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 this report indicates, at ABSSLC, progress continued to be made in a number of areas. However, the Monitoring Team also identified a number of areas in which adequate progress had not been made. Particularly, given the numbers of individuals ABSSLC supported with complex medical needs, it was concerning that more progress had not been made with regard to the provision of medical, nursing, and other healthcare supports. Beyond the fact that this meant that compliance with the Settlement Agreement had not been achieved, it most importantly meant that individuals did not

yet have the protections, supports, and services they needed. It is essential that as the Facility continues down the path to compliance, staff keep this in mind as the ultimate goal.

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 Abilene State Supported Living Center's status with regard to relevant the sections of the Settlement Agreement:

Restraints

- The Monitoring Team found the Facility was not in substantial compliance with the provisions in Section C. Areas of progress included:
  - A reduction in the numbers of restraints had occurred.
  - The Restraint Reduction Committee was reviewing restraints and issues related to restraints, and taking action.
  - Steps were being taken to address alternatives to sedation plans for people going for dental appointments.
  - Training on the new DADS restraint policy was underway.
- Some of the areas that needed improvement included:
  - Ensuring restraint monitors were on site within 15 minutes.
  - Clarifying for staff that restraints can be used in certain crisis situations.
  - Clarifying how the review of the use of restraint by the Unit Teams and the Incident Management Team will be documented, so that it will be clear that the circumstances of the restraint have been determined and any necessary plans are put in place.

Abuse, Neglect and Incident Management

- Progress was noted in a number of areas with regard to Section D. Highlights of progress included:
  - Trend reports had resumed.
  - There was progress in reviewing injuries for patterns that need evaluation.
  - ISP annual reviews increasingly included discussion of abuse history and distribution of the abuse resource manual.
- Some of the areas in which improvements were necessary included the need to:
  - Track recommendations in the investigation reports to conclusion.

- Produce Corrective Action Plans (CAPs) for issues identified through analysis of trend data.
- Work on the monitoring guidelines to ensure they provided exact descriptions of what to look for in each provision to improve reliability.
- Ensure that Unusual Incident Reports (UIRs) include a list of people interviewed and a summary of the information gathered from those interviews.

Quality Assurance

- Since the Monitoring Team's last visit, the Facility had made some progress with regard to Section E, including:
  - Quality Assurance (QA) monitoring tools were in use for all sections of the Settlement Agreement, except Sections E and U;
  - Analyses of the resulting data were being done quarterly for most sections. However, these analyses needed to focus on the identification of systemic issues, not just the sufficiency of the data collection process.
  - Meetings between discipline heads and Program Compliance Monitors (PCMs) were taking place monthly to resolve issues with audit tools and improve reliability.
- Some of the areas that will need to continue to improve for the Facility to progress toward substantial compliance with the Settlement Agreement included:
  - The Facility needed to use the QA monitoring tool to self-assess Section E.
  - The tools for medical compliance and the associated data needed to be operationalized.
  - Data reports needed review to identify areas in need of corrective action. Corrective Action Plans needed to be developed, logged, and tracked to completion.
  - The Facility needed to work with the State Office on identifying a set of key indicators of performance. These then needed to be tracked and analyzed to help identify system issues as well as major issues with individuals that need high-level intervention to ameliorate.
  - Updated Facility procedures needed to be developed to compliment the revised State Office policy.
  - The data analyst that had been hired just prior to the Monitoring Team's previous review had resigned. A Program Compliance Monitor had been assigned to temporary duty at the data analyst desk. This important position will need to be refilled as soon as possible to assure this important role can be carried out.

Integrated Protections, Services, Treatments and Supports

- In July 2012, the State Office provided additional training on a revised ISP format and process to ABSSLC's Qualified Developmental Disabilities Professionals (QDDPs) and many other team members. A revised Individual Support Plan (ISP) Meeting Guide was introduced to assist the QDDPs in preparing for the meetings and in organizing the meetings to ensure teams covered relevant topics. In addition, according to the new procedures, more pre-planning was to begin 90 days prior to the ISP meeting. In addition to the team using a new tool to identify the individual's preferences, strengths, and priorities, at the ISP Preparation Meeting, the

team also was to make decisions regarding which team members should attend the annual meeting, and the assessments that needed to be completed prior to the meeting. At the time of the Monitoring Team's review, two teams had been selected to pilot the new process.

- Timeliness and quality of assessments continued to be problematic. Although it appeared that teams had begun to review and incorporate more assessment information and clinical data into the decision-making regarding individuals' risk ratings, assessments continued to lack adequate recommendations to appropriately define the protections, supports, and services the individuals required. In addition, even when recommendations were included, teams did not consistently address them in the ISPs.
- Teams appeared to be talking more about individuals' preferences and strengths, as well as community activities, including sometimes the development of community skill acquisition goals. However, further refinement of these discussions was needed, including expanding the scope and types of preferences and strengths the teams identified, and better incorporating them into the ISP action plans and using them creatively to expand individuals' opportunities or address their needs; and increasing individuals' opportunities for community integration through the inclusion of measurable and meaningful objectives in their ISPs.
- The Facility identified that the development of action plans was an area in which more work was needed, as well as more training and technical assistance. A review of the ISPs as well as the Integrated Risk Rating Forms (IRRFs) showed that teams were talking more about the various "protections, services and supports, treatment plans, clinical care plans, and other interventions provided for the individual." The revised meeting guide prompted the teams to discuss, revise, and approve plans that previously had been viewed as separate plans, such as the Physical and Nutritional Management Plan (PNMP), Positive Behavior Support Plan (PBSP), crisis intervention plan, psychiatric treatment plan, and integrated health care plans. Although the Facility was in the beginning stages of implementing this new process, it showed promise for the development of more comprehensive ISPs.
- In conjunction with State Office, the Facility was in the process of deciding on a new format for monthly reviews. As the Monitoring Team discussed with staff, whatever system is decided upon should provide various team members with responsibility for conducting monthly reviews with a practical method for documenting their reviews, including relevant data. It also should provide the QDDPs with a user-friendly way of pulling these reviews together and making decisions about whether further team review is necessary.
- Progress was being made in setting up the infrastructure for the quality assurance processes, including development of a monitoring tool that more closely tracked the current ISP process, delineation of guidelines to supplement the indicators in the monitoring tool, establishment of inter-rater reliability amongst auditors, development of a database to aggregate information, and meetings between programmatic and Quality Assurance (QA) Department staff to review and analyze the data, and make recommendations for corrective action plans. However, all of these activities remained in a development stage and required additional work.

Integrated Clinical Services

- The morning medical meetings provided a focus of integrated clinical care. They appeared to be well attended. The Facility had begun to record departmental attendance at the morning medical meeting as part of the evidence of an integrated approach to clinical services. More recently, a closure column was added to the morning medical meeting minutes to provide documentation when concerns needing resolution were raised. However, several steps were yet to be taken:
  - To ensure a timely answer was provided to the morning medical meeting committee, once a need was identified, assignment of tasks should have been followed by a due date.
  - There was no follow-up of concerns when tasks were assigned or recommendations made to the Interdisciplinary Team (IDT). IDTs should be accountable to answer the concerns identified in the morning medical meeting, and the Individual Support Plan Addenda (ISPAs) should demonstrate critical discussion reflecting integration of disciplines. The related documentation should be returned in a timely manner to the morning medical meeting for review to determine if the IDT answered their concern. This process had not occurred.
  - Further, few concerns were identified. Although acute care was timely and appropriate, critical probing to ensure prevention of repeat hospitalizations and Emergency Room (ER) visits was often absent. There was little evidence the morning medical meeting committee or the IDT met to determine preventive steps for each hospitalization that occurred. There were a few ISPAs that did reflect critical thinking, but there was no tracking of the ISPA process.
  - Minutes of the morning medical meeting did not have the structure to reflect interdisciplinary discussion of important cases or issues, but appeared to use a nursing morning report format. This was an important start, but considerable documented input from the Primary Care Practitioners (PCPs) and other disciplines was needed in a succinct format.
- In addition, a format did not appear to exist to ensure the PCPs processed the consult reports in a timely manner in the Integrated Progress Note (IPN), and the rate of compliance of writing an IPN to review the content of the consult remained at 50 percent. No review was occurring of the quality of the IPN to ensure it documented how the plan of care was to be changed or not changed based on this information (i.e., integrating the results into the care plan for the individual). No system was in place to ensure the consult report and PCP response was forwarded to the IDT for review, with interdisciplinary discussion, and ISPA development based on the consult, if indicated. The Monitoring Team determined that the Facility was noncompliant with both sub-sections of Section G.

Minimum Common Elements of Clinical Care

- The Medical Department added a full-time staff member to assist in quality improvement within the department. However, much of Section H remained under-developed, because the PCPs all had clinical care assignments, including the Medical Director. At the time of the Monitoring Team's visit, little development of

methods to organize and maintain data had occurred. Many databases appeared incomplete or lacked essential components, and as a result, adequate analysis could not be completed. The database tracking quarterly medical reviews was an important start, but appeared to be user-unfriendly.

- Section H is also interdisciplinary. Other departments needed to cooperate in providing complete and accurate data concerning routine annual and periodic assessments. Other departments should assist in providing their own interpretation of this data. Overall, there did not appear to be a coordinated system that tracked all clinical departments for timely completion of routine assessments or assessments based on health status changes and the needs of the individual.
- In addition, the Facility had not completed an audit to determine if there were criteria (based on clinical guidelines or other sources) to justify the major diagnoses in the active problem list.
- Clinical guidelines had not been utilized (except through the general medical audit) as a standard in completing record reviews to ensure practice patterns reflected the content of the guidelines.
- In addition, clinical indicators of success of treatment had not been selected and/or monitoring completed, as a way to guide the PCP and the IDT in determining if treatment was effective or needed to be changed. The Medical Department relied heavily and almost exclusively on the use of the questions in the general medical audit and the medical management audit to attempt to provide evidence of compliance with Section H, but the general audit should have been seen as a start to quality improvement rather than an endpoint. The Facility remained noncompliant with all subsections of Section H.

<u>At-Risk Individuals</u>

- Since the last review, the State Office had made revisions to the At-Risk Individuals policy (in draft form at the time of the review). Some of the changes included regrouping the Risk Guidelines so that the risk factors that were clinically inter-related regarding outcomes or provision of services and supports were listed together, and linking each risk factor with specific clinical indicators. In addition, the Integrated Risk Rating Form (IRRF) was revised to follow the same grouping sequence as the Risk Guidelines. Some additional revisions included replacing the Risk Action Plans for the identified high and medium risk indicators with Integrated Health Care Plans (IHCPs) designed to provide a comprehensive plan that will be completed annually; different forms regarding IRRF and the IHCP were developed addressing changes in status; the Aspiration Pneumonia Enteral Nutrition was revised as a data collection tool; and Trigger Data Sheets were developed to include observable and measurable clinical signs and symptoms that alert the staff to possible changes in status.
- In June 2012, two teams at ABSSLC had been trained on the new policy and processes, and had begun to pilot them. It was important that the new system was being piloted with two teams to determine any additional implementation steps/changes that needed to be made, or any additional training that would be beneficial before broadening its scope to the entire campus. The many changes that had occurred with regard to the At-Risk system were reflected in the different ISP documents, and the varying quality of the IRRF indicated some confusion amongst the teams with the previous process. Developing a successful program on a small scale that

can then be implemented across campus should reduce such issues. Staff from the pilot systems in two residences also could act as mentors to the other teams, another important step in providing consistency across campus and improving the quality of the process. Until now, the quality of the risk reviews and implementation process varied depending on the understanding and expertise of the various IDTs. Hopefully, the process will become more standardized, which should benefit the individuals residing at ABSSLC.

- From review of the ISP and addendum documentation, individuals' teams were having discussions of the individuals' status, and more pertinent clinical information was being included in the Integrated Risk Rating Forms than previously. However, the overall lack of clear documentation included in the ISPs, the Risk Action Plans, and the associated disciplines' assessments regarding what actions were taken in response to pertinent events or health issues, and the lack of dates and supporting documentation addressing actions and completion of action plans made the Monitoring Team's review of the At-Risk system difficult, and the lack of progress noted was troubling at this juncture of the compliance process.

Psychiatric Care and Services

- At the time of the Monitoring Team's previous review, ABSSLC had three full-time Psychiatrists, who were supported by one Psychiatric Nurse and two Psychiatry Assistants. Based on an analysis the Chief Psychiatrist completed it appeared that this number of Psychiatrists should be adequate. Two of these Psychiatrists left the Facility in the spring of this year, but the Psychiatry Department has since added a half-time Psychiatry Consultant, as well as a full-time Psychiatric Nurse Practitioner.
- The progress with regard to the completion of the Comprehensive Psychiatric Evaluations (CPEs) had continued. However, the progress in completing the CPEs had been disrupted by the departure of the two full-time Psychiatrists noted above. The current plan was to complete these in conjunction with the annual ISP. The annual updates also would be completed to coincide with the annual ISP, which would make the process self-sustaining. The Psychiatrists or a member of the Psychiatry Department Support Staff also had begun to attend the ISPs of individuals who were receiving psychotropic medication. It will be important for the Psychiatry Department to ensure that the documentation that concerns psychiatric treatment, which appears in the ISP, conforms to the requirements the Settlement Agreement specifies.
- Monthly reviews continued for individuals undergoing changes in their medications and/or experiencing an exacerbation of their psychiatric disorder, and quarterly reviews were conducted for individuals considered stable. Observation of the Psychiatric Clinics of the two 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, attended the clinics. The Living Unit Supervisor represented the direct support professionals.
- The documentation that accompanied the Quarterly Psychiatric Reviews was recently updated. The Quarterly Psychiatric Reviews now 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.

There was also an expanded Risk versus Benefit section. The teams had made progress in implementing this new section, which initially had been difficult to implement.

- The Chief Psychiatrist had developed a Physician Psychotropic Medication Treatment Plan (PPMTP), which served as a Treatment Plan for the psychotropic medication, because this information no longer appeared in the Positive Behavior Support Plan (PBSP).
- Members of the Monitoring Team attended a Human Rights Committee (HRC) meeting, during the onsite review, and it was clear that the system was more functional than it had been at the time of the previous review. The Chief Psychiatrist had been attending HRC meetings, when possible, and this had contributed to the improved operation of the process.
- Progress continued in decreasing the rates of polypharmacy at ABSSLC, which had been reduced to approximately 24 percent of those prescribed psychoactive medications. In addition, a number of individuals had active tapering schedules in process. 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. For individuals in the latter group, the Facility had made additional progress in assembling the necessary documentation to justify the efficacy of psychotropic medications.
- A plan recently had been approved to have all of the individuals followed by both Psychiatry and Neurology reviewed in a distinct Neuro-Psychiatry Clinic. This should provide improved coordination of clinical care by both specialties.
- Thus, in summary, the Facility had made significant progress in a number of areas related to Section J. However, the impact of many of these positive initiatives was not fully reflected in the current review, due to the time lag before the new procedures were fully assimilated into the ongoing clinical processes and were documented in the individual records.

<u>Psychological Care and Services</u>

- The Facility continued to make good progress in supporting Behavioral Services Department staff to obtain professional certification. Several members of the Department had completed the required coursework and supervision required by the Behavior Analyst Certification Board. One staff member had achieved professional certification and another recently had been hired with the certification.
- Peer review continued to evolve. Internal peer review occurred on a regular basis through meetings of the Behavior Support Committee. Monthly external peer review involving staff from other State Supported Living Centers had been initiated. Expansion of these activities to include regularly scheduled opportunities for review of particularly challenging cases is recommended.
- Data collection and monitoring of Behavior Support Plan implementation remained a challenge, yet the Facility had initiated steps to improve both. Staff were beginning to gather monthly data regarding staff knowledge of plans as identified through interview, were collecting measures of inter-observer agreement, and were initiating

methods to ensure high levels of treatment integrity. As this monitoring was completed, measures of engagement also were being recorded. This information was reported in the individual's Psychology Monthly Progress Note.

- Work continued on developing comprehensive behavioral assessments and behavior support plans for individuals. Review of all assessments and plans continued through the Behavior Support Committee and templates for self-assessment had been developed. Although progress was being made, a number of concerns identified in previous report still existed.
- A pilot project had been implemented to test specific staff training strategies. Plans were discussed to use the information gained from this experience to develop training programs in additional homes and other areas of the Facility.

Medical Care

- Particularly with regard to individuals' chronic health concerns that placed them at risk on an ongoing basis, little improvement was seen in the Facility's critical analysis of treatment provided, and the need for additional or different assertive treatment of such conditions. The morning medical meeting was an important daily forum to review changes in status of individuals. The morning medical meeting also was occasionally used to discuss potential Adverse Drug Reactions (ADRs), provide updates in drug interactions, and to discuss system concerns. However, overall, the process needed more PCP leadership, in providing succinct presentations, asking other departments represented or other PCPs for directed input on specific concerns, and providing a discussion/rationale for the diagnostic and treatment plan. Perceived delays in care or lack of aggressive treatment should be questioned. There was little to no discussion documented concerning how to prevent a recurrent pneumonia, or other significant health concerns.
- There was considerable progress in completing preventive testing. Database reports provided appeared to be helpful. However, it did not appear the Medical Department used these databases to provide guidance to the PCPs, because they were not mentioned in the Facility's Self-Assessment.
- There did not appear to be limitations to access to specialists. However, there was concern regarding the prolonged time before consultations occurred, including the time between when the PCP ordered the consultation to the time the appointment was set, to the time the appointment was completed, and the report was returned back to the PCP. The Facility should review potential causes for these delays, especially in cases where the individual's health status was deteriorating. There did not appear to be a system to provide a fast track for consultation, or if there was, it did not appear it was used in cases when it would have been helpful.
- Acute care appeared appropriate. PCP assessment and treatment was timely and thorough once an acute care concern was communicated. However, the Facility needed to consider completing record reviews for most hospitalizations to determine the quality and completeness of the documentation, nursing assessments, respiratory therapy assessments, and potential missed opportunities that could have led to earlier interventions, and earlier communication to the PCPs. Diagnostic testing and treatment early in the course of illness as a result

of earlier communication potentially would have led to less emergent situations. Completing a quality review of this critical time period would assist in ensuring the Facility is providing all essential supports in a timely manner, and/or determine areas needing improvement.

