the Records Coordinator continued to consistently conduct record reviews. Extensive follow-up was completed regarding any issues these audits revealed in individual records. Aggregate data was available, but an area in which further work was needed was in the analysis of this data. Such analysis should result in the identification of systemic issues, and the development and implementation of action plans to address the causes. Since the last review, the Facility had continued to implement the policy designed to improve the timeliness of filing items in the records. The policy clearly identified roles and responsibilities, and set timelines for completion of specific activities. Although the timelines in the policy had not yet been met, 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. 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.

#	Provision	Assessment of Status	Compliance
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: ▪ According to staff, all of the individuals at ABSSLC had Active Records and Master Records. The Records Coordinator and Unified Records Coordinators recently had met with the State Office and other Facilities' staff responsible for recordkeeping. During this meeting, the minimum requirements for the Master Records were discussed. ABSSLC staff reported that their current Table of Contents met these minimum requirements, and, as a result, changes would not need to be made. ▪ At the time of the Monitoring Team's last review, the Facility did not have Individual Notebooks. Since then, an interdisciplinary group had met, and made	Noncompliance

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		decisions regarding the Individual Notebooks. In doing so, the group had kept in mind three core issues related to the intent of the Individual Notebooks, including ensuring: 1) staff knowledge of the programs; 2) implementation of programs; and 3) documentation, including integrity of the data. It was positive that an interdisciplinary group was assigned, and based on the group's minutes, that they informally sought the advice of direct support professionals responsible for the implementation of programs, and maintenance of documentation. As a result, it appeared that a reasonable table of contents had been devised. It included a combination of information (e.g., DNR orders, level of supervision information, PBSP Summary, Safety Plan, PNMP, etc.), and data collection forms (e.g., PNMP check sheet, scatterplot for behavioral data, training skills, and observation notes). If implemented correctly, this format should assist in addressing the core issues upon which the group focused. The Facility had set forth a plan for implementation. It involved by 2/28/12, the File Clerks setting up the Individual Notebooks, in-service training being provided to all staff, and by 3/5/12, beginning use of the Individual Notebooks. The Individual Notebook Guidelines, dated 2/8/12, set forth the process for the maintenance of updated information and data sheets. This involved a number of staff, for whom specific responsibilities were detailed. The guidelines also set forth a reasonable approach to when the Individual Notebooks would accompany an individual. In terms of when they would accompany the individual, the guidelines took into consideration normalization principles, as well as privacy/security issues (e.g., they would not accompany the individual on short leisure activities on campus, for example, a dance, or off community recreational activities). However, the guidelines left open the possibility of the IDT modifying these parameters to meet the needs of an individual. The guidelines also indicated that each residence would be responsible for identifying a secure place for the storage of the Individual Notebooks, when they were not with the individuals. ▪ The Facility continued making changes, as appropriate to the content of the records. As indicated in the Monitoring Team's last report, 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 two meetings showed discussion of relevant issues, and the development of practical solutions. Areas in which improvements should be made in order to achieve compliance, included: ▪ The audits that Facility staff had conducted showed that records did not meet all of the requirements of Appendix D. For example, based on the Facility's self-	

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		assessment, based on a review of 40 individuals' records between 9/1/12 and 12/31/11, the following was a list of some of the 29 indicators that fell below 70%: o Legibility was at 50%; o Accuracy was at 59%; o Current was at 30%; o Complete was at 30%; and o No evidence of inaccurate recordkeeping procedures was at 46%. Some of the challenges with this data, including its interpretation are discussed with regard to Section V.3. However, Facility staff recognized the need for continued improvements. Although a system was in place for following up to ensure that issues identified in individual records were completed, limited work had been done on identifying systemic issues, and resolving them. As some of the data from the Facility's self-assessment showed, some of the issues required more analysis to determine their scope across campus, as well as potential causes, and solutions. ▪ As was discussed during the onsite review, one of the challenges was the timely filing of documents in the Active Records. Based on data the Facility was maintaining, filing often took up to seven business days. This issue required additional discussion and problem-solving between the Records Department, Unit Directors, and Facility Administration. Such discussion should include the job responsibilities of the Clerks, different ways in which the filing and other responsibilities assigned to the Clerks could be distributed amongst the Clerks, as well as other resources that might be used to assist with the filing or other responsibilities. 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 implementing the Individual Notebooks, ABSSLC should continue to address issues related to the quality of the records and timeliness of filing information in 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	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. 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:	Noncompliance