- The Skin Integrity Committee remained focused on data collection, with no current systems approach to begin to reduce the incidence of decubiti.
- The Facility was not yet using the mortality review process as an opportunity to learn from the deaths that occurred, and identify systemic actions necessary to improve the quality of care. In addition, a system for tracking of mortality review recommendations was not in place. The Facility needed to review the quality of the recommendations that were made, and needed to ensure closure on those recommendations.
- The external peer review process appeared to have had a positive impact on quality care, but questions had been raised about the inter-rater reliability between the auditors. The Medical Department relied heavily on the general medical audit. The Facility should focus on monitoring the many other areas of medical care. The Facility remained in noncompliance with all subsections of Section L.

<u>Nursing Care</u>

- Since the Monitoring Team's last review, nursing staffing continued to be a challenge for the Facility, especially for Licensed Vocational Nurses (LVNs). In response to this challenge, the Facility converted 4.5 LVN positions to three Registered Nurse (RN) 2 positions. In addition, ABSSLC had some changes regarding the Nursing Department and nursing positions, which included an additional full-time Infection Control Nurse (RN), a full-time Hospital Liaison, a full-time Registered Nurse was hired for the Nurse Case Manager Supervisor position, five new Nurse Case Managers were to be added in order to decrease the number of individuals on each Nurse Case Manager's caseload, and the existing Quality Assurance Nurse had been on leave since June 2012.
- Some of the Facility's positive steps forward included:
  - The Facility reported that approval was obtained to focus auditing efforts mainly on three problems areas, including: Urgent Care/Emergency Room Visits/Hospitalizations, Acute Illness and Injury, and Annual Nursing Assessments.
  - The minutes of the Infection Control Committee Meetings had developed into an exceptional document that provided clear and concise information.
  - In April 2012, infection control had an Integrated Progress Note approved through the Medical Records Committee and had begun to implement its use.
  - The Facility had a tracking form that clearly identified the audit information regarding the emergency mock drills by item, by month, and the drill status (passed or failed).
  - The Facility was in the process of developing a Nursing Education database to track the training classes and in-services nurses completed. The expected completion date for the database was noted to be September 2012.

- Two pilot residences, 6400 and 6480, had made a transition from using the Health Management Plans (HMPs) to address high and medium health and mental health risks to using an Integrated Health Care Plan that will ultimately replace the current Risk Action Plans and Health Management Plans.
- In March 2012, a new database was developed and implemented to more accurately track the medication variances leading to better trending and analysis of the variance data.

- Although the Facility had made some positive steps forward in the areas noted above, the overall lack of progress, and in some areas, regression, found regarding the nursing care plans, the nursing assessments and documentation in response to changes in status, the quality of the quarterly and annual Comprehensive Nursing Assessments, the lack of emergency equipment drills conducted, and the unreliable systems regarding medication variance data were very concerning at this juncture in the review process.

<u>Pharmacy Services and Safe Medication Practices</u>

- The Facility demonstrated that new orders in which there were concerns for drug-drug interactions, allergies, dosage concerns, significant side effects, and need for further testing were appropriately followed up and had documentation of each step of the process.
- The quality and completeness of the QDRRs continued to improve. The rate of timely completion was high. Laboratory reviews, benzodiazepine reviews, and atypical antipsychotic monitoring for metabolic side effects were thorough. Chemical restraint usage appeared to be reviewed in each case by pharmacy in a timely manner. This had been a challenge in the past, but a system appeared to be in place for the Pharmacy's review of all emergency chemical restraints. Polypharmacy identification and anticholinergic risk/benefit analysis needed further review and documentation. PCPs were responding to the QDRRs in a timely manner, but psychiatrists needed to improve their timely review of the QDRRs.
- The Adverse Drug Reaction (ADR) identification and reporting process had progressed in its development. Direct support professionals had been trained, but only 12% of nursing had undergone training.
- The DUE process also was in place. The reports were timely and the results were pragmatic and shared with the PCPs and psychiatrists.
- Medication variances in the pharmacy needed tracking, data collection, and proof of progress. Little to no progress had been made in addressing medication variance issues.

<u>Physical and Nutritional Supports</u>

- The Facility had a Physical and Nutritional Management Team (PNMT) that included all relevant members. However, although the Facility had plans to do so, the Facility had not yet completed an analysis to determine appropriate caseloads for PNMT members or other clinicians, based on acuity and other factors. The other responsibilities of the PNMT members appeared to impact the functioning of the PNMT. Based on review of attendance records, the PNMT was meeting frequently without the required membership as outlined in the Settlement Agreement.

- At the time of the review, the Facility had just finalized the PNMT policy. Consequently, the IDTs had not been provided training on the policy.
- A review of PNMT assessments and actions plans identified multiple missing components. In addition, individuals the PNMT discharged did not have adequate discharge plans as multiple components were missing.
- Lists presented by the Facility to identify individuals having physical and nutritional management problems were not accurate, and the Habilitation Therapy (HT) Director acknowledged there were no Facility policies and/or procedures to maintain, update, and sustain these lists.
- The Facility was in the process of implementing an individual-specific Physical and Nutritional Management Plan (PNMP) revision schedule home by home, which was to be completed by February 2013. In addition, since the last review, the HT Department had developed PNMPs for an additional 73 individuals, which was a positive development. However, a review of the list of individuals without PNMPs and their risk ratings showed that some additional individuals needed a PNMP.
- The Monitoring Team, HT Director and members of the PNMT team completed direct observations of the implementation of PNMP strategies in the Infirmary and residences for a sample of individuals on the PNMT caseload. The HT Director and members of the PNMT had to intervene with staff during every observation to correct staff's approach for wheelchair positioning, alternate positioning, bathing, transfers, and medication administration. These observations revealed that staff was not competent in implementing individuals' PNMPs. However, in reviewing monitoring data for these same individuals, the Facility's monitoring did not identify similar problems.
- At new employee orientation staff were responsible for completing performance check-offs for physical management. However, there were no performance check-offs to test staff competency for nutritional management/support skills.
- The Facility had not implemented an effectiveness monitoring system to assess the progress of individuals with Physical and Nutritional Management (PNM) difficulties, or provide evidence that interventions were modified if an individual was not making progress.
- On a positive note, on 5/17/12, the Facility had implemented Mandatory Training regarding Aspiration Pneumonia and Enteral Nutrition. The Facility also was in the process of implementing a new Aspiration Pneumonia Enteral Nutrition (APEN) process. However, current APEN assessments for individuals who received enteral nutrition were not following the State and/or Facility-established template and content guidelines, including the participation of recommended disciplines, providing justification that the continued use of the tube was medically necessary, or assessing the individual's potential to receive a less restrictive form of enteral nutrition or transition to oral intake, if appropriate.

<u>Physical and Occupational Therapy</u>

- Based on acuity, an Occupational Therapy/Physical Therapy (OT/PT) Evaluation Priority List had been developed to create a schedule for the completion of individuals' OT/PT comprehensive assessments. The

development of an OT/PT priority assessment list was a positive step forward in prioritizing individuals with OT/PT needs. Based on interview with the Director of Habilitation Services and therapists, this system was also to be utilized in assigning OT and PT caseloads based on acuity. However, at the time of the review, this priority list for assessments had not yet been implemented.

- Based on a review of individuals' OT/PT assessments, they were missing important essential components and, consequently, were not considered adequate OT/PT assessments. However, some of these assessments included some promising practices.
- OT/PT direct interventions and/or programs were not integrated into individuals' ISPs. In addition, monthly progress notes were not adequate to provide the results of effectiveness review/monitoring of the individual's progress with direct and/or indirect OT/PT supports.
- Individuals with PNMPs and dining plans were not monitored at the Facility's reported monitoring frequency of two times per month using the Compliance Monitoring form. The monitoring also did not address the status of their identified occupational and physical therapy needs, and the effectiveness of their OT and PT therapy programs. Furthermore, all prescribed adaptive equipment was not assessed for its condition, availability, and effectiveness.

Dental Services

- The Dental Department had developed a number of databases that appeared to be complete and accurate. The Dental Department used these to ensure compliance with the Settlement Agreement, but also as their own internal monitoring measurements to ensure the provision of quality dental care. Annual assessments were timely, emergency dental logs demonstrated prompt care, and for any outstanding issues, there was a monthly review to ensure closure of all cases. The annual assessments appeared to be complete except for documentation of tooth brushing instruction and recommendations for community living. A review of dental records indicated a lack of a periodontal chart in those with teeth. Many odontograms remained incomplete, but some progress had been made in this area. The level of risk did not appear to be part of most dental records.
- Oral hygiene appeared to continue to improve. It was noted that a high percentage (41%) of the population was edentulous. A total of 37% of the population used suction tooth brushing.
- Oral sedation was used at a very low rate, and a monitoring system for vital signs pre- and post-procedure was in place. Missed appointments were tracked closely. The Dental Department tracked IDT response to missed appointments and the development of ISPAs in response to missed appointments, but this was an area that needed improvement. Desensitization plans and plans for improved cooperation had some success, but each step of success needed to be quantified in the form of measurable parameters.
- Although the Facility remained out of compliance with both subsections, significant progress had been made towards compliance.

Communication

- Although some improvements were seen with regard to comprehensive speech/language assessments, these assessments were missing some essential components.
- Observations by the Monitoring Team and the lead Speech Language Pathologist (SLP) of individuals with alternative and augmentative communication (AAC) systems noted an improvement in the presence of some of these individuals' AAC systems. In addition, some staff had been provided with individual-specific competency-based training and performance check-offs to demonstrate their competency in supporting individuals in the use of their AAC systems.
- Although the Facility's Communication Services policy included some important components, a number were missing. It did not include the following key elements: monitoring for the use of communication adaptive equipment in multiple environments (e.g., home, day program, work); the process for identification, training, and validation for monitors; the process of achieving inter-rater reliability; and a process for data trend analysis and utilization of findings to drive training and problem resolution (individual and systemic).

Habilitation, Training, Education, and Skill Acquisition Programs

- Since the Monitoring Team's last review, the Facility had taken a number of steps to improve its compliance with Section S of the Settlement Agreement. Positive actions included the following:
  - Numerous staff had been trained in the Individual Support Plan process.
  - The Functional Skills Assessment was increasingly being completed in full for the individual.
  - Similarly, vocational services staff had completed comprehensive assessments for 36 individuals the Facility served. Although some issues were noted with regard to the quality of these assessments.
  - A pilot program had been completed in one of the residential units to assess the level of individual engagement. This same measure examined the availability of functional and age appropriate materials and the quality of the environment. The plan was to expand this monitoring system to other units, activity centers, and workshop areas.
  - QDDP staff had just been trained to use a tool to monitor skill acquisition plans. This offered an introduction to competency-based training of all direct support professionals.
- Areas in which continued work was necessary included the following:
  - Information gathered through assessment of functional skills and vocational interests and strengths did not consistently translate into the design of comprehensive habilitation services.
  - Skill acquisition programs continued to be poorly written with limited opportunities for learning.
  - Engagement remained limited, particularly in the residential units and the activity centers.
- In sum, much of the feedback the Monitoring Team has provided in the past remained relevant.

Most Integrated Setting

- An increasing number of assessments prepared for annual ISP meetings had begun to include the assessor's recommendation regarding transition to the community. In addition, based on review of ISPs using the new

template, individuals' ISPs had begun to include a recommendation from the professional team members' with regard to whether or not community placement was appropriate. This was positive. However, unfortunately, the assessments and/or ISP narratives included statements showing disagreements amongst the team members regarding the individuals' appropriateness for community transition. The teams' recommendations were that the individuals remain at the Facility. However, it was not clear how the teams' disagreements about this had been resolved and/or the teams had not provided adequate justification for their decisions.

- ABSSLC had made some progress in identifying obstacles to community referral, but more work was needed. Teams had not yet begun to systematically identify obstacles to transition that individuals encountered after the referral was made. The quality of the action plans teams had developed to overcome obstacles remained inadequate, largely because they lacked individualization and often were not measurable. 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. This included providing training to teams and QDDPs, and working with the data analyst to develop user-friendly data entry tools.
- Admissions and Placement Department staff were clearly working hard with individuals' teams to expand the scope and definition of pre-move and post-move required supports in individuals' CLDPs. Additionally, 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. However, at the time of the current review, teams did not consistently identify all the pre-move and poste-move required supports that the individual needed to transition safely and successfully to the community. Although the measurability of supports was improving, this was an area that required attention, particularly as more complex supports were included in the plans.
- 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.

<u>Consent</u>

- At the time of the review, the State Office Guardianship Policy had been disseminated, but the policy on consent remained in the development phase. ABSSLC had adopted the State Office policy and had begun to implement portions of the policy. In March 2012, the Human Rights Officer provided a training session to QDDPs on the process for completing the Guardianship Priority Discussion form that they were to submit after each ISP meeting with input from the team. This form included the factors for prioritization from the DADS State Office

policy, which were consistent with those in the Settlement Agreement. However, the definition of terms or criteria with which teams were to make decisions were not clear. This likely will result in teams using different criteria and recommendations regarding prioritization being inconsistent. At the time of the review, teams had just begun to implement the process, and, appropriately, were conducting the reviews as part of individuals' ISP meetings.

- As a threshold issue, prioritizing an individual's need for guardianship cannot be done adequately until a process is in place to screen for an individual's need for a guardian. 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.
- In the meantime, ABSSLC had maintained its prioritized list of individuals in need of guardians, which was based on the previous tool the Facility had created in the absence of a State Office policy. Based on this list, a total of 81 out of 411 (20%) 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, one individual had obtained a guardian, and another individual had a successor guardian appointed. For an additional eight individuals, some steps reportedly had been taken to initiate guardianship proceedings.
- Facility staff were continuing to attempt to identify family members or other involved individuals that might be interested in pursuing guardianship for individuals that teams believed needed such support. Information was provided to such individuals about funding sources. Since the last review, more information had been obtained about a local nonprofit agency that offered guardianship services. This appeared to be a promising possibility. In addition, a newsletter article provided contact information for people interested in becoming a guardian. Although these were positive efforts, given the number of individuals the Facility estimated needed guardians, ongoing collaboration was needed with State Office to identify additional viable guardianship resources.

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

- According to staff, all of the individuals at ABSSLC had Active Records and Master Records. Since the last review, the Facility also had developed and implemented Individual Notebooks for all individuals. This was a significant undertaking. Staff appeared to find them helpful, particularly with regard to documenting essential data.
- 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 conducting audits of records and correcting issues identified. However, more in-depth analyses of data should result in the identification of more specific areas or departments in need of attention, the development and implementation of action plans to address the underlying causes, and follow-up to determine if the desired outcomes are achieved.
- The Facility was continuing to develop and revise policies to address the requirements of the Settlement Agreement. The policy related to policy development and dissemination was in the process of being reviewed 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 with the assistance of the Competency Training and Development Department had designed a system to track training.

- The Facility had continued to implement the policy designed to improve the timeliness of filing items in the records, and some recent improvements were seen. However, this was an area that required continued diligence.
- Based on observations of team meetings, improvements were noted particularly with regard to teams using more data in making decisions regarding risk ratings. However, additional work was needed in this area as well as with the use of data to make other decisions, such as in relation to skill acquisition programs. In addition, issues related to the maintenance of complete and accurate data had the potential to impact negatively on teams' decision-making ability, such as in relation to individuals' PBSPs and prescription of psychotropic medication.

VI. Status of Compliance with the Settlement Agreement

<table>
<tr><th>SECTION C: Protection from Harm-Restraints</th><th></th></tr>
<tr><td>Each Facility shall provide individuals with a safe and humane environment and ensure that they are protected from harm, consistent with current, generally accepted professional standards of care, as set forth below.</td><td>
Steps Taken to Assess Compliance: The following activities occurred to assess compliance:

Review of Following Documents:

State Policy #001.1: Use of Restraint, dated 4/10/12;
ABSSLC Policy: Use of Restraints, dated 6/10, (revisions to match the revised DADS policy were in process per response to Document Request #1208.II.1);
ABSSLC Self-Assessment, dated 8/8/12;
ABSSLC Action Plan, dated 8/9/12;
Presentation Book for Section C;
Presentation for Section C at the entrance meeting on 8/20/12;
Section C Self-Monitoring Questionnaire, dated 3/22/12, which replaced the previous monitoring tool;
QA/QI Data Summaries, dated 2/13/12 and 5/8/12;
Restraint Checklists, dated April 2012;
Abilene State Support Living Center: Restraint by Facility, from 2/1/12 through 6/30/12;
ABSSLC Restraints Trend Analysis Reports for January through June 2012;
Restraint Reduction Committee Minutes, dated 2/16/12, 3/22/12, 4/30/12, 5/25/12, and 6/29/12;
Do Not Restrain/Modification of Restraint List, undated;
List of Restraint Monitors, dated 5/31/12;
Sample #C.1 was drawn from a list of individuals restrained between 2/1/12 and 6/30/12. The list included 66 incidents of restraints involving 25 individuals. A sample of 13 (20%) of the incidents, involving 12 (48%) of the individuals was drawn. The sample was divided over the time period, with an effort to avoid selecting the same person twice, with one exception. The complete restraint records for the selected sample were requested, including:

Restraint checklist form,
Face-to-face/debriefing form,
The individual's Safety Plan, if applicable,
Documentation of any and all reviews of this use of restraint; and
Addenda or changes to the ISP or Safety Plan that resulted.

This documentation was requested for the following restraint episodes:
<table>
<tr><th>Individual</th><th>Date of Restraint</th><th>Time of Restraint</th></tr>
<tr><td>Individual #384</td><td>3/25/12</td><td>10:30 a.m.</td></tr>
<tr><td>Individual #99</td><td>2/10/12</td><td>10:54 a.m.</td></tr>
<tr><td>Individual #99</td><td>4/29/12</td><td>3:06 p.m.</td></tr>
<tr><td>Individual #231</td><td>4/28/12</td><td>5:05 p.m.</td></tr>
<tr><td>Individual #486</td><td>3/10/12</td><td>1:12 p.m.</td></tr>
</table>

</td></tr>
</table>

Individual #137	5/20/12	1:10 p.m.
Individual #507	4/19/12	3:40 p.m.
Individual #323	5/28/12	8:36 p.m.
Individual #107	2/2/12	1:13 p.m.
Individual #95	4/6/12	8:05 a.m.
Individual #247	4/13/12	8:20 p.m.
Individual #150	5/31/12	10:50 a.m.
Individual #534	6/6/12	8:22 p.m.

*In this report, individuals in Sample #C.1 have been referred to solely by number, except for Individual #99 where citations include the date.

- The Restraint Checklists and Face-to-Face Debriefing Forms for the following additional restraint episodes:
  - For Individual #99: 4/19/12 at 9:15 a.m., 9:45 p.m., and 11:10 p.m.; 4/29/12 at 4:32 p.m.;
  - For Individual #231: 3/30/12 at 1:20 p.m.; 4/28/12 at 5:14 p.m., 5:41 p.m., and 6:15 p.m.;
  - For Individual #384: 3/23/12 at 8:35 and 9:55 a.m.; 3/24/12 at 12:05 a.m. and 6:02 p.m.; 3/26/12 at 8:02 a.m., 8:25 a.m., and 10:25 a.m.; 3/27/12 at 10:30 a.m.; 3/28/12 at 11:00 a.m., 12:50 p.m., and 4:35 p.m.; 3/29/12 at 11:30 a.m.;
- Sample #C.2, included 25 staff, selected at random from the list provided. For each staff member the following were requested:
  - Their training transcripts showing date of most recent:
    - PMAB training;
    - Training on use of restraints;
    - Training on abuse/neglect/exploitation; and
    - The signed forms to show that each identified staff member had acknowledged his/her responsibility to report abuse/neglect;
- Sample #C.3 was drawn from the list provided in response to the document request for medical restraints, including 115 restraint instances involving 64 individuals. Sample #C.3 included 13 individuals (20%). The sample was divided over the time period, with an effort to avoid selecting the same person twice. The restraint record for the selected sample of individuals with medical restraint was requested to include:
  - The physicians' orders for the restraint including the monitoring schedule;
  - The restraint checklist;
  - The documentation of the monitoring that occurred;
  - Any reviews of this use of restraint; and
  - Any applicable desensitization plan for the following:

Individual	Date of Restraint	Time of Restraint
Individual #479	5/26/12	8:02 a.m.
Individual #252	6/14/12	5:30 a.m.
Individual #293	4/10/12	12:30 p.m.

Individual #415	6/12/12	7:30 a.m.
Individual #69	4/23/12	1:30 p.m.
Individual #108	2/27/12	7:27 a.m.
Individual #502	6/14/12	10:15 a.m.
Individual #333	5/2/12	10:00 a.m.
Individual #152	3/29/12	11:05 p.m.
Individual #371	4/20/12	6:30 a.m.
Individual #215	4/30/12	12:05 p.m.
Individual #321	5/16/12	12:35p.m.
Individual #363	3/27/12	9:10 p.m.

- Sample #C.4 was drawn from the list provided in response to document request for a list of chemical restraints. The total number of chemical restraints was 26 and the sample included four, or 15%. The sample was chosen to cover the time period, and a duplicate name was chosen due to the frequency of restraint. (Documentation for one individual was not provided.) Documentation included:
  - The restraint checklist;
  - Face-to-face/debriefing form;
  - Any reviews of the use of the restraint; and
  - Evidence of contact between the psychologist and physician prior to the use of the chemical restraint, for the following individuals:

Individual	Date of Restraint	Time of Restraint
Individual #384	3/26/12	8:25 a.m.
Individual #384	3/28/12	4:35 p.m.
Individual #137	5/20/12	1:10 p.m.
Individual #99	4/29/12	4:32 p.m.

- Sample #C.5 was drawn from the list of two individuals restrained off-grounds for crisis intervention. One individual was selected and the documentation provided for Sample C.1 was reviewed. The restraint for Individual#534, on 6/6/12 at 8:22 p.m. was selected.
- Restraint documentation completed by nursing staff for the following individuals: Individual #384, Individual #99, Individual #231, Individual #313, Individual #323, Individual #163, Individual #303, Individual #107, Individual #534, Individual #422, Individual #301, Individual #215, Individual #94, and Individual #48;
- ABSSLC Chemical Restraint by Facility;
- Behavior Support Plans: Individual #87, Individual #267, Individual #517, Individual #540, Individual #61, Individual #95, Individual #216 (draft), Individual #518 (draft), Individual #375, Individual #218, Individual #156, Individual #145, Individual #120, Individual #197, Individual #315, Individual #49 (draft), Individual #89, Individual #127, Individual #318 (draft), Individual #355, Individual #268, Individual #99 (draft), Individual #231, Individual #274, Individual #533, Individual #56, Individual #461,

	Individual #320, Individual #252, Individual #67, Individual #397, Individual #525, Individual #142, Individual #144, Individual #384, Individual #150 (draft), Individual #103, and Individual #39; o Crisis Intervention Plans for: Individual #163, Individual #95, Individual #48, Individual #268, Individual #486, and Individual #323; o Dental Desensitization Plans for: Individual #488, Individual #242, Individual #104, Individual #140, Individual #189, and Individual #469; o For Section C.7: ▪ Restraint Checklists and Face-to-Face Debriefing Forms for Individual #99: 4/19/12 at 9:15 a.m., 9:45 p.m., and 11:10 p.m.; 4/29/12 at 3:06 p.m. and 4:32 p.m.; ▪ Restraint Checklists and Face-to-Face Debriefing Forms for Individual #231: 3/30/12 at 1:20 p.m.; 4/28/12 at 5:05 p.m., 5:14 p.m., 5:41 p.m., and 6:15 p.m.; ▪ Restraint Checklists and Face-to-Face Debriefing Forms for Individual #384: 3/23/12 at 8:35 and 9:55 a.m.; 3/24/12 at 12:05 a.m. and 6:02 p.m.; 3/25/12 at 10:30 a.m.; 3/26/12 at 8:02 a.m., 8:25 a.m., and 10:25 a.m.; 3/27/12 at 10:30 a.m.; 3/28/12 at 11:00 a.m., 12:50 p.m., and 4:35 p.m.; 3/29/12 at 11:30 a.m.; ▪ Behavior Support Plan: Individual #231 and Individual #384; ▪ Behavior Monitoring Plan, Behavior Protocol, Brief Behavioral Assessment, and One-to-One Instruction Sheet: Individual #99; ▪ Psychology Monthly Progress Note (3/12) for Individual #99; ▪ Psychology Monthly Progress Note (3/12 and 4/12): Individual #231 and Individual #384; ▪ Personal or Individual Support Plan: Individual #99, Individual #231, and Individual #384; ▪ Unit Meeting Minutes related to: Individual #99, Individual #231, and Individual #384; ▪ Restraint Follow-Up for Individual #384; ▪ ISP Addenda: Individual #99, Individual #231, and Individual #384; ▪ IDT Review of Restraints: Individual #99 and Individual #384; ▪ Safety Plan for Crisis Intervention for: Individual #231; and o Restraint Reduction Committee minutes, from 2/16/12 through 7/26/12. ▪ **Interviews with**: o Linda Hindshaw, Facility Director; o Jolene Willis, Assistant Director of Programs; o Pat Smith, Quality Assurance Director; o Cathy Northrup, RN, MSN, CPN, Chief Nurse Executive (CNE); o Mary Willingham, RN, Program Compliance Nurse; o Carole Ivy, RN, Nurse Operations Officer; o Amy Jo Bramlett, LVN, At Risk Coordinator; o Shae Butts, Human Rights Officer, on 8/21/12; o Ron Manns, Director of Behavioral Services, on 8/21/12 and 8/23/12;

	○ Jeff Branch, Active Treatment Coordinator; and Ron Manns, Director of Behavioral Services, on 8/22/12; and ○ Twenty-two Direct Support Professionals. ▪ **Observations of**: ○ Restraint Reduction Committee Meeting, on 8/23/12; ○ QA/QI Council Meeting, on 8/20/12; ○ Incident Management Team (IMT) meeting, on 8/20/12; and ○ Residences #6480, #6350, and #6330; day programs in buildings #6340, #5921, and #5923, and the Senior Program.
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section C, dated 8/8/12. In its Self-Assessment, for each sub-section, 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. For Section C, in conducting its self-assessment, the Facility: ▪ Used monitoring/auditing tools. Based on a review of the Facility Self-Assessment, the monitoring/audit templates and instructions/guidelines, a sample of completed monitoring/auditing tools, inter-rater reliability data, as well as interviews with staff: ○ The monitoring/audit tools the Facility used to conduct its self-assessment included: ▪ The Settlement Agreement Cross Referenced with ICF/MR Standards: Section C – Protection From Harm tool, revised January 2012; and ▪ The Section C Self-Monitoring Questionnaire: effective 3/22/12, which replaced the previous tool. ○ These monitoring/audit tools did identify a number of important indicators to allow the Facility to determine compliance with the Settlement Agreement. However, additional indicators were needed. The Facility is encouraged to review the Monitoring Team's report to identify indicators that are relevant to making compliance determinations. ○ The Self-Assessment identified the sample(s) sizes. It did not include the number of individuals/records reviewed in comparison with the number of individuals/records of restraint in the time period reviewed (i.e., n/N for percent sample size). ○ The monitoring/audit tools did not have instructions/guidelines to ensure consistency in monitoring and the validity of the results. In interview the Chief Psychologist and the QA Program Compliance Monitor (PCM), they indicated they were working on this during their monthly meetings. ○ The following staff/positions were responsible for completing the audit tools: ▪ The Chief Psychologist; ▪ The Quality Assurance Program Compliance Monitor; and ▪ Other Psychologists assigned to complete monitoring. ○ The staff responsible for conducting the audits/monitoring had not been deemed competent in the use of the tools, and there was no process for doing so. Although all of the staff responsible had some experience with restraints and/or conducting monitoring, no formal methodology was in place to ensure they were programmatically competent in

	the relevant areas, and could effectively use the tool to monitor. o Adequate inter-rater reliability was being tested between the Facility staff responsible for the completion of the tools, and data was available to indicate the degree of reliability on specific indicators. Not all indicators were scored at 80% or above. ▪ Did not use other relevant data sources and/or key indicators/outcome measures except in a limited way. For example for Section C.5, the Self-Assessment noted that the Director of Behavioral Services reviewed each restraint checklist and debriefing form to ensure inclusion of the Face-to-Face assessment, the prompt arrival of the restraint monitor, and immediate notification of restraints outside the Facility. Section C.5.1.b of the Self-Assessment included a table indicating average and longest response times for Restraint Monitors. Relevant data sources were not generally cited other than the QA Monitoring Tool. Key indicators of performance or outcome measures were not specifically cited. Topics for key indicators could be such things as the average length of time in restraint, the number of people restrained, the number of injury reports that are filed as a result of restraint use, the number of serious injuries that occur while an individual is in restraint, the number of people restrained off campus, number of individuals for whom restraint use has declined, etc. The Facility needs to decide what data they have and how to use it to provide an outcome measure(s) of their use of restraints. The point is that the Facility should not rely solely on data from samples, but include the analysis of outcome data in its Self-Assessment as well. ▪ The Facility presented data based primarily on the QA Monitoring Tool. Specifically, the Facility's Self Assessment: o Presented findings based on specific, measurable indicators, citing the specific provision in the Tool, the score based on the composite of all who rated the provision and the inter-rater reliability score between Behavioral Services Staff and the QA staff for the provision. o Did not distinguish data collected by the QA Department versus the program/discipline in the quarterly QA/QI Data Summary or in the Self-Assessment. ▪ The Facility rated itself as being in compliance with none of the sub-sections of Section C. This was consistent with the Monitoring Team's findings. ▪ The Facility data identified areas of need/improvement. For these areas of need, the Facility Self-Assessment did not provide an 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. However, there was evidence in Restraint Reduction Committee minutes to show that actions were being taken to remedy issues identified through the Committee's reviews and through Trend Analysis Reports. While these activities did not connect to formal Corrective Action Plans, they were indicative of on-going efforts to reduce restraint use and promote understanding of how and when restraints could be appropriately employed. Connecting this positive work to the Self-Assessment could be a next step.
	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: ▪ A reduction in the numbers of restraints had occurred.

	▪ The Restraint Reduction Committee was reviewing restraints and issues related to restraints, and taking action. ▪ Steps were being taken to address alternatives to sedation plans for people going for dental appointments. ▪ Training on the new DADS restraint policy was underway. Some of the areas that needed improvement included: ▪ Ensuring restraint monitors were on site within 15 minutes. ▪ Clarifying for staff that although restraint should be used to the minimum extent possible, restraint can and should be used in crisis situations for which other alternatives to protect the individual are not feasible (e.g., lying in the middle of a busy street and refusing to move). ▪ Clarifying how the review of the use of restraint by the Unit Teams and the Incident Management Team will be documented, so that it will be clear that the circumstances of the restraint have been determined and any necessary plans are put in place.

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td>C1</td><td>Effective immediately, no Facility shall place any individual in prone restraint. Commencing immediately and with full implementation within one year, each Facility shall ensure that restraints may only be used: if the individual poses an immediate and serious risk of harm to him/herself or others; after a graduated range of less restrictive measures has been exhausted or considered in a clinically justifiable manner; for reasons other than as punishment, for convenience of staff, or in the absence of or as an alternative to treatment; and in accordance with applicable, written policies, procedures, and plans governing restraint use. Only restraint techniques approved in the Facilities' policies shall be used.</td><td>The Department of Justice has indicated an interest in certain statistics. In response to this request, the Monitoring Team has included some such numbers in this report, such as the following information related to numbers of restraints. The Monitoring Team is not in a position to verify these numbers, or provide in-depth analysis of these numbers. Clearly, it is the Facility's responsibility to conduct such analyses, and as these analyses have been made available to the Monitoring Team, they are discussed as appropriate with regard to the sections of the Settlement Agreement to which they apply. The following numbers are provided for informational purposes only, and are based on data available from the Facility at the time of the review.

In response to a request made while the Monitoring Team was onsite, the Facility provided a trend analysis report which showed:

<table>
<tr><th>Type of Restraint</th><th>Date range: 1/1/11 to 12/31/11</th><th>Date range: 1/1/12 to 7/31/12</th></tr>
<tr><td>Personal restraints (physical holds) during a behavioral crisis</td><td>198</td><td>51</td></tr>
<tr><td>Chemical restraints during a behavioral crisis</td><td>65</td><td>28</td></tr>
<tr><td>Mechanical restraints during a behavioral crisis</td><td>60</td><td>13</td></tr>
<tr><td>TOTAL restraints used in behavioral crisis</td><td>323</td><td>92</td></tr>
<tr><td>TOTAL individuals restrained in behavioral crisis</td><td>69</td><td>32</td></tr>
</table>
</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance

Of the above individuals, those restrained pursuant to a Safety Plan	Not available	Not available
Medical/dental restraints	389	142
TOTAL individuals restrained for medical/dental reasons	148	28

A concern was raised when reviewing the requested restraint documentation for Individual #384. In addition to the Restraint Checklists requested by the Monitoring Team, three additional checklists were provided that were not included in the document entitled: Restraint by Facility, from 2/1/12 to 6/30/12. These were three personal restraints that occurred on the following dates/times: 3/23/12 at 8:20 a.m., 3/23/12 at 9:53 a.m., and 3/25/12 at 10:24 a.m. This raised concerns regarding the accuracy of the database used to track restraints.

Prone Restraint

Based on Facility policy review, prone restraint was prohibited.

Based on review of other documentation, including Trend Reports, prone restraint was not identified as having been used.

A sample, referred to as Sample #C.1, was selected (as defined in the Documents Reviewed section above). Based on a review of the restraint records for individuals in Sample #C.1 involving 12 individuals, none (0%) showed use of prone restraint.

Based on interviews with 22 direct support professionals, all were aware of the prohibition on prone restraint.

Other Restraint Requirements

Based on document review, the Facility policies stated that restraints may 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; and for reasons other than as punishment, for convenience of staff, or in the absence of or as an alternative to treatment.

In the previous monitoring report, the Monitoring Team wrote: "Facility policies identified a list of approved restraints. Specifically, ABSSLC Policy: Use of Restraints, dated June 2010, at Section II.E.2 identified four mechanical restraints that could be used: helmet, mittens, boxing gloves, and wrist-to-waist restraints, and then only as part of an approved Safety Plan or Behavior Support Plan. Section II.C.4 of the policy indicated that certain mechanical restraints were to be used only in a Safety Plan, or with prior

#	Provision	Assessment of Status	Compliance
		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." While a new DADS policy had been issued, the Facility indicated that it had not completed revisions to its local procedures to conform to the new state policy. Those revisions should include addressing the clarifications mentioned above. Restraint records were reviewed for Sample #C.1 that included the restraint checklists, face-to-face assessment forms, and debriefing forms. The following are the results of this review: ▪ In 12 of the 13 records (92%), there was documentation showing that the individual posed an immediate and serious threat to self or others. For Individual #95 it was not clear what happened, why it was not possible to evade the individual's punches, and why the Safety Plan was not followed. There also was no documentation of any attempt to summon the Restraint Monitor or a nurse. ▪ For the 13 restraint records, a review of the descriptions of the events leading to behavior that resulted in restraint found that 13 (100%) contained appropriate documentation that indicated that there was no evidence that restraints were being used for the convenience of staff or as punishment. A total of 34 restraint checklists for 11 individuals were reviewed (i.e., the sample for Section C.1 as well as the additional restraint episodes for Individual #99, Individual #231, and Individual #384 identified in the documents reviewed section). One section of the checklist provided a list of possible interventions that staff employed prior to restraint. In only 16 of these checklists (47%) did staff indicate that they had applied the interventions outlined in the individual's behavior support plan to avoid restraint. It appeared that in every instance the behavior support plan should have been implemented. For 20 of the 34 restraints reviewed (59%), there was evidence that the restraint had been reviewed at the Unit Meeting. For five of the 34 restraints (15%), there was a written Restraint Follow-Up included in the documents. Missed steps in the restraint protocol were identified with instructions to retrain staff involved. While this appeared to be an effort to correct problems in a timely manner related to the use of restraint before a graduated range of less restrictive measures had been exhausted and/or in the absence of adequate treatment, these documents were not dated, did not identify the sender or receiver, and did not include timelines for completion of retraining.	