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	this Agreement.	▪ Based on the revised Dissemination, Training, and Implementation of New/Revised Policies and Procedures, dated January 2012, the Policy Review Committee reviewed 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 once such recommendations had been addressed, the policy was sent to the Facility Director for final review and approval. A list was provided of eight policies that had been developed/revised and approved since the last review. Areas in which efforts are needed in order to achieve compliance, included: ▪ The Facility provided a list of SSLC Policies, dated 1/23/12. It listed the Settlement Agreement Section, the SSLC Policy number and Title (i.e., the State Office policy) with the effective date, and the Title of the Center's policy with the corresponding number, and effective or revised date. This showed that three State Office policies remained in draft format. In addition, the Monitoring Team was aware that others were being revised. The list also showed that for a number of State Office policies, the Facility did not have a corresponding Facility policy. Although not all State Office policies require the Facility to individualize them, as Chris Adams' email, dated 2/15/12 stated: "… the facility is responsible for evaluating the statewide policy to determine how much further customization is required (i.e., if specific roles, responsibilities, or processes in addition to those outlined in the policy need to be implemented at that particular facility). The facility may not take away from or replace statewide policy but may add additional information or processes." As noted in this report, in a number of instances, further work was needed to individualize the State Office policies. 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. ▪ At the time of the review, the Dissemination, Training, and Implementation of New/Revised Policies and Procedures Policy had been revised recently, in January 2012. It required that Department Heads were trained on new or revised policies, and that: "Department heads will assure that relevant staff are trained and training is documented." The policy also noted that the Competency Training and Development Department would become involved if newly hired staff needed to be trained, or if the policy or procedure affected a large portion of staff working at ABSSLC. Although these basic training requirements were a positive step, as discussed while the Monitoring Team was onsite, the decision-making regarding which staff needed to be trained on which policies should be better defined. It is recommended that the Facility refine its policy and procedure incorporate mechanisms for communicating specifically which staff	

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		require training on new or revised policies, such as the list of job categories to whom training should be provided. In addition, for each policy approved, consideration should be given to having the QA/QI Committee define who will be responsible for certifying that staff who need to be trained have successfully completed the training, what level of training is needed (e.g., classroom, review of materials, competency demonstration, etc.), and what documentation will be necessary to confirm that such training has occurred. At the time of the Monitoring Team's review, the Unified Records Coordinators were tracking the training completed. As the Facility's policy recognized, sometimes the Competency Training and Development Department maintained copies of in-service sheets, but often other departments would have responsibility. Timeframes also would need to be determined for when training needed to be completed. It would be important to define, for example, which policy revisions need immediate training, and which could be incorporated into annual or refresher training (e.g., ISP training). Based on documentation provided, it appeared a system was available to track which staff had completed which training, and to run exception reports showing who still required training. Incorporation into this system of the training on policies would appear necessary and appropriate. ▪ Of the eight policies that were developed or revised since the last review, some documentation showing that staff training had occurred was provided for all. Based on the documentation, it could not be determined if all relevant staff had been trained, and/or if the staff trained had met the required competency level to successfully complete the training. Tracking should occur to ensure that all staff who require training on new or revised policies and/or procedures successfully complete the training, and the Facility should be able to identify clearly those staff who have not completed the training, or have not mastered the competency-requirements. 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	Progress had been made and/or sustained with this provision of the Settlement Agreement. Positive developments included: ▪ At ABSSLC, the Unified Records Coordinators were conducting reviews of at least five records each month, as the Settlement Agreement requires. In fact, they were conducting 10 per month. The QA Department also was conducting reviews of a subsample of records, as was the Records Coordinator. ▪ As described in the Monitoring Team's last report, to accomplish this, the Facility was randomly selecting a sample of 10 records. Based on interview and	Noncompliance