#	Provision	Assessment of Status	Compliance
		The Facility should include this information. Facility policies did identify a list of approved restraints. ▪ Based on the review of 13 restraints, 12 (92%) were approved restraints. Examples where this was not the case included: o On 5/31/12 at 10:50 a.m., Individual #150 was lifted from the ground using a Y-belt. This did not appear to be an appropriate lifting device, and it was not clear why an emergency two-person lift was not employed. o It was noted that on 4/6/12 at 8:05 a.m., Individual #95 was restrained with a bear hug instead of the baskethold restraint described in the Safety Plan. However, the bear hug was an approved restraint. A review was completed of 38 Behavior Support Plans (35 for Section K.9 and three additional for Section C.7). There was no evidence of restraint in any of these plans. 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. Therefore, it was likely that restraint was sometimes used in the absence of adequate treatment. Further, as is discussed with regard to Section C.7, individuals for whom more than three restraints occurred in 30 days did not have adequate BSPs. Clear documentation was not consistently provided that restraints were not used in the absence of adequate treatment. In addition, attention needed to be paid to ensure that only approved restraints were used. Based on the Monitoring Team's review, the Facility was not in compliance with this provision. This was consistent with the Facility's Self-Assessment.	
C2	Effective immediately, restraints shall be terminated as soon as the	The restraint records involving the 12 individuals in Sample #C.1 were reviewed. Of these, five of the individuals had Safety Plans that defined the use of restraint:	Noncompliance

#	Provision	Assessment of Status	Compliance
	individual is no longer a danger to him/herself or others.	▪ For five individuals who had Safety Plans, none (0%) included sufficient documentation to show that the individual was released from restraint according to the criteria set forth in the Safety Plan. In these cases, the Safety Plan was not followed (i.e., Individual #95 and Individual #231) or documentation was not provided (i.e., Individual #323, Individual #486, and Individual #137). ▪ For seven individuals who did not have Safety Plans, seven (100%) included sufficient documentation to show that the individual was released as soon as the individual was no longer a danger to him/herself, or, in one case, the restraint was chemical and "release" from the restraint cannot be determined. The Facility was not in compliance with this provision of the Settlement Agreement due to the lack of documentation to demonstrate that individuals were released according to their safety plans. In its Self-Assessment, the Facility found itself to be in noncompliance as well.	
C3	Commencing within six months of the Effective Date hereof and with full implementation as soon as practicable but no later than within one year, each Facility shall develop and implement policies governing the use of restraints. The policies shall set forth approved restraints and require that staff use only such approved restraints. A restraint used must be the least restrictive intervention necessary to manage behaviors. The policies shall require that, before working with individuals, all staff responsible for applying restraint techniques shall have successfully completed competency-based training on: approved verbal intervention and redirection techniques; approved restraint techniques; and adequate supervision of any individual in restraint.	The Facility's policies related to restraint are discussed above with regard to Section C.1. In addition, the Facility had set forth a list of approved restraints and required staff to complete competency-based training on the use of verbal intervention and redirection techniques and use of restraints prior to working with individuals. While a new State Office policy on restraint (Policy #001.1) was adopted on 4/10/12, ABSSLC had not yet revised its procedures to match the new policy. The Facility indicated that procedures were under development. The Facility had adopted the State's revised training on the use of restraint. A review of that curricula together with the PMAB curricula that has been reviewed in previous reports revealed that it included training and competency-based measures in the following areas: ▪ Policies governing the use of restraint; ▪ Approved verbal and redirection techniques; ▪ Approved restraint techniques; and ▪ Adequate supervision of any individual in restraint. Sample #C.2 was selected from a current list of staff. A description of Sample #C.2 is provided in the Documents Reviewed section above. A review of the training transcripts showed that 25 out of 25 (100%) staff had been properly trained on restraint and its related topics. Based on interviews with 22 direct support professionals, 19 were able to describe:	Noncompliance

#	Provision	Assessment of Status	Compliance
		▪ Policies governing the use of restraint (86%); ▪ Approved verbal and redirection techniques (86%); and ▪ Approved restraint techniques (86%). All 22 were able to describe adequate supervision of any individual in restraint (100%). As noted above with regard to Section C.1, 85% 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. Based on the findings that the Facility needed to update its policies and ensure clarity across different policies, it was not clear that restraint was used only after a graduated range of less restrictive measures, and some staff were not able to describe restraint policies and procedures, the Facility was found to be in noncompliance with this provision. In its Self-Assessment, the Facility did not find substantial compliance with this provision either.	
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 13 restraint records (Sample #C.1), in 12 (92%) there was evidence documented that restraint was used as a crisis intervention. For Individual #95 it was not clear what happened, why it was not possible to evade the individual's punches and why the Safety Plan was not followed. There was no attempt to summon the Restraint Monitor or a nurse. Based on the review of 38 Behavior Support Plans, no evidence was found of the use of programmatic restraint. In 13 of 13 restraint records reviewed (100%), there was evidence that the restraint used was not in contradiction to the individuals' medical orders according to the "Do Not Restrain" list. The Monitoring Team had requested copies of 10 dental desensitization plans. The plans provided included three plans that had been reviewed during the last visit and one plan that addressed cooperation with administration of cataract medication. These were excluded from this review. Dental desensitization plans were reviewed for six individuals. These plans followed a similar format as described in the Monitoring Team's last report, including: 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, each objective indicated the individual was to participate with verbal	Noncompliance

#	Provision	Assessment of Status	Compliance
		prompts for one trial across a designated number of sessions. ▪ Baseline was reported as the current need for sedation and restraint (four plans), or sedation (two plans). 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. It is recommended that the individual's performance on all steps of the task analysis be determined prior to teaching. A true baseline is necessary to determine the needs of the individual. ▪ One training trial was to be conducted between one to three times per week. It is likely 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 four of the six plans (67%), praise alone was identified as the reinforcer. The remaining plans (33%) indicated the individual was to receive praise and an edible reinforcer for his/her cooperation. Completion of formal preference assessments is recommended to ensure that individual specific reinforcers are incorporated into these plans. ▪ The task analysis outlined in these plans frequently provided a more in-depth description of staff behavior than the individual's behavior. Five of six plans (83%) included task analyses in which the majority of the steps described staff behavior. It will be essential to describe the individual's observable and measurable response to allow for objective assessment of his/her progress. At the time of the Monitoring Team's visit, the Facility was switching from using a Safety Plan for Crisis Intervention to a Crisis Intervention Plan. For this report, the Crisis Intervention Plans for six individuals were also reviewed. A summary is provided below. ▪ Two of the plans identified the implementation date (33%), and one plan (17%) noted the date of the most recent IDT review. It was unclear when the remaining three plans had been written or implemented. ▪ The type of restraint was identified in all of the plans (100%). ▪ The maximum duration was identified in all five of the plans that addressed personal or mechanical restraint (100%). All of these indicated 15 minutes as the maximum time allowed without an attempted release. ▪ Five of the six plans (83%) identified situation specific events that would result in restraint. The plan for Individual #268, for whom chemical restraint was prescribed, did not provide a clear description of events that would lead to restraint. It was noted that her behavior posed an immediate and serious risk of injury to herself, yet the descriptors that followed suggested she was harming staff or peers, could not be redirected, or she had a "cold, unblinking, unresponsive stare." It is suggested that clear risks of harm should be the	

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		criteria used to determine crisis situations. ▪ All five of the plans (100%) that involved personal or mechanical restraint identified a termination criterion. Two noted the person should be released when he stopped struggling or attempting aggression, two noted the person should be released when he was no longer a danger to himself or others, and one indicated the person should be calm (i.e., body still, breathing heavy) for one minute. It was unclear why heavy breathing would be an indication of "calm" behavior.	
C5	Commencing immediately and with full implementation within six months, staff trained in the application and assessment of restraint shall conduct and document a face- to-face assessment of the individual as soon as possible but no later than 15 minutes from the start of the restraint to review the application and consequences of the restraint. For all restraints applied at a Facility, a licensed health care professional shall monitor and document vital signs and mental status of an individual in restraints at least every 30 minutes from the start of the restraint, except for a medical restraint pursuant to a physician's order. In extraordinary circumstances, with clinical justification, the physician may order an alternative monitoring schedule. For all individuals subject 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	Review of Facility training documentation showed that there was an adequate training curriculum on the application and assessment of restraint. Much of the restraint training on policy was newly designed to compliment the new DADS restraint policy. This training was competency-based. The DADS Restraint Policy #001.1, effective in April 2012, included requirements to: ▪ Conduct a face-to-face assessment within 15 minutes; ▪ Review the application and consequences of the restraint; and ▪ Have a nurse monitor vital signs and mental status every 30 minutes, or within 30 minutes of return to the Facility: Based on review of training records, 26 staff at the Facility successfully completed the training to allow them to conduct face-to-face assessment of individuals in restraint. Based on a review of 13 restraint records (Sample #C.1), a face-to-face assessment was conducted: ▪ In nine out of 13 instances of restraint (69%) by an adequately trained staff member. Records that did not contain documentation of this included those for: Individual #95, Individual #99 on 4/29/12, Individual #384, and Individual #486. ▪ In eight out of 13 instances (62%), the assessment began as soon as possible, but no later than 15 minutes from the start of the restraint. Records that did not contain documentation of this included those for: Individual #486, Individual #95, Individual #247, Individual #150, and Individual #534. ▪ In 10 instances (77%), the documentation showed that an adequate assessment was completed of the application of the restraint. Records that did not contain documentation of this included those for: Individual #95 (no monitor called), Individual #247 (did not include an identification of the safety of a peer as an issue and noted that staff's emotions were not addressed, but did not comment), and Individual #323 (no concerns with safety when two staff were bitten and no comment on the observation that staff's emotions were not addressed); and ▪ In eight out of 13 instances (62%), the documentation showed that an	Noncompliance

#	Provision	Assessment of Status	Compliance
	shall specify the schedule and type of monitoring required.	assessment was completed of the circumstances of the restraint. Records that did not contain documentation of this included those for: Individual #95 (no monitor called), Individual #99 on 2/10/12 when the monitor missed an opportunity to clarify the antecedent behavior, and Individual #486 and Individual #137, where clarification of the antecedents was needed, but not provided. For Individual #384, there was no clarification of antecedents, but they were clarified in the ISP addendum. ▪ There were no reported instances of physicians ordering alternative monitoring. In order to ensure that nursing documentation could be adequately reviewed, a separate sample was selected. It was random, except it included only the first restraint if multiple restraints that occurred over a short period of time (i.e., one right after the other). In such instances, the initiation of restraint would be counted from the time the first restraint began. Based on a review of 17 restraint records for 14 individuals for restraints that occurred at the Facility (i.e., Individual #384, Individual #99, Individual #231, Individual #313, Individual #323, Individual #163, Individual #303, Individual #107, Individual #534, Individual #422, Individual #301, Individual #215, Individual #94, and Individual #48), there was documentation that a licensed health care professional: ▪ Conducted monitoring at least every 30 minutes from the initiation of the restraint in eight (47%) of the instances of restraint. Records that did not contain documentation of this included: Individual #99, on 2/9/12, and 2/10/12; Individual #231, on 3/30/12; Individual #163, on 5/30/12; Individual #107, on 4/15/12; Individual #534, on 6/6/12; Individual #422, on 4/6/12; Individual #215, on 4/24/12; and Individual #48, on 4/10/12. ▪ Monitored and documented vital signs in 10 (59%) episodes. Records that did not contain appropriate documentation of this included: Individual #384, on 3/26/12; Individual #99, on 2/9/12 and 4/9/12; Individual #163, on 5/30/12; Individual #303, on 3/16/12; Individual #107, on 4/15/12; and Individual #534, on 6/6/12. Problematic issues that were noted to result 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, and did not include documentation that the vital signs were retaken to ensure the individuals were medically stable. ▪ Monitored and documented mental status in 15 (88%) episodes. Records that did not contain appropriate documentation of this included: Individual #384, on 3/26/12; and Individual #303, on 3/16/12. Problematic issues that were noted to result in noncompliance included either the mental status were not recorded, or were noted to be generic, such as "alert, and oriented" without a specific	

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		description of the behavior included to support the generic documentation. From discussions with the Program Compliance Nurse who audits these areas, she reported that her findings were based on the completion of the areas on the Restraint Checklists, and not on the quality of the nursing documentation. For example, if the vital signs were noted to be significantly high or low and had not been retaken according to nursing standards of practice, she did not score the area as not being in compliance. In addition, the Chief Nurse Executive reported that no system had been established to review and analyze these data and to address the problematic issues found for the above data. The same was true for the data related to Section C.6 that addressed the documentation of an assessment by a licensed health care professional as to whether any restraint-related injuries or other negative health effects had occurred. Sample #C.3 was selected from the list of individuals who had medical restraint in the last six months. This sample is defined in the Documents Reviewed section. For these individuals, the physicians' orders were reviewed, as well as documentation of monitoring. ▪ In three out of 13 (23%), the physician specified the schedule of monitoring required; and ▪ In three out of 13 (23%), the physician specified the type of monitoring required. The following provide examples of medical restraint that for which the monitoring had been defined appropriately: Individual # 215, Individual #321 and Individual #69. For the three individuals who had schedules for monitoring, one appeared to have had the monitoring carried out as prescribed (i.e., Individual #69). While the rest of the medical restraints were monitored to some degree, it was not clear what the schedule was or exactly what type of monitoring was required. As a result, there was no way to determine whether the monitoring was sufficient. Since physicians were not routinely documenting a schedule for monitoring and when they did document a schedule, it was not routinely implemented as written; restraints were not timely monitored by a trained restraint monitor; assessments of the circumstances and application of restraint were not adequate; and nursing staff were not properly assessing individuals that had been restrained, the Facility remained out of compliance with this provision. The Facility made a similar finding in its Self-Assessment.	
C6	Effective immediately, every individual in restraint shall: be	A sample (Sample #C.1) of 13 Restraint Checklists for individuals in crisis intervention restraint was selected for review. The following compliance rates were identified for	Noncompliance

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	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.	each of the required elements: ▪ In 13 (100%), continuous one-to-one supervision was provided; ▪ In 13 (100%), the date and time restraint was begun; ▪ In 13 (100%), the location of the restraint; ▪ In six (46%), information about what happened before, including prior to the change in the behavior that led to the use of restraint. For example: o Individual #384 was physically restrained and then chemically restrained. His behavior was described as "agitated," and aggressive. The question not answered was what was happening before he became agitated. While his ISP addendum indicated discussions about his mental health and that it was possible that the "agitation" was a medical or dental issue rather than a behavioral issue, knowing what preceded the "agitated" behavior could have helped to determine the nature of his problem. o Individual #247 was restrained when he began hitting a peer. It was not clear from the Restraint Checklist what caused the outburst or why staff, when they knew he was agitated, did not redirect him from the peer. However, in the Debriefing the Psychologist interviewed staff and ascertained the order of events and established that staff had allowed the individual to sit near a peer when he was agitated, and staff did not redirect him to another activity. Staff conducted a search of his clothing for contraband without engaging him in the search, as required by his PBSP and did not use his communication dictionary to aid in discussion with him. This was an excellent example of a debriefing in that it reached conclusions that could form the basis for recommending retraining for staff. o Individual #95 was restrained when he tried to punch staff. It was not clear from the Restraint Checklist what happened before he began mumbling to himself and cracking his knuckles (two signs of impending aggression.) The Debriefing indicated that he was upset because he wanted to shave before his family visit. It would have been helpful to know why he was not allowed to shave. o Other restraints where the information about antecedents was needed included: Individual #99 on 2/10/12, Individual #486, Individual #137, and Individual #323. While some restraint checklists did not contain information about antecedents, the Face-to-Face checklists sometimes identified and added that information as noted with regard to Section C.5 above. The Behavioral Services Department had initiated a new process for Debriefings that showed potential for further improvements by separating the Debriefing	

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		from the Face-to-Face assessment and having it completed by a psychologist. This process provided an opportunity for a more in-depth review of antecedent behaviors. ▪ In 13 (100%), the actions taken by staff prior to the use of restraint to permit adequate review per C.8 were documented. ▪ In 13 (100%), the specific reasons for the use of the restraint were documented. In all cases there was a specific reason for the restraint, even if there was not clear documentation of the antecedents or the actions taken prior to restraint. For example: o As described previously, on 4/29/12, Individual #99 was aggressive and throwing objects. While it was not clear why staff apparently did not know how to implement her behavior plan, her behavior was sufficiently dangerous to constitute a crisis. o Individual #95 was restrained when he began punching staff, which was dangerous behavior. While it was not clear why staff did not allow him to shave, at the time he began punching, the behavior had to be stopped. ▪ In 13 (100%), the method and type (e.g., medical, dental, crisis intervention) of restraint was recorded; ▪ In 13 (100%), the names of staff involved in the restraint episode were recorded; ▪ Observations of the individual and actions taken by staff while the individual was in restraint: for eight restraint episodes, the restraint lasted between less than a minute and 10 minutes, and the observations included the initial application and release. In two, the restraint was chemical and staff observations did not apply. In the remaining three restraints (i.e., Individual #507, Individual #231, and Individual #323: o In one (33%), the observations were documented every 15 minutes and at release. Those that were not were: Individual #231 where there were two periods of over 15 minutes with no documentation, and Individual #323 where there was no second page on the Restraint Checklist; o In one (33%), the specific behaviors of the individual that required continuing restraint (same restraints as preceding bullet); and o In one (33%), the care provided by staff during the restraint, including opportunities to exercise restrained limbs, to eat as near meal times as possible, to drink fluids, and to use a toilet or bed pan (same individuals as last bullet. ▪ In 13 (100%), the level of supervision provided during the restraint episode was recorded; ▪ In 12 (92%), the date and time the individual was released from restraint	

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		was recorded. The one exception was Individual #323, where the second page of the Restraint Checklist was missing. Based on a review of 17 restraint records for 14 individuals for restraints that occurred at the Facility: Individual #384, Individual #99, Individual #231, Individual #313, Individual #323, Individual #163, Individual #303, Individual #107, Individual #534, Individual #422, Individual #301, Individual #215, Individual #94, and Individual #48): ▪ In nine (53%), the results of assessment by a licensed health care professional as to whether there were any restraint-related injuries or other negative health effects was appropriately documented. Records that did not contain documentation of this included: Individual #384, on 3/26/12; Individual #99, on 2/10/12; Individual #231, on 3/30/12 and 4/28/12; Individual #323, on 5/19/12; Individual #163, on 5/30/12; Individual #422, on 4/6/12; and Individual #215, on 4/24/12. Problematic issues noted that resulted in noncompliance included either the Post Restraint Assessment section being left blank, a lack of appropriate documentation regarding an assessment, or a lack of appropriate nursing documentation regarding injuries or the specific descriptions of injuries. In the sample of 13 records (Sample #C.1), restraint debriefing forms had been completed for 13 (100%). A sample of 13 individuals subject to medical restraint was reviewed (Sample #C.3), and in one (8%), there was evidence that the monitoring had been completed as required by the physician's order. Sample #C.4 was selected (as described in the Documents Reviewed section) for individuals that had chemical restraint in a behavioral crisis since the last onsite review. This sample of four individuals was reviewed. In four (100%), 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. There had been definite progress with regard to this provision, particularly with regard to the use of an improved format and process for debriefing that helped to clarify the often brief and incomplete notes on the Restraint Checklist. However, the documentation of antecedents and actions taken by staff prior to use of restraint needed further work. In addition, documentation of the observations of the individual while in restraint, as well as nursing documentation of injuries, and documentation of medical restraint monitoring all required improvement. As a result the Monitoring Team found the Facility to be	

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		noncompliant with this provision. This was the same as the Facility's finding in the Facility's Self-Assessment.	
C7	Within six months of the Effective Date hereof, for any individual placed in restraint, other than medical restraint, more than three times in any rolling thirty day period, the individual's treatment team shall:		
	(a) review the individual's adaptive skills and biological, medical, psychosocial factors;	According to the restraint review the Facility provided, during the five-month period (2/1/12 to 6/30/12) prior to the Monitoring Team's onsite visit, a total of three individuals were placed in restraint more than three times in any rolling 30-day period. This represented a noticeable decrease in the number of individuals meeting this criterion. All three of these individuals (100%) were selected for review to determine if the requirements of the Settlement Agreement were met. The three individuals reviewed included: Individual #99, Individual #231, and Individual #384. The following documents were reviewed: Restraint Checklist and Face-to-Face Debriefing Form, Behavior Support Plan (i.e., Individual #231 and Individual #384 only), the Personal or Individual Support Plan, addenda to the Personal Support Plan, Unit Meeting notes, and Psychology Monthly Progress Note. Additional documents reviewed included: the Behavior Monitoring Plan, Behavior Protocol, Brief Behavioral Assessment, and 1:1 Instruction Sheet for Individual #99; the IDT Review of Restraints for Individual #99 and Individual #384; Restraint Follow-Up for Individual #384; the Safety Plan for Crisis Intervention for Individual #231, and the Behavior Support Plan Addendum for Individual #384. The results are discussed below with regard to Section C.7.a through C.7.g of the Settlement Agreement. For all of the individuals (100%) reviewed, the individual's team met to discuss the restraints. Reviews were documented either through the Individual Support Team Addendum and/or the IDT Review of Repeated Restraints. The date of the review was included in the ISP addendum, but not in the IDT Review of Repeated Restraints. Neither document identified the team members who participated in the review. The Facility should provide the date of the review, the names of the team participants, and the responsible staff and expected date of completion for all recommended action plans. For two of the individuals (67%), the team reviewed the individual's adaptive skills. The following are examples of individuals for whom this was done appropriately: ▪ The team agreed to teach Individual #99 to track her menses using stickers and a calendar. Although this is an adaptive skill, it appeared the primary goal was to gather more reliable information about the correspondence between her menses	Noncompliance

#	Provision	Assessment of Status	Compliance
		and increased aggressive behavior. ▪ This same individual was referred to counseling to develop better anger management skills. While this was a good recommendation, there was no documentation to indicate that the referral had been made or that she had begun participating in these services. ▪ A skill acquisition program addressing communication training was identified for Individual #384. The following are examples where the team failed to do this adequately: ▪ Although the Team for Individual #384 discussed the need for expanded activities, a systematic plan to teach new skills was not evident. Staff should have reviewed his current adaptive behavior and developed training objectives that would address his identified needs, with sufficient opportunities for learning to occur. For three of the individuals (100%), the individual's team met to review biological, medical, and psychosocial factors. The following are examples of individuals for whom this was done appropriately: ▪ During review of more than three restraints in 30 days, several factors were considered for Individual #99. Discomfort before and during her menses was identified as a possible contributing variable, as was her possible awareness of her father's recent illness. As visits from her family were identified as very important to her, the IDT recognized that others receiving visitors might be upsetting to her. As identified in the second review of restraints in April, the Team recommended that Individual #99 be scheduled for an activity out of her home when family and/or friends visited her peers. ▪ Following observed increases in problem behaviors, the team for Individual #384 met and determined the best course of action was a referral to Big Springs Hospital. In the interim, the psychiatrist recommended changes to the individual's medication.	
	(b) review possibly contributing environmental conditions;	For one of the individuals reviewed (33%), the individual's team adequately reviewed the possibly contributing environmental conditions. The following is an example of an individual for whom this was done appropriately: ▪ Individual #231 had expressed an interest in working in the Diner. During the meeting held on 4/30/12, the team noted safety concerns regarding her scheduled introduction to work in the Diner. It was agreed that due to recent repeated restraints following aggressive episodes, and in consideration of her highly restricted diet, the Diner was currently not a safe option for her. It should be noted that this individual had begun working at the Second Edition by the time of the Monitoring Team's visit.	Noncompliance

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		The following are examples where teams failed to do this appropriately: ▪ Loud and busy environments were identified as a contributing factor for the display of problem behaviors by Individual #99. While this suggested a good observation of environmental conditions, the team did not take steps to address this in her behavior support plan. ▪ Many of the Restraint Checklists for Individual #384 suggested that he was being encouraged to watch television or movies. His ISP, dated 12/12/11, indicated that he attended the activity center were he looked at books and magazines, and watches television and movies. These were the same activities often described when he was at home. In the restraint meeting documentation, the team did not adequately examine the variety of interesting and challenging activities available to this individual and whether the lack of such options was potentially a contributing environmental factor.	
	(c) review or perform structural assessments of the behavior provoking restraints;	As part of the review of more than three restraints in 30 days, the team reviewed the functional behavior assessment for two of the individuals in the sample (67%). Regrettably, there were problems identified for both individuals. ▪ A Brief Behavioral Assessment, dated 3/19/12, was completed for Individual #99. The assessment was conducted in the workshop area. Workshop staff were directed to implement three different conditions (i.e., non-contingent attention, contingent attention, and contingent escape) as the psychologist observed and recorded data. The outcome suggested that the function of aggression was escape. While this was a commendable attempt to clearly identify the variables maintaining problem behavior, there were several concerns. First, in the month of April, there were five restraints, all of which occurred in the home. There was no indication that a functional behavior assessment had been completed in this environment. Second, there were no recommendations included in the assessment. Lastly, the assessment was identified as a draft. As this documentation was requested in August, it is concerning that the assessment remained a draft five months later. ▪ During the team meeting on 4/2/12 for Individual #384, staff noted that the behavioral assessment was "Still pretty accurate but doing additional formal observation and FAST since the assessment was done with staff and under conditions of his previous home." This was not addressed in the recommendations section of the ISP addendum. This should have taken priority as soon as steady increases in problem behavior were observed.	Noncompliance
	(d) review or perform functional assessments of the behavior provoking restraints;	Refer to Section C.7.c.	Noncompliance

#	Provision	Assessment of Status	Compliance
	(e) develop (if one does not exist) and implement a PBSP based on that individual's particular strengths, specifying: the objectively defined behavior to be treated that leads to the use of the restraint; alternative, positive adaptive behaviors to be taught to the individual to replace the behavior that initiates the use of the restraint, as well as other programs, where possible, to reduce or eliminate the use of such restraint. The type of restraint authorized, the restraint's maximum duration, the designated approved restraint situation, and the criteria for terminating the use of the restraint shall be set out in the individual's ISP;	For two of the individuals reviewed (67%), there was a Behavior Support Plan in place at the time of the restraint review meeting. The following summarizes a review of these BSPs. ▪ Neither of the plans (0%) included the date of the ISP meeting. ▪ The implementation date was identified in one of the two plans (50%). ▪ Both of the plans (100%) included operational definitions of targeted problem behavior. ▪ Clear comparison or baseline data was included in one plan (50%). ▪ One of the plans (50%) included expected treatment outcome presented in observable and measurable terms. Neither plan (0%) included a statement regarding review and/or revision of the plan following an identified period of time without observed progress. ▪ Replacement behaviors were identified in both of the plans (100%). However adequate operational definitions were provided in only one of the plans (50%). ▪ Adequate instructions and schedules for teaching replacement behavior were identified in one of the plans (50%). Although both plans included instructions and schedules for teaching replacement behaviors, the plan for Individual #384 indicated that he would be taught a total of three signs. Two of these signs were to be taught across three trials each during the afternoon shift. Three of the signs were to be taught across three trials each during the morning shift. This represented a lean and inadequate schedule of training. ▪ Preventative strategies that corresponded to information gathered through behavioral assessment were clearly identified in both of the plans (100%). ▪ Clearly described and sufficient scheduling of reinforcement was found in neither of the plans (0%). ▪ Although the psychologist who authored the plan was identified in both of the plans (100%), none of the plans were signed. Feedback specific to the supports provided to Individual #99 are provided below: ▪ The documents provided to the Monitoring Team suggested that a Behavior Monitoring Plan was first developed for Individual #99 on 1/6/12. On 2/13/12, a Behavior Protocol was written to indicate that a functional assessment would be completed at the workshop. Although the IDT Review of Repeated Restraints in April suggested that a behavior support plan had been developed and was awaiting approval by the BSC, a Behavior Support Plan was not developed until recommended at her ISP meeting on 7/12/12. There was a document entitled 1:1 instruction sheet that did address daily reinforcement for the absence of aggressive behavior, but this was not dated so it was difficult to determine when this had been introduced and whether it was still being used. Of the three individuals in this sample, only one (Individual #231) had a safety plan at the	Noncompliance

#	Provision	Assessment of Status	Compliance
		time the restraints occurred. Her plan included the following information: implementation date, restraint type, maximum duration, identification of situations leading to restraint, and termination criterion. The plan was not signed. While the absence of a safety plan was identified in an ISP addendum for Individual #384, there were no recommendations to develop a plan. In fact, an IDT review of more than three restraints in 30 days suggested a safety plan was not recommended for the following reason: "Chemical restraint had limited affect and can not be included in safety plan." Safety plans should have been developed for both Individual #99 and Individual #384, because they continued to exhibit increased rates of identified problem behavior resulting in repeated restraint.	
	(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	As noted in Section K.12 of this report, the Facility had begun monitoring the implementation of behavior support plans. On 3/8/12, it was noted that measures of Interview Integrity and Reliability for staff working with Individual #99 were 100%. The Psychology Monthly Progress Note for 3/12 and 4/12 for Individual #231 noted that when interviewed about her BSP, two staff member scored 100%. A third staff member initially scored 50%, but with retraining, she too was able to answer all questions with 100% accuracy. As noted in Section K, staff should discriminate between integrity and interview as these measure different responses. The first results from an observation of staff as he/she implements the behavior support plan, the latter assesses a staff member's knowledge of the plan as determined by interview. Reliability references agreement between two or more observers in collecting data on the targeted problem behavior. Concerns with these measures are addressed with regard to Section K.4. However, at the time of the review, adequate measures were not yet in place to assess treatment integrity.	Noncompliance
	(g) as necessary, assess and revise the PBSP.	In none of the records reviewed (0%) was there documentation that the individual's PBSP had been revised as appropriate.	Noncompliance
C8	Each Facility shall review each use of restraint, other than medical restraint, and ascertain the circumstances under which such restraint was used. The review shall take place within three business days of the start of each instance of restraint, other than medical restraint. ISPs shall be revised, as appropriate.	According to the ABSSLC Restraint Policy, the process for 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. At the time of this review, the restraint review process had been modified to separate the Face-to-Face and Debriefing form, and have a psychologist complete the Debriefing Form within three days of the restraint use. The Restraint Checklist, and Face-to-Face and Debriefing sheet then went to the next Unit	Noncompliance

#	Provision	Assessment of Status	Compliance
		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 called, and an addendum added to the Individual Support Plan. A sample of documentation related to 13 incidents of crisis intervention restraint was reviewed (Sample #C.1), including any and all reviews of each restraint that were provided in response to the Monitoring Team's document request. The available documentation showed that: ▪ In 12 (92%), the review by the Unit IDT occurred within three business days of the restraint episode, and this review was documented by signature on the Restraint Checklist. Where this did not occur was: o Individual #95 where the review was late by three days. ▪ In 11 (85%), the review by the IMT occurred within three business days of the restraint episode, and this review was documented by signature on the Restraint Checklist and/or the Debriefing form. Examples where this did not occur included: o Individual #384, where there was no documentation of the IMT review in either the Restraint Checklist, or the Debriefing form; and o Individual #95 where the review was three days late. ▪ In 12 (92%), the circumstances under which the restraint was used were determined and documented on the Face-to-Face Assessment Debriefing form, including the signature of the staff responsible for the review. Examples of where this did not occur included: o Individual #95, where it was not clear why he was not allowed to shave before his family visit. ▪ In none (0%), the review conducted by the Unit IDT and the IMT was sufficient in scope and depth to determine if the application of restraint was	

#	Provision	Assessment of Status	Compliance
		justified, if the restraint was applied correctly and to determine if factors existed that, if modified, might prevent future use of restraint with the individual, including adequate review of alternative interventions that were either attempted and were unsuccessful or were not attempted because of the emergency nature of the behavior that resulted in restraint. None of the reviews by the Unit Team or the IMRT were comprehensive enough or detailed enough to determine what might have prevented future restraints, ▪ In four (31%) of the 13 records in Sample C.1, the review conducted by the Unit IDT and the IMT resulted in an additional referral to the IDT for review and consideration of possible changes in active treatment. An example where this did not occur was Individual #150 where no documentation was presented to show that the IMT had made a recommendation, or that it had resulted in an IDT meeting. ▪ Of the four referred to their IDTs, three (75%) resulted in changes made to the individuals' ISPs and these changes appeared appropriate to the circumstances. An example of where this was not the case was Individual #99 for the restrain that occurred on 2/10/12. The IMT recommendation was that the individual be checked medically to ensure no health problems were causing the increase in aggression. The IDT addendum did not mention having her checked medically. Sample C.4 included chemical restraints. In three (75%) of the chemical restraints, the clinical review conducted by the pharmacist and psychiatrist was sufficient in scope and depth to determine: 1) whether the chemical restraint was used in a clinically justified manner; 2) that medication-related risks were considered prior to the use of the chemical restraint; and 3) the apparent effectiveness of the chemical restraint in reducing the dangerous behavior in the hours after administration. In addition, in these instances of restraint, the pharmacist and the psychologist made appropriate recommendations. This information was properly documented on the Chemical Restraint Consult Form and the pharmacist and the psychiatrist had properly signed it. An example where this review did not occur appropriately was related to the chemical restraint administered to Individual #99, on 4/29/12, where no clinical review documentation was provided. Restraint procedures used across the Facility also were reviewed at the monthly Restraint Reduction Committee meetings. The Restraint Reduction Committee had been meeting once per month. Membership included the Director of Behavioral Services, the Assistant Director of Programs, the Quality Assurance Director, the Medical Director, the Dental Director, the Active Treatment Coordinator, the Director of Residential Services, the Human Rights Officer, one Associate Psychologist, one Home Supervisor, and one Shift Leader. The minutes of these meetings reflected discussion of restraint trend data,	

#	Provision	Assessment of Status	Compliance
		review of individuals with repeated restraints, discussion of goals for further restraint reduction, and discussion of concerns and actions to address those concerns, including follow-up. Staff are commended for their ongoing efforts to address the Facility's use of restraint. The Monitoring Team found the Facility was not in compliance with this provision due to the lack of scope and depth of reviews documented by the Unit and Incident Management Review Teams. This Facility's Self-Assessment also included a finding of noncompliance.	