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	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.	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. However, the Facility continued to address discrepancies found in monitoring 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. ▪ Facility staff were continuing to critically analyze some of the issues related to monitoring activities. For example, in an attempt to ensure that monitoring results were identifying relevant issues, Facility staff had questioned how many errors of the same type (i.e., legibility, date, time, title, misfiled documents) should be considered when determining compliance with the monitoring indicators. They had developed Section V Monitoring Tool Guidelines for Acceptable Deviations from 100% Compliance, revised 12/22/11. These guidelines allowed one such deviation for these specific categories. The Monitor will be discussing this criterion with the other Monitoring Teams, and looks forward to seeing if it assists ABSSLC in further delineating where the more systemic issues exist in the records. ▪ 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. However, this often was being done more quickly. The Monitoring Team's review of documentation submitted continued to show effective and strong follow-up to ensure deficiencies were corrected. ▪ 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. ▪ As illustrated in its Self-Assessment, the Facility had made some progress in aggregating monitoring data, and identifying problematic trends. Utilizing data reports, the Records Department had identified specific indicators for which data showed problematic trends. However, at the time of the review, corrective actions largely were focused on individual record issues, as opposed to systemic issues.	

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		Areas in which improvements should be made in order to achieve compliance, included: ▪ As noted above, the Facility had implemented 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 IDT 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, ISP 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. Given recent discussion between the Monitors and the parties during a December parties' meeting, the State Office likely will provide additional guidance. ▪ Facility staff had been taking some steps to establish inter-rater reliability. However, as discussed during the onsite review, due to the constantly changing nature of records, when trying to establish inter-rater reliability, staff should review the record independently, but at the same time, or very close in time (i.e., within the same day). In addition, inter-rater reliability should be established between all auditors. For example, the two Unified Records Coordinators should review the same record to determine if they are evaluating records in the same way. ▪ The Facility was in the beginning stages of using information gained from internal audits to develop and implement corrective actions. As noted above, at the time of the review, these efforts largely targeted corrections to individual records. These efforts were laudable. However, as discussed onsite, it will be important to analyze data to identify potential systemic issues, develop and implement corrective actions, 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. 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.	

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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.	Recently, the Monitors and the parties agreed to a list of actions that the SSLCs would engage in to demonstrate substantial compliance with this provision item. Even though ABSSLC did not yet have this list, the items are presented below. It is likely that the DADS State Office will provide additional direction and guidance to the MRC and URC. ▪ **Records are accessible to staff, clinicians, and others**: Although ABSSLC was not yet self-assessing this. The monitoring team, however, observed that: o On a positive note, in an effort to ensure accessibility of certain documents that teams needed to develop ISPs and engage in related activities, Personal Folders for each individual were maintained on the shared drive. The Records Department also had developed a naming format to assist staff in finding documents. o As noted in the Monitoring Team's last report, 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. 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. As noted above, some issues continued to exist with the timely filing of documents, but the lag time had been reduced. o Generally, it appeared that records were available in the residences, and, as needed, at clinic appointments, in individuals' meetings, etc. ▪ **Data are documented/recorded timely on data and tracking sheets (e.g., PBSP, seizure)**: The Monitoring Team observed some problems. For example: o 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. In fact, as discussed with regard to Section K.4, observations during the onsite review indicated that staff were not recording behaviors that occurred, completing data sheets hours after they should have, and/or completing documentation for time periods that had not yet occurred. This last issue, in particular, raised the issue of potential falsification of records. ▪ **Staff surveyed/asked indicate how the unified record is used as per this provision item:** The Unified Records Coordinators were asking a sample of team members to complete the questions that State Office had sent related to	Noncompliance