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. Staff should clearly describe the events that lead to restraint application. (Section C.1).
3. 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; and f) individual-specific consequences relevant to the hypothesized function of the problem behavior(s). (Section C.1).
4. 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)
5. 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).
6. The Facility should ensure that restraint monitors are in place within the 15 minutes the Settlement Agreement requires. (Section C.5)
7. 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)
8. 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)
9. 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 episode, except for a medical restraint pursuant to a physician's order. (Section C.5)
10. The Facility should ensure that compliance monitoring regarding nursing documentation is in alignment with generally accepted standards of nursing practice. (Section C.5)
11. The Facility should develop and implement a system to ensure that auditing data regarding restraints are being regularly reviewed by nursing, and that plans of correction are implemented addressing the problematic issues identified. (Section C.5)
12. Physicians and dentists who order medical restraint should indicate a schedule of monitoring and indicate the time the monitoring may stop. These schedules should then be followed as written. (Sections C.5 and C.6)
13. 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)

14. The Facility should ensure that nursing assesses and appropriately documents any restraint-related injury. (Section C.6)
15. When reviews of more than three restraints in 30 days are documented, either through the ISP Addendum or the IDT Review of Repeated Restraint, the following should be clearly identified: the date of the review, the review participants, and the responsible person and due date for all action plans. (Section C.7).
16. Staff should consistently review teaching of adaptive skills to individuals who experience more than three restraints in 30 days. (Section C.7.a).
17. 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).
18. Staff should consistently review environmental conditions for individuals who experience more than three restraints in 30 days. (Section C.7.b).
19. 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).
20. 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).
21. Staff should ensure that necessary Safety Plans for Crisis Intervention or Crisis Intervention Plans 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).
22. As appropriate, staff should make changes to the Behavior Support Plan and/or Individual Support Plan when events leading to restraint are identified. (Section C.7.g).
23. The Unit and IMT'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)
24. 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. (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 Policy/Procedure: Spurious Allegations of Abuse/Neglect/Exploitation (A/N/E), dated 4/18/12, no approval date; o ABSSLC Self-Assessment, dated 8/8/12; o Presentation Book for Section D; o ABSSLC Action Plan, dated 8/9/12; o Since the last review, a list of DFPS-Investigated Cases; o Since the last review, a list of investigations conducted solely by the Facility; o Log of employees reassigned due to allegations of abuse and neglect in the past six months, including name of employee, investigation number, date of return to direct contact work, or date of termination. If the employee was returned to work prior of the completion of the investigation, an explanation, including any disciplinary action taken; o DADTX Course delinquency list for Abuse/Neglect/Exploitation Training, dated 7/10/12; 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, undated; o Aggression Injuries, from 7/1/11 to 7/13/12, undated; o List of staff who alleged they had been retaliated against, undated. o Sample #D.1: included a sample of 15 DFPS investigations of abuse, neglect, and/or exploitation with the Facility investigation reports that were drawn from the list of abuse/neglect/exploitation cases for the time period from 2/12/12 through 7/4/12. Investigation records included: DFPS #41931374, #41312337, #41545232, #41573952, #41898012, #41793616, #41840773, #41931374, #41997492, #42131093, #42363467, #42310312, #42346216, #42157672, and #41933512; o Sample #D.2: included a sample of four investigation reports completed by the Facility-only that were drawn from list of cases for the time period from 2/21/12 to 7/2/12. Investigation records included: Facility #389, #425, #465, and #510; o Sample #D.3: Unusual Incident Reports #465, #539, and #500; o Sample #D.4: included five Individual Support Plans (ISPs) reviewed for Section F, including those for: Individual #407, Individual #170, Individual #371, Individual #377, and Individual #403; o Sample #D.5: 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 four of the DFPS investigations from Sample #D.1 where abuse or neglect was confirmed and one of the Facility investigation from Sample #D.2, including the following investigations: Facility Investigation #389, and DFPS Investigations: #41931374, #41545232, #41573952 and #42310312. ▪ **Interviews with**: o Linda Hindshaw, Facility Director; o Jolene Willis, Assistant Director of Programs; o Pat Smith, Quality Assurance Director; o Luee McCreary, Incident Management Coordinator (IMC); o Larry Jones, Director of Residential Services; and o Twenty-two Direct Support Professionals. ▪ **Observations of**: o QA/QI Council Meeting, on 8/20/12; o Incident Management Team (IMT) meeting, on 8/20/12, o Residences #6480, #6350, and #6330; day programs in buildings #6340, #5921, and #5923; and the Senior Program.
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section D, dated 8/8/12. In its Self-Assessment, for each sub-section, 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. In its Self-Assessment, the Facility indicated it was in substantial compliance with 16 of the 22 provisions in Section D of the Settlement Agreement. The Monitoring Team found the Facility to be in compliance with 16 of the 22. The Monitoring Team differed from the Facility on four of the 22 provisions. For Section D, in conducting its self-assessment, the Facility: ▪ Used monitoring/auditing tools. Based on a review of the Facility Self-Assessment, the monitoring/audit templates and instructions/guidelines, a sample of completed monitoring/auditing tools, inter-rater reliability data, as well as interviews with staff: o The monitoring/audit tools the Facility used to conduct its self-assessment included: Section D – Protection From Harm: Abuse/Neglect and Incident Monitoring Tool and Management Guidelines for Completing Tool. These monitoring/audit tools included indicators to allow the Facility to determine compliance with the Settlement Agreement. The Facility is encouraged to review the Monitoring Team's report to identify additional indicators that are relevant to making compliance determinations. o The monitoring tool included methodologies, such as observations and record reviews. o The Self-Assessment identified the sample size as 24 records for the third quarter of FY12, but did not indicate the total cases of abuse/neglect for the period. The Quality Assurance Plan called for 10 records per month or 30 for the quarter. o The monitoring/audit tools had instructions/guidelines to ensure consistency in monitoring. However, there was not consistency (inter-rater reliability) on all questions

of the tool. The Facility should assess whether the current instructions are adequate, or if other issues (e.g., staff training on the tools) were contributing to the lack of reliability.
    - The following staff/positions were responsible for completing the audit tools: The investigators, the Program Compliance Monitor, and the Incident Management Coordinator.
    - There were no formal criteria for determining whether staff responsible for applying the tools were competent to do so.
    - Inter-rater reliability had not been established between the various Facility staff responsible for the completion of the tool. However, it was being measured and efforts were being made to improve it.
- Used other relevant data sources, such as training logs.
- The Facility presented data in a meaningful/useful way. Specifically, the Facility's Self Assessment:
    - Presented findings based on specific, measurable indicators.
    - Distinguished data collected by the QA Department versus the program/discipline.
- A comparison of the differences in the findings between the Facility and the Monitoring Team revealed:

Provision	Facility Finding	Monitoring Team's Findings	Explanation
D.1	Noncompliance	Substantial Compliance	As the parties recently agreed, the Monitoring Team's finding was based on the presence of policy, not on implementation.
D.2.i:	Substantial Compliance	Noncompliance	An audit of injuries was only completed once (as discussed in more detail with regard to this provision).
D.3.e	Noncompliance	Substantial Compliance	Monitoring Team found reports to be completed timely in the sample reviewed for this report.
D.3.g	Substantial Compliance	Noncompliance	Supervisory notes for DFPS investigations were not present.

- The Facility data identified areas in need of improvement. For these areas of need, the Facility Self-Assessment did not provide an 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. However, the Facility did provide Action Plans for each of the provisions found to be noncompliant.

Summary of Monitor's Assessment: During this review, the Monitoring Team found the Facility to be in compliance with 16 of 22 provisions of Section D, as opposed to 13 provisions that were in compliance

	during the last review. Progress was noted in a number of areas. Highlights of progress included: ▪ Trend reports had resumed. ▪ There was progress in reviewing injuries for patterns that need evaluation. ▪ ISP annual reviews increasingly included discussion of abuse history and distribution of the abuse resource manual. Some of the areas in which improvements were necessary included the need to: ▪ Track recommendations in the investigation reports to conclusion. ▪ Produce Corrective Action Plans for issues identified through analysis of trend data. ▪ Work on the monitoring guidelines to ensure they provided exact descriptions of what to look for in each provision to improve reliability. ▪ Ensure that Unusual Incident Reports (UIRs) include a list of people interviewed and a summary of the information gathered from those interviews.

#	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.	Based on a recent agreement of the parties and the Monitors, Section D.1 has been interpreted to only address the development of a policy. Implementation of the policy is assessed in other Section D provisions. ABSSLC had a policy that: ▪ Included a commitment that abuse and neglect of individuals would not be tolerated; and ▪ Required that staff report abuse and/or neglect of individuals. As a result the Facility was found to be in compliance with this provision.	Substantial Compliance
D2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall review, revise, as appropriate, and implement incident management policies, procedures and practices. Such policies, procedures and practices shall require:		
	(a) Staff to immediately report serious incidents, including but not limited to death, abuse, neglect, exploitation, and serious injury, as follows: 1) for deaths, abuse, neglect, and exploitation to the Facility	According to Facility Policy #021.1, revised 11/15/11, staff were required to report abuse, neglect, and exploitation within one hour to the DFPS call-in number and to the Director or her designee. 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	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) and such other officials and agencies as warranted, consistent with Texas law; and 2) for serious injuries and other serious incidents, to the Facility Superintendent (or that official's designee). Staff shall report these and all other unusual incidents, using standardized reporting.</td><td>Management Coordinator for follow-up.

According to data the Facility provided in response to Document Request III.16, the numbers of abuse/neglect/exploitation allegations for approximately the past one and a half years were:
*Data provided by the Facility did not include a date range, but to be consistent with other data would have been approximately 7/31/12.
<table>
<tr><th></th><th>1/1/11 to 12/31/11 (12 months)</th><th>1/1/12 to unknown date * (Approximately seven months)</th></tr>
<tr><td>Total abuse allegations</td><td>439</td><td>289</td></tr>
<tr><td>Abuse substantiated</td><td>53</td><td>48</td></tr>
<tr><td>Total neglect allegations</td><td>199</td><td>170</td></tr>
<tr><td>Neglect substantiated</td><td>78</td><td>71</td></tr>
<tr><td>Total exploitation allegations</td><td>0</td><td>3</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 III.16, the numbers of Unusual Incidents investigated over approximately the past one and a half years included:
<table>
<tr><th></th><th>1/1/11 to 12/31/11 (12 months)</th><th>1/1/12 to 7/31/12 (seven months)</th></tr>
<tr><td>Deaths</td><td>12</td><td>6</td></tr>
<tr><td>Serious Injuries</td><td>54</td><td>41</td></tr>
<tr><td>Sexual Incidents</td><td>20</td><td>10</td></tr>
<tr><td>Suicide Threat (credible)</td><td>22</td><td>2</td></tr>
<tr><td>Unauthorized Departure</td><td>19</td><td>1</td></tr>
<tr><td>Choking</td><td>4</td><td>0</td></tr>
<tr><td>Other</td><td>15</td><td>0</td></tr>
</table>

Based on an interview of 22 staff responsible for the provision of supports to individuals, all (100%) were able to describe the reporting procedures for abuse, neglect, and/or exploitation.

Based on an interview of 22 staff responsible for the provision of supports to individuals, all (100%) were able to describe the reporting procedures for other serious incidents.

Based on a review of the 19 investigation reports included in both Sample #D.1 and</td><td></td></tr>
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#	Provision	Assessment of Status	Compliance
		Sample #D.2, two were reports from known chronic callers (#41793616 and #42157672) and not required to be reported within one hour, and for one (#41997492), the date of the incident was unknown. Of the remaining 16 investigation reports: ▪ 12 (75%) included evidence that allegations of abuse, neglect, and/or exploitation were reported within the timeframes required by Facility policy. Those that did not include such evidence were DFPS reports: o #41312337, which was late by two hours; o #42131093, which was late by three days; o #42346216, which was late by three hours; o #41933512, which was late by two days to DFPS. The incident was reported on the date of occurrence, 4/28/12, to the Director Designee. The information did not reach DFPS until 4/30/12. It was not clear who made the call to the Director Designee, but the Designee should have assured that the information was conveyed to DFPS on the 28th; and ▪ There was one instance of staff reporting both to DFPS and to the Director (#41840773). 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. Of the 19 reports in the sample, 16 were recorded on the UIR as reported by DFPS, with no notation that staff had reported directly to the Director. In three cases, it was not clear from the UIR or the accompanying intake sheet whether the reporter was staff or someone at DFPS (DFPS #41840773, #42346216, and #41933512). Unless both calls from DFPS and calls from staff or others are routinely included on the UIR, it will be difficult to determine if staff are reporting to the Director in addition to calling DFPS Based on a review of 19 investigation reports included in Sample #D.1 and Sample #D.2, 19 (100%) contained a copy of the report utilizing the required standardized format.	
	(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	In 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).	Substantial Compliance

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	action to protect the individuals involved, including removing alleged perpetrators, if any, from direct contact with individuals pending either the investigation's outcome or at least a well- supported, preliminary assessment that the employee poses no risk to individuals or the integrity of the investigation.	Based on a review of 19 investigation reports included in Sample D.1 and Sample D.2, of those cases where the staff was not removed: ▪ Three cases had no identified staff (DFPS #41997492, #42131093, and #41933512) and monitoring was put in place. ▪ One case (DFPS #42310312) involved allowing an individual, who was known to scratch peers if seated near them, to sit near a peer at a day program, resulting in scratches to the arm of the peer. It was not clear which staff member was responsible for that individual at the time of the incident. ▪ One case (DFPS #42157672) involved an allegation of sexual abuse by an individual who had been identified as making spurious allegations. The case was handled as "streamlined," and as a result, staff were not placed on Temporary Work Reassignment. ▪ In the four Facility-only cases: staff were not removed from duty, since there was no suspicion of abuse or neglect. If the investigation had uncovered any such suspicions, the case would have been handled as an abuse/neglect case and referred immediately to DFPS. Of the remaining 10 investigations, 10 (100%) of alleged perpetrators were removed from direct contact with individuals immediately following the Facility being informed of the allegation. Based on a review of 10 investigation files included in Sample #D.1 and Sample #D.2 that showed staff had been removed from direct contact, a total of 10 (100%) showed that staff were reinstated only at the conclusion of the investigation. In two cases, staff were suspended or resigned. In three cases, retraining on restraints or reporting was provided to all staff in the home. In five cases, no abuse was found and staff were returned to work. Based on a review of 19 investigations, it was documented that adequate additional action was taken to protect individuals in all cases (100%), by conducting a head-to-toe medical assessment (13 investigations), conducting an emotional security assessment (two cases), revising the Level of Service (one case), modifying environmental procedures to keep floor dry (one case), and providing emergency treatment for an injury (one case). Based on the Facility's actions to remove staff from duty pending the investigation, adding monitoring when the alleged perpetrator could not be identified or when a case was being handled as streamlined and documenting additional actions to protect the alleged victims, the Monitoring Team found the Facility was in substantial compliance. This finding was in agreement with the Facility's Self-Assessment.	
	(c) Competency-based training, at	According to ABSSLC Policy #021.1, all staff were required to attend competency-based	Substantial

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	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.	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 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 defined "competency-based training" as "the provision of knowledge and skills sufficient to enable the trained person to meet specified standards of performance as validated through that person's demonstration that he or she can use such knowledge or skills effectively in the circumstances for which they are required." In this regard, the training included opportunities for discussions and to test one's understanding of the requirements, as well as tests for competency. ▪ The training included content regarding recognizing and reporting signs and symptoms of abuse, neglect, and exploitation. 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. Review of a list of staff who were delinquent in training (Course Delinquency list for ABU0100 and UNU0100) showed that 1291 or 1293 (99.8%) of staff had completed annual refresher training on abuse/neglect and unusual incidents. Based on interviews with 22 staff: ▪ 22 (100%) were able to list signs and symptoms of abuse, neglect, and/or exploitation; and ▪ 22 (100%) were able to describe the reporting procedures for abuse, neglect, and/or exploitation. A quiz for staff was being used to keep working knowledge of the reporting system sharp. In addition, a monthly reminder was sent to departments to keep training up-to-date. The Monitoring Team the Facility to be in substantial compliance with this provision. This was the Facility's finding in its Self-Assessment.	Compliance
	(d) Notification of all staff when commencing employment and	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,	Substantial Compliance

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	at least yearly of their obligation to report abuse, neglect, or exploitation to Facility and State officials. All staff persons who are mandatory reporters of abuse or neglect shall sign a statement that shall be kept at the Facility evidencing their recognition of their reporting obligations. The Facility shall take appropriate personnel action in response to any mandatory reporter's failure to report abuse or neglect.	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. A list of 48 Foster Grandparents was provided by the Facility with copies of their signed acknowledgement forms. The Facility was asked for a list of staff who had been identified as having failed to report abuse and/or neglect. This generated a list of no staff. In DFPS investigation #41312337 the report referenced a witness who indicated he had seen a staff member pull an individual's hair and did not intervene, and it was not clear whether he had reported it. The conclusion of the report was that no abuse had occurred, but that there was confusion among staff at the workshop about whether to intervene when staff from the residence were attempting to manage a difficult behavior. The Facility should have addressed that lapse with the staff member, even though the incident was otherwise reported and no abuse was found. The Monitoring Team found the Facility to be in substantial compliance with this provision. The Facility made the same finding. While the incident of a staff member indicating that he thought he saw something abusive and did not report it was serious, it was an isolated incident in a complicated case that did not confirm abuse and did not appear to warrant a finding of noncompliance. However, the Facility should address all indications that staff might not have reported abuse with retraining and appropriate discipline.	
	(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 Plan team meeting and documented in the annual ISP. 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.	Noncompliance

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		Based on a review of five individuals' ISPs (Sample #D.4), all five individuals, or 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. However, these five individuals all had new ISPs using the new format, which included a section to correct the issue of teams not discussing this at annual meetings. It will take some time for a substantial number of individuals to benefit from this process. The Presentation Book for Section D included memos from the Incident Management Coordinator to the QDDP Coordinator sharing the results of monitoring for this provision and requesting assistance in getting QDDPs to include the material at annual meetings and to document it in the ISPs. Some individuals were able to, and did know how to report abuse. This was evident in Sample #D.1, in which the investigation reports clearly showed that the reporter was an individual residing at ABSSLC. Examples included DFPS cases #41793616 and #42157672. In these cases, it was clear that staff had facilitated access to the phone and DFPS phone number. However, most individuals at ABSSLC were not able to understand or communicate about possible abuse or neglect. As a result of the new ISP process that QDDPs followed, which included prompts to distribute the guide and to provide some training about it at the annual ISP meeting, as well as the continued monitoring of this provision by the IMC, there has been progress towards compliance. However, since the newest ISP process had been in place only for a short time with only approximately 10 ISP completed using the new template, and the ISPs conducted under the previous processes did not contain the necessary documentation, it will take additional time for a substantial number of individuals to benefit from the new process. As a result, the Facility remained out of compliance with this provision. The Facility's Self-Assessment was in agreement with the Monitoring Team's finding.	
	(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. A review was completed of the posting the Facility used. It did include a brief and easily understood statement of: 1) individuals' rights; 2) information about how to exercise such rights; and 3) information about how to report violations of such rights. Observations by the Monitoring Team of seven of 38 living units and day programs/vocational sites and recreation areas on campus showed that seven (100%) of those reviewed had postings of individuals' rights in an area to which individuals	Substantial Compliance

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		regularly had access. In addition the Facility maintained an active Self-Advocacy group, and posted notices about the availability of the Ombudsman. The Facility had maintained substantial compliance with this provision. The finding in the Facility's Self-Assessment was the same.	
	(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 15 allegation investigations completed by DFPS (Sample #D.1) for which referral was necessary/appropriate in 10, DFPS had made referrals in all 10 (100%). Based on a review of four investigations completed by the Facility (Sample #D.2), there were none for which a referral to law enforcement was necessary/appropriate. 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 remained in substantial compliance with this provision of the Settlement Agreement. The Facility made the same finding in its Self-Assessment.	Substantial Compliance
	(h) Mechanisms to ensure that any staff person, individual, family member or visitor who in good faith reports an allegation of abuse or neglect is not subject 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	ABSSLC Policy #021.1 prohibited retaliation against staff, individuals, family members, or others who reported abuse. Anyone that 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. The following actions were being taken to prevent retaliation and/or to assure staff that retaliation would not be tolerated: ▪ ABSSLC Policy addressed this mandate by stating that any employee or individual who in good faith reported abuse, neglect, or exploitation should not be subjected to retaliatory action by any employee of ABSSLC. ▪ Both initial and annual refresher training stressed that retaliation for reporting would not be tolerated by the Facility, and disciplinary action would be taken if	Substantial Compliance

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	failure to report an incident in an appropriate or timely manner.	this occurred, including reporting to the Office of the Inspector General. The Facility was asked for a list of staff that alleged they had reported good faith allegations of abuse/neglect/exploitation and reported they had been retaliated against as a result. The Facility reported 15 cases where allegations of retaliation were reported. There was no information provided to document how these cases were addressed. However, in discussion with the Director, it was learned that investigations of these allegations were usually conducted by the Ombudsman or by the Unit Director and did not relate to retaliation for reporting of abuse or neglect, but rather to a personnel issue. Any retaliation for reporting of abuse would be referred to the Office of the Investigator General for action, but no case has risen to that level. Based on interviews with the Director, the Assistant Director for Programs, and the Incident Management Coordinator, the following actions were being taken to prevent retaliation and/or to assure staff that retaliation would not be tolerated: ▪ Posters remind staff of the Facility's zero tolerance for retaliation; and ▪ Annual abuse training reminds staff of the prohibition and what to do should someone retaliate against them. Based on interviews with 22 staff, 19 (86%) reported they were confident that retaliation would not be tolerated. The three that were not confident were not specific about their concerns other than that they were not always confident about what they saw and they have to work with a lot of staff they do not always know very well. Based on interviews with 10 individuals served by the Facility, 10 (100%) reported they thought they could tell staff or call to report that someone had hurt them or not taken care of them, and they would not get into trouble. Based on a review of investigation records (Sample #D.1 and Sample #D.2), one concern was noted related to potential retaliation. DFPS Case #41573952 contained a report of an interview with the alleged perpetrator of verbal abuse and neglect. The alleged perpetrator was reported to have threatened to retaliate against whoever reported her. This threat was reported to the Director, addressed with the employee by the Unit Director, and recorded in the Employee Development Notes for that individual. While the threat was made, it was reported and addressed and there was no information to suggest the employee acted on that threat. The Facility was asked for a list of staff against whom disciplinary action had been taken due to their involvement in retaliatory action against another employee who in good faith had reported an allegation of abuse/neglect/exploitation. None were reported.	

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		The Monitoring Team found the Facility remained in substantial compliance based on the general awareness of retaliation and training about it, and the recourse staff had if it happened. In addition, when an employee made a threat to retaliate, the Facility took it seriously, and took action to prevent retaliation. The Facility's findings in its Self-Assessment were in agreement.	
	(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. In interview with the Incident Management Coordinator it was learned that an audit of injuries was done in March 2012 of injuries that occurred from 9/1/11 through 2/29/12. The IMC conducted the review with the Campus Administrators. They reviewed the injuries, their causes, location (particularly if they occurred to areas of the body such as the back) and whether they were attributed to SIB or other reasons. The IMC reported finding no patterns or numbers that triggered concerns or any failures to report. As a result, the finding of the reviewers was that injuries were being reported, investigated if serious, and there were no patterns of injuries to suggest a need for further investigation. However, no documentation of the audit was available for review. As a result, it was not clear what process the reviewers used, or what criteria were used to determine the need for investigation. The following need to be clarified and/or completed as part of the next audit: ▪ The process for the audit, including criteria for determining what might need further investigation needs to be documented; ▪ Comparison of data to make sure significant or repeated incidents of injuries are referred for investigation; ▪ A description of regular injury record reviews to ensure all injuries have been reported; and ▪ A review of peer-caused injuries. This is particularly important considering that there were nearly 400 "aggression injuries" from July 2011 to July 2012. While the audit still needed work, definite progress had been made toward addressing this provision. Since there was only one audit, that audit did not contain all the information in the above bullets, and the documentation of the audit was not available	Noncompliance

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		for review, the Facility remained out of compliance with this provision. This differed from the Facility's Self-Assessment, which found substantial compliance.	
D3	Commencing within six months of the Effective Date hereof and with full implementation within one year, the State shall develop and implement policies and procedures to ensure timely and thorough investigations of all abuse, neglect, exploitation, death, theft, serious injury, and other serious incidents involving Facility residents. Such policies and procedures shall:		
	(a) Provide for the conduct of all such investigations. The investigations shall be conducted by qualified investigators who have training in working with people with developmental disabilities, including persons with mental retardation, and who are not within the direct line of supervision of the alleged perpetrator.	ABSSLC Policy #002.3: ▪ Described in a comprehensive fashion the conduct of investigations; ▪ 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 of the direct line of supervision of the alleged perpetrator. Training curricula was reviewed for the Department of Family and Protective Services and Facility investigators. The Monitoring Team generally found the curricula to be adequate. Training curricula for the ABSSLC investigators included: ▪ People with Mental Retardation (MEN0300); ▪ Comprehensive Investigator Training (CIT0100); ▪ Conducting Serious Investigations (CSI0100); and ▪ Root Cause Analysis (RCA0100). DFPS had eight investigators assigned to complete investigations at ABSSLC. The training records for these investigators were reviewed with the following results: ▪ Eight out of eight DFPS investigators (100%) had completed the requirements for investigations training. ▪ Eight out of eight DFPS investigators (100%) had completed the requirements for training regarding individuals with developmental disabilities. At ABSSLC, the IMC, two investigators, two Quality Assurance nurses, and four Campus Administrators conducted or participated in investigations. None were in the direct line	Substantial Compliance

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		of supervision of those investigated. The training records for these investigators were reviewed with the following results: ▪ Eight out of nine Facility investigators (88%) had completed the requirements for investigations training. One Quality Assurance Nurse, who sometimes investigated serious injuries and deaths or provided information regarding medical issues for investigations, had not completed CSI0100 Conducting Serious Investigations. ▪ Nine out of nine Facility investigators (100%) had completed the requirements for training regarding individuals with developmental disabilities. The Monitoring Team found the Facility remained in substantial compliance with this provision. While the QA nurse that had not completed the investigator training course should not have conducted investigations, there was no evidence in Samples #D.2 or #D3 that she had. She could, however, provide medical expertise to the trained investigators assigned to such cases. This finding was in agreement with the finding of the Facility in its Self-Assessment.	
	(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 in the Documents Reviewed section above, 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-only investigations, respectively. ▪ Review of the investigation files in Sample #D.1 showed that in 15 out of 15 investigations (100%), Facility staff cooperated with DFPS investigators. ▪ Review of the investigation files in Sample #D.2 showed that in four out of four (100%) investigations, there was minor or no involvement with outside entities and no indication in the files of any problems with cooperation. The Monitoring Team found that the Facility remained in substantial compliance with this provision. In its Facility Self-Assessment, the Facility made the same finding.	Substantial Compliance
	(c) Ensure that investigations are coordinated with any investigations completed by law enforcement agencies so as not to interfere with such investigations.	The Memorandum of Understanding, dated 5/28/10, provided for interagency cooperation in the investigation of abuse, neglect and exploitation. This MOU superseded all other agreements. In the MOU, "the Parties agree to share expertise and assist each other when requested." The signatories to the MOU included the Health and Human Services Commission, the Department on Aging and Disability Services, the Department of State Health Services, the Department of Family and Protective Services, the Office of the Independent Ombudsman for State Supported Living Centers, and the Office of the	Substantial Compliance

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		Inspector General. DADS Policy #002.2 stipulated that, after reporting an incident to the appropriate law enforcement agency, the "Director or designee will abide by all instructions given by the law enforcement agency." Based on a review of the investigations completed by DFPS and the Facility, the following was found: ▪ Of the 15 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. ▪ None of the four the investigation records from the Facility (Sample #D.2) had been referred to law enforcement agencies. The Monitoring Team found the Facility remained in substantial compliance with this provision. In its Self-Assessment, the Facility did as well.	
	(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. While on site, the Monitoring Team observed the area the Facility uses for safeguarding evidence. There was a locked cabinet in the Investigators' office for storing evidence. Access was limited to investigators. Based on a review of the investigations completed by DFPS (Sample #D.1) and the Facility (Sample #D.2) and the death investigations in Sample #D.3, there was no physical evidence that required safeguarding. Documentary evidence was secured in the investigation files that were kept in the investigation offices. Surveillance tapes were routinely requested and examined whenever they were available as part of investigations to confirm witness statements, to identify additional witnesses, and to establish timeframes for incidents. The Facility had a process for safeguarding these tapes. The Monitoring Team found the Facility remained in substantial compliance with this provision. In its Self-Assessment, the Facility made the same finding.	Substantial Compliance
	(e) Require that each investigation	Based on Facility Policy #002.3, investigations of serious incidents:	Substantial

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	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.	▪ Were to commence within 24 hours or sooner, if necessary; ▪ Were to be completed within 10 calendar days of the incident; ▪ Required a written extension request from the Facility Director or Adult Protective Services Supervisor to be completed outside of the 10-day period, and only under extraordinary circumstances; and ▪ Were to result in a written report that included a summary of the investigation findings, and, as appropriate, recommendations for corrective action. To determine compliance with this requirement of the Settlement Agreement, samples of investigations conducted by DFPS (Sample #D.1) and the Facility (Sample #D.2) were reviewed. The results of these reviews are discussed in detail below, and the findings related to the DFPS investigations and the Facility investigations are discussed separately. <u>DFPS Investigations</u> The following summarizes the results of the review of DFPS investigations: ▪ 15 out of 15 (100%) commenced within 24 hours or sooner, if necessary. This was determined by reviewing information included in the investigation that described the steps taken to determine the priority of investigation tasks, as well as documentation regarding the tasks that were undertaken within 24 hours of DFPS being notified of the allegation. ▪ 12 out of 15 (80%) were completed within 10 calendar days of the incident, including sign-off by the supervisor. However: o For the three that were not completed within 10 days, two (67%) had documentation of a written extension request the Adult Protective Services Supervisor approved, and there was documentation of the extraordinary circumstances that necessitated the extension. One report, DFPS #41573952, was completed within 10 days, but ABSSLC requested a methodology review and it took another 10 days before the report was completed. ▪ 15 (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 investigations reviewed, recommendations for corrective action were included. In nine of the investigations (90%), the recommendations were adequate to address the findings of the investigation. The following was the investigation for which concerns were noted with regard to the adequacy of the recommendations: o DFPS #41312337: In the original report the investigator included a concern that the behavior of Individual #313 was violent and that she	Compliance

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		was making homicidal threats. The investigator described staff as fearful of this individual and afraid to express their concerns. In the final report, these concerns were modified to: "It is a concern that her LOS is inadequate." This change occurred after discussions between the DFPS supervisor and the Incident Management Coordinator. There was an expectation that supervisors would review and effect changes in the interest of producing an accurate report. However, Individual #313 was on a routine Level of Supervision (LOS) with 1:1 staffing when she exhibited certain behaviors. It was not clear whether the statement meant to suggest the LOS be increased at all times or something else. It was a concern to the Monitoring Team that there was no explanation for the change in the wording of the DFPS investigator's concerns and that the finding that the LOS needed to be reconsidered did not appear to address the concerns about the individual's behavior. While it was true that no abuse or neglect was found, the DFPS investigator apparently had encountered staff concerns about Individual #313 that needed to be addressed either with counseling with staff and/or review of the behavior plan for the individual. <u>Facility Investigations related to DFPS Investigations</u> The Facility began an Unusual Incident Report (UIR) as soon as the report of an incident was received. If the incident involved abuse or neglect, steps were taken to protect the individual, temporarily reassign involved staff, and secure any evidence, if it was available. The Facility then suspended work on the case to allow DFPS to conduct interviews and prepare a report. When the DFPS report was received, the information in the report related to interviews, evidence, findings and the determination of abuse/neglect were copied into the UIR format. The IMC reviewed the report to determine if additional information was necessary and to add or disagree with recommendations. Once the recommendations were finalized, she tracked the follow-up including notifying responsible parties of the recommendations and requesting follow-up. The requirement related UIR was that it be completed within 10 days of the receipt of the DFPS report. Review of these showed: ▪ 15 out of 15 (100%) were commenced timely. ▪ 15 out of 15 (100%) were completed within 10 days of the receipt of the DFPS report. ▪ 15 out of 15 (100%) included a summary of the findings. ▪ 14 out of 15 (93%) included recommendations that addressed the findings of the investigation. In most cases, the IMC accepted the recommendations of the DFPS report. In some cases, she added to the recommendations or clarified them. For example: o DFPS #41312337 Facility Case #309, the IMC added a concern that staff	

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		at the vocational site did not assist when residential staff were attacked. However, this addition did not address the initial DFPS findings of violent behavior in the original DFPS report or explain the change. DFPS #41312337, as noted above, did not appear to have considered and addressed staff concerns with the individual's behavior, and the Facility's addition did not rectify this issue. o DFPS #41573952 Facility Case #350, the IMC added a concern that the staff did not protect the individual from verbal abuse. This addition assured that the recommendations in the final report addressed the relevant concerns. <u>Facility-Only Investigations</u> The following summarizes the results of the review of Facility-Only investigations: ▪ Four out of four (100%) commenced within 24 hours or sooner, if necessary. This was determined by reviewing information included in the investigation that described the steps taken to determine the priority of investigation tasks, as well as documentation regarding the tasks that were undertaken within 24 hours of the Facility being notified of the serious incident. ▪ Three out of four (75%) were completed within 10 calendar days of the incident, including sign-off by the supervisor. However: o The one that was not completed within 10 days (Facility #465) involved a death. There was a preliminary report the Facility investigators completed, and there was documentation of an approved written extension request to allow for the autopsy report to be obtained and reviewed. ▪ Four (100%) resulted in a written report that included a summary of the investigation findings. As noted in the previous bullet, one report had been filed as "preliminary" pending the outcome of the autopsy. 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 three of the investigations reviewed, recommendations for corrective action were included. In three of those investigations (100%), the recommendations were adequate to address the findings of the investigation. o Facility Case #465 remained in preliminary form and recommendations had not been included. The Monitoring Team found the Facility had attained substantial compliance with this provision. The Facility found noncompliance based on inconsistency in the completion of reports within 10 calendar days and requests for extension where that timeframe was exceeded. However, in the sample the Monitoring Team reviewed, the reports were completed on time or there were requests for extensions in all but one DFPS report. In	

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		order to maintain compliance with this provision, the Facility will need to remain vigilant and take action as necessary with regard to the issues its Self-Assessment identified.	

	(f) Require that the contents of the report of the investigation of a serious incident shall be sufficient to provide a clear basis for its conclusion. The report shall set forth explicitly and separately, in a 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.	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;
		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.
		