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		Section V.4. Review of a small sample of these completed forms generally showed that staff were able to articulate how they used the records. Sometimes, team members included recommendations to improve the records, such as increasing the time that information from individuals' stays in the Infirmary was maintained in the records. However, it was not clear how the Facility used the information gained from these interviews. ▪ **Observation at meetings, including ISP meetings, indicates the unified record is used as per this provision item:** The Facility had not yet developed a process for incorporating information regarding the use of records during relevant meetings into the database for Section V.4. As discussed with regard to Section V.3, this should include observations of a variety of meetings in which information from the records needs to be utilized (e.g., psychiatric reviews, ISP meetings, etc.). The Unified Records Coordinators might not do this, but such indicators might be distributed in other monitoring tools, and the data fed back to the Records Department. Based on the Monitoring Team's observations: o Continued emphasis was needed on using records for decision-making purposes. For example at the CLDP meeting during the week of the Monitoring Team's review, as well as the weekly IDT meetings, staff were observed trying to remember facts. The records should have been present, and used to inform the teams' deliberations. o As discussed with regard to Section F of the Settlement Agreement, ISPs continued to lack evidence of teams making data-based decisions. 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 Facility should implement the Individual Notebooks. (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 Facility should develop a standardized system to train staff, and ensure staff have the necessary knowledge and skills to implement the new or revised policies. To accomplish this, the Facility should define in policy or procedure the process that will be used to ensure this occurs. In revising its current policy, the following should be considered:
    a. It should incorporate mechanisms to communicate the issuance of new policies and training requirements, such as an email/correspondence being sent to the departments impacted by the policy, including the list of job categories to whom training should be provided.
    b. In addition, for each policy approved, consideration should be given to having the QA/QI Committee define who will be responsible for

certifying that staff who need to be trained have successfully completed the training, what level of training is needed (e.g., classroom training, review of materials, competency demonstration, etc.), and what documentation will be necessary to confirm that such training has occurred. It would seem that sometimes this responsibility would be with the Competency Training and Development Department, but often others would have responsibility.

c. Timeframes also would need to be determined for when training needed to be completed. It would be important to define, for example, which policy revisions need immediate training, and which could be incorporated into annual or refresher training (e.g., ISP annual refresher training).

d. Based on documentation provided, it appeared a system was available to track which staff had completed which training, and to run exception reports showing who still required training. Incorporation into this system of the training on policies would appear necessary and appropriate. (Section V.2)

4. 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)
5. 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)
6. Additional efforts should be made analyze data collected through internal audits, and, as appropriate, action plans should be developed and implemented to address underlying issues. As such plans are implemented, 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)
7. 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)
8. 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)
9. As the Facility's self-assessment processes continue to evolve, the Self-Assessment 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
ACP	Acute Care Plan
ADL	Adaptive Daily Living
ADOP	Assistant Director of Programs
ADR	Adverse Drug Reaction
AED	Automatic External Defibrillator
AED	Antiepileptic Drug
A/N/E	Abuse/Neglect/Exploitation
AP	Active Polypharmacy
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
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
DRTx	Disability Rights Texas
DSM	Diagnostic and Statistical Manual
DUE	Drug Utilization Evaluation
EADL	Electronic Aides for Daily Living
ECU	Environmental Control Unit
EGD	Esophagogastroduodenoscopy
EKG	Electrocardiography
EPS	Extrapyramidal Motor Side Effects
ER	Emergency Room
FBA	Functional Behavioral Assessment
FTE	Full-time Equivalent
FY	Fiscal Year
GAP	Guardianship Assistance Program
GERD	Gastroesophageal Reflux Disease
GI	Gastrointestinal
gm	Gram
G-tube	Gastrostomy feeding tube
HCG	Health Care Guidelines
HCS	Home and Community-Based Services
HIV	Human Immunodeficiency Virus
HMP	Health Management Plans
HMT	Health Monitoring Tool
HOBE	Head of Bed Elevation
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

ICN	Infection Control Nurse
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
IMT	Incident Management Team (IMT)
IPN	Integrated Progress Notes
I/R	Integrity/Reliability
IV	Intravenous
J-tube	Jejunostomy feeding tube
L	Liters
LA	Local Authority
LAR	Legally Authorized Representative
LPM	Liters per Minute
LRA	Labor Relations Alternatives
LTAC	Long Term Acute Care
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
MRI	
MRSA	Methicillin-resistant Staphylococcus aureus
NEPT	New Employee Pre-service Training
NG	Nasogastric
NM	Nutritional Management
NMP	Nutritional Management Plan
NMT	Nutritional Management Team
NOO	Nursing Operations Officer
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
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
QEN	Quality Enhancement Nurse
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
SP	Stable Polypharmacy
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
TWR	Temporary Work Reassignment
UTI	Urinary Tract Infection
VNS	Vagus Nerve Stimulator
VPA	Valproic Acid
VTE	Venous Thromboembolism