		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 15 out of 15 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 15 (100%), each serious incident or allegations of wrongdoing;
		o In 15 (100%), the name(s) of all witnesses;
		o In 15 (100%), the name(s) of all alleged victims and perpetrators;
		o In 15 (100%), the names of all persons interviewed during the investigation;
		o In 15 (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 15 (100%), all documents reviewed during the investigation;
			Substantial Compliance

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		o In 15 (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. DFPS investigators acknowledged review of previous investigations in a note at the conclusion of each report. In one case the investigator noted the injuries caused by the alleged victim in previous cases. In one other case (DFPS investigation #41997492), there were references in the report to the numerous injuries the individual had sustained due to repeated Self-Injurious Behavior (SIB) that involved throwing herself to the floor. Theses references were used to support the conclusion that the injuries in the current case were caused by SIB. o In 15 (100%), the investigator's findings; and o In 15 (100%), the investigator's reasons for his/her conclusions. <u>Facility Investigations</u> The following summarizes the results of the review of Facility-Only investigations: ▪ In three out of three completed investigations reviewed (100%), the contents of the investigation report were sufficient to provide a clear basis for its conclusion o Facility case #465 was in a preliminary draft, awaiting an autopsy report. ▪ The report utilized a standardized format that set forth explicitly and separately: o In four (100%), each serious incident or allegations of wrongdoing; o In four (100%), the name(s) of all witnesses; o In four (100%), the name(s) of all alleged victims and perpetrators; o In four (100 %), the names of all persons interviewed during the investigation; o In three of the three completed investigations (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. In Facility case #465, the investigation was not complete. It was noted that the Facility's style of reporting witness interviews was in a chronological order, rather than by witness. While the information from the interviews appeared to be included, a presentation by witness might prove easier to follow. o In four (100%), all documents reviewed during the investigation; o In four (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 three of the three completed investigations (100%), the investigator's findings and o In three of the three completed investigations (100%), the investigator's	

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		reasons for his/her conclusions. The reports in the samples met the requirements of this provision of the Settlement Agreement. As a result, the Monitoring Team found substantial compliance, as did the Facility.	
	(g) Require that the written report, together with any other relevant documentation, shall be reviewed by staff supervising investigations to ensure that the investigation is thorough and complete and that the report is accurate, complete and coherent. Any deficiencies or areas of further inquiry in the investigation and/or report shall be addressed promptly.	Based on review of ABSSLC Policy #002.3, 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. <u>DFPS Investigations</u> The following summarizes the results of the review of DFPS investigations: ▪ In 15 out of 15 investigation files reviewed (100%), the supervisor had signed the investigation report, indicated he/she had conducted a review of the investigation 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. When the Monitors met with DFPS in April 2012, they indicated they would submit a proposal to address this issue. ▪ In none (0%), there was evidence that the review had resulted in changes being made to correct deficiencies or complete further inquiry. ▪ In 15 out of 15 investigation files (100%), the IMC had reviewed the DFPS investigations and the UIRs that accompanied the DFPS investigations. ▪ In seven of the investigations the IMC found errors or additions/deletions that were needed to the reports. For example: o DFPS cases #41931374, #42363467, and #41545232 needed some technical corrections, such as conforming definitions to Facility terminology. o DFPS case #41573952 needed a methodological review, which was done and resulted in a change in the finding from unconfirmed to confirmed verbal abuse and from confirmed to unconfirmed neglect. o For DFPS case #41898012, the IMC found a need for further Facility investigation of an inconclusive finding, which was done. o DFPS case #41312337, the IMC requested a clarification on concerns in the DFPS report, which were done.	Noncompliance

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		o For DFPS case #42310312, the IMC found that the warning to keep the individual at arms length from peers was not documented in the PBSP or in the rights assessment, which was not reflected in the DFPS report. <u>Facility- Only Investigations</u> The following summarizes the results of the review of Facility investigations: ▪ In three out of three completed investigation files reviewed (100%), there was evidence that the supervisor had conducted a review of the investigation report. The remaining investigation, Facility #465, was incomplete. ▪ In one (i.e., Facility #389), there was evidence that the review had resulted in changes being made to correct deficiencies or complete further inquiry. Although the Facility found it was in substantial compliance, the Monitoring Team found noncompliance based on the lack of any supervisory notes for the reviews by the DFPS supervisor. This issue is under discussion between the Monitors and the parties.	
	(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 required that when corrective action was needed, it would be documented on the Unusual Incident Investigation Report in the section entitled: "Recommendations for Current/Future Actions." ABSSLC was recording recommendations (often expressed as "concerns" in the DFPS reports), whether offered by DFPS investigators or by the Facility investigators, in the UIR with the person assigned responsibility and the date due. The IMC followed up by sending a memo to responsible people with the request for action and space for the response. Responses were sent together with evidence of completion, such as disciplinary letters, or training rosters to assure that the requested action had been completed. In order to determine compliance with this provision of the Settlement Agreement, a subsample of five of the investigations from Sample #D.1 and Sample #D.2 was selected for review. This subsample, Sample #D.6, is listed in the Documents Reviewed section above. Documentation was requested to show what follow-up had been completed to	Noncompliance

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		address the recommendations resulting from these investigations. ▪ For five out of five of the investigations reviewed (100%), prompt and adequate disciplinary action had been taken and documented, where required. For example, the following disciplinary actions had been taken: o Letters of reprimand were issued in DFFS case #41931374, and #41573952 within a month of the reports. o Two suspensions were issued in case #41545232 and one resignation was accepted. o Two investigations did not warrant disciplinary action, because no staff was identified as responsible. ▪ For five out of five of the investigations reviewed (100%), prompt and thorough programmatic action had been taken and documented when warranted. For example, the following programmatic actions had been taken: o DFPS case #41545232 involved leaving individuals on a van with one staff member, while the rest of the staff and individuals played a game at a park. The levels of supervision were breached for the individuals on the van. The three staff assigned to the individuals were disciplined, but the entire staff was retrained to assure understanding of requirements when assigned to one-to-one staffing coverage and to assure that all understood the need to protect individuals from harm. o In Facility case #389, where an individual slipped on a wet bathroom floor, a plan was put in effect to dry the floor between showers and to take other steps to prevent falls. ▪ For none out of five investigations (0%) was there documentation to show the expected outcome had been achieved as a result of the implementation of the programmatic and/or disciplinary action. While there was documentation to show that training happened or that disciplinary letters were on file, it was not clear whether there had been any efforts made to assure that the discipline or training had had the desired result. For example: o In DFPS case #42310312, a group of individuals were transported to a day activity program by van. Staff from the home were supposed to accompany them to the program, but were held back by other duties. The individuals were dropped off at the program site, but not properly supervised resulting in one individual sustaining seven scratches to his arm when a peer, who was known to scratch others, got too close. The finding was that the Facility was neglectful in not providing the necessary staff. A memo was sent to the Director of Residential Services, and the response reiterated that staff from the residence were assigned to attend the day program when the morning meal at the home was complete. The response did not explain how the situation would be avoided in the future. There was no information from the operator of	

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		the day program to indicate how program staff might be assigned to monitor incoming individuals until residential staff arrived to avoid future issues. In addition, there was no evidence that monitoring had or would take place to assure that procedures were in place to prevent similar peer-to-peer aggression o In Facility case #389, an individual fell and sustained an injury when he went into a bathroom where another individual was showering and slipped on the wet floor. The individual was agitated because staff had removed his suitcase from where he placed it by the front door, since it was viewed as a hazard to others. Two actions were recommended and taken. One was that staff be instructed to wipe the floor between showers. The second was that the individual be allowed to place his suitcase by the door, but that psychology staff would design a fading program to reduce his need to do so. However, it was not clear whether follow-up had occurred, and/or that these steps had been completed and with what result. The Monitoring Team found the Facility in noncompliance with this provision, since it was not clear whether steps taken to address findings of abuse/neglect or findings requiring were monitored to ensure they were implemented and that the corrective action resulted in the desired changes in performance. The Facility found itself in noncompliance based on concerns about the promptness of corrective actions.	
	(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 investigations 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, all investigation records were kept in the QA/Incident Management file room. 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. Facility 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 and in the files to allow access to their authorized personnel.	Substantial Compliance

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		According to the Facility's Self-Assessment, the IMC reviewed files monthly to assure they were properly maintained. The Monitoring Team found the Facility in substantial compliance with this provision. The results of the Facility Self-Assessment were the same.	
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. Although this information was collected in the database, the Trend Report did not include data on "staff alleged to have caused the incident" due to the confidential nature of the information. Production of Trend reports for incidents and allegations had resumed. Incident counts were available for 33 categories of incident for FY 2010, FY 2011, and for FY 2012 through May 2012. In the report for the period between March 1, 2012 and May 31, 2012, data were graphed by hour, location, cause, home and top ten types. The data on abuse/neglect were not displayed by disposition (confirmed, unconfirmed, etc.). While data was displayed by month for two and a half years, there was no trending of the data to show whether incidents were increasing or decreasing and in what categories, such as location or time of day. While individuals with the 10 most incidents were displayed, there was no indication whether they had been the top 10 for just the quarter or for a longer period. While the Trend Reports were shared with the QA/QI Council, there was no indication that any corrective plans had been implemented as a result of findings related to the Trend Reports. Since none had been implemented, there were no indications that improved outcomes had resulted. Because the Trend Reports did not include all the required data, and there was no evidence of trending of that data or corrective action plans emerging from an analysis of the data, the Facility remained out of compliance with this provision. The Facility's finding in its Self-Assessment was the same.	Noncompliance

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D5	Before permitting a staff person (whether full-time or part-time, temporary or permanent) or a person who volunteers on more than five occasions within one calendar year to work directly with any individual, each Facility shall investigate, or require the investigation of, the staff person's or volunteer's criminal history and factors such as a history of perpetrated abuse, neglect or exploitation. Facility staff shall directly supervise volunteers for whom an investigation has not been completed when they are working directly with individuals living at the Facility. The Facility shall ensure that nothing from that investigation indicates that the staff person or volunteer would pose a risk of harm to individuals at the Facility.	By statute and by policy, all State Supported Living Centers were authorized and required to conduct the following checks on an applicant considered for employment: criminal background check through the Texas Department of Public Safety (for Texas offenses) and an FBI fingerprint check (for offenses outside of Texas); Employee Misconduct Registry check; Nurse Aide Registry Check; Client Abuse and Neglect Reporting System; and Drug Testing. Current employees who applied for a position at a different State Supported Living Center, and former employees who re-applied for a position also had to undergo these background checks. In concert with the State Office, the Director had implemented a procedure to track the investigation of the backgrounds of Facility employees and volunteers. Documentation was provided to verify that each employee and volunteer was screened for any criminal history. A random sample of 25 employees confirmed that their background checks were completed. The information obtained about volunteers was discussed and confirmed with the Facility Director. 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 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 documented that one employee was terminated due to conviction of a crime, and one was on leave pending the legal outcome of having been charged with an offense. 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 The Monitoring Team found the Facility to be in substantial compliance with this provision. In its Self-Assessment, the Facility did as well.	Substantial Compliance

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 Facility should provide a system for tracking reports made to the Director or her designee that includes the date and time reported. (D.2.a)

2. When it is identified that staff have failed to report a serious incident or allegation in a timely manner or to intervene in what they believe to be an abusive act or do not understand their responsibilities with regard to reporting, the Facility should evaluate the reasons, and address the underlying issues. (Section D.2.a)
3. The Facility should routinely test staff's competence regarding the reporting of unusual incidents and abuse and neglect by having supervisors quiz them regularly on what is expected, including notification of the Director. (Section D.2.a)
4. The Facility should 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)
5. With regard to the Facility's semi-annual audit, the following should be clarified and/or completed:
    a. The process for the audit, including criteria for determining what might need further investigation needs to be documented;
    b. Comparison of data to make sure significant or repeated incidents of injuries are referred for investigation;
    c. A description of regular injury record reviews to ensure all injuries have been reported; and
    d. A review of peer-caused injuries.
6. 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)
7. DFPS should finalize the system for documenting the activities related to the commencement of the investigation. (Section D.3.e)
8. The Facility should develop and implement a system for documenting the activities related to the commencement of the investigation. (Section D.3.e)
9. 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)
10. 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)
11. Trend Reports for Abuse/Neglect/Exploitation and Unusual Incidents should be revised to include data on disposition of cases of abuse/neglect/exploitation, to provide a trend analysis of the data to indicate whether cases in general and confirmed dispositions in particular are increasing/decreasing over time, and to identify and trend key indicators of performance, such as individuals who are repeatedly involved in abuse allegations. (Section D.4)
12. 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 (QA), 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 Quality Assurance: Participating in Quality Assurance and Improvement Council, dated 7/11/11; o ABSSLC Review Processes: Quality Assurance Plan/Process, revised 7/18/11; o Abilene State Supported Living Center Policies and Procedures Index, current as of 7/10/2012; o Presentation Book for Section E; o Abilene QA Process Flowchart, undated; o Incident Management Team Presentation for 8/20/12; o ABSSLC FY 2010: Quality Enhancement Plan FY 2012, undated; o ABSSLC Self-Assessment, dated 8/8/12; o ABSSLC Trend Analysis Report: Allegations of Abuse/Neglect/Exploitation, for 1/1/11 to 7/10/12; o ABSSLC Trend Analysis Report: Injuries - January, February and March 2012; o ABSSLC Trend Analysis Report: Injuries - March through May 2012; o ABSSLC Unusual Incidents Trending Report March through May 2012; o ABSSLC Restraints Trend Analysis Reports: January, February, March, April, May, and June 2012; o ABSSLC Leadership Council/Quality Assurance/Quality Improvement (QA/QI) Council meeting notes, dated January through June 2012; o ABSSLC Leadership Council/Quality Assurance/Quality Improvement Council meeting agenda and handouts for meeting on 8/20/12; o Monitoring tools associated with the Quality Enhancement Plan; o Settlement Agreement Compliance Report, for 3/1/12 through 5/31/12; o QA/QI Data Summaries for: ▪ Section C, FY12, Quarter 3 (March, April, and May); ▪ Section D, FY12, Quarters 2 and 3; ▪ Section F, FY12, Quarter 2 (December, January, and February); ▪ Section J, FY12, Quarters 2 and 3; ▪ Section K, FY12, Quarters 2 and 3; ▪ Section L, FY12, Quarters 2 and 3; ▪ Section M, FY12, Quarters 2 and 3; ▪ Section O, FY12, Quarter 2 and 3; ▪ Section P, FY12, Quarters 2 and 3; ▪ Section Q, FY12, Quarter 2 and 3; ▪ Section R, FY12, Quarters 2 and 3;

	▪ Section S, FY12, Quarters 2 and 3; ▪ Section T, FY12, Quarters 2 and 3; ▪ Section V, FY12, Quarters 2 and 3; and ▪ Internal Medical Audit Preliminary Summary: Audit dates: July 16 to 18, 2012; and o Individual Support Plans for Individual #407, Individual #170, Individual #371, Individual #377, and Individual #403. ▪ **Interviews with**: o Linda Hindshaw, Facility Director; o Jolene Willis, Assistant Director of Programs; o Pat Smith, Quality Assurance Director; o Luee McCreary, Incident Management Coordinator; o Larry Jones, Director of Residential Services; o Tracyl Gandee, Settlement Agreement Coordinator; o Program Compliance Monitors (PCMs); and o Various staff in residential units, including 22 Direct Support Professionals. ▪ **Observations of**: o QA/QI Council Meeting, on 8/20/12; o IMT meeting, on 8/20/12; and o Residences #6480, #6350, #6330; day programs in buildings #6340, #5921, #5923, and the Senior Program.
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section E, dated 8/8/12. In its Self-Assessment, for each sub-section, 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. For Section E, in conducting its self-assessment, the Facility: ▪ Did not use monitoring/auditing tools. According to the QA Director, a tool had been developed for the section, but had not yet been applied and was awaiting finalization of a revised State Office tool. Application of a monitoring tool to the Quality Assurance Section is important, both as a means of collecting information about the section's performance, but also as a demonstration of the importance of self-assessment to the other section leads. ▪ Did not use other relevant data sources and/or key indicators/outcome measures except in a limited way. For example, for the assessment of Section E.1, the only trend data reviewed was quarterly trend data for Abuse/Neglect/Exploitation, unusual incidents, and injuries. No reason was given for not reviewing risk data, Plan of Improvement (POI) data, and the quality assurance monitoring data for the Settlement Agreement sections to determine if it had been tracked and trended as described in this provision. The Self-Assessment, however, did include evidence based on interviews with Section Leads to determine if certain elements of a provision were in place such as the dissemination of Corrective Action Plans (CAPs). ▪ The Facility did not consistently present data in a meaningful/useful way. Specifically, the Facility's Self Assessment:

	o Did not present findings consistently based on specific, measurable indicators. For example, for Section E.2, there was a listing of the sections monitored and the sections with data analysis completed. These findings did not address the requirement of the provision that CAPs be developed and implemented in response to the data or that the CAPs met the expectations outlined in the provision. o Did not consistently measure the quality as well as presence of items. For example, in Section E.2, there was no explanation of how the identified trend reports addressed trending across program areas or areas of care. ▪ The Facility rated itself as being in compliance with none of the sub-sections of Section E. This was consistent with the Monitoring Team's findings. ▪ The Facility data did not identify areas of need/improvement, but did include two Action Plans. The Action Plans targeted creation of measurable outcomes in CAPs and tracking of CAPs. There needed to be Action Plans to address other topics, such as key indicators of performance.
	Summary of Monitor's Assessment: Since the Monitoring Team's last monitoring visit, the Facility had made some progress with regard to Section E, including: ▪ QA Monitoring Tools were in use for all sections of the Settlement Agreement except Sections E and U; ▪ Analyses of the resulting data were being done quarterly for most sections. However, these analyses needed to focus on the identification of systemic issues, not just the sufficiency of the data collection process. ▪ Meetings between discipline heads and Program Compliance Monitors (PCMs) were taking place monthly to resolve issues with audit tools and improve reliability. Some of the areas that will need to continue to improve for the Facility to progress toward substantial compliance with the Settlement Agreement included: ▪ The Facility needed to use the QA monitoring tool to self-assess Section E. ▪ The tools for medical compliance and the associated data needed to be operationalized. ▪ Data reports needed review to identify areas in need of corrective action. Corrective Action Plans needed to be developed, logged, and tracked to completion. ▪ The Facility needed to work with the State Office on identifying a set of key indicators of performance. These then needed to be tracked and analyzed to help identify system issues as well as major issues with individuals that need high-level intervention to ameliorate. ▪ Updated Facility procedures needed to be developed to compliment the revised State Office policy. ▪ The data analyst that had been hired just prior to the Monitoring Team's previous review had resigned. A Program Compliance Monitor had been assigned to temporary duty at the data analyst desk. This important position will need to be refilled as soon as possible to assure this important role can be carried out.

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E1	Track data with sufficient particularity to identify trends across, among, within and/or regarding: program areas; living units; work shifts; protections, supports and services; areas of care; individual staff; and/or individuals receiving services and supports.	DADS had issued a revised policy for Quality Assurance, SSLC Statewide Policy #003.1, effective 1/26/12. If the Monitoring Teams have comments on the revised policy, they will be submitted jointly. The policy called for SSLCs to adopt procedures to implement the policy. However, at the time of the Monitoring Team's previous review in February 2012, due to the proximity of the effective date of the State Office policy to the visit, no local procedures were in place, and the Facility was operating under procedures related to the previous policy. At the time of the Monitoring Team's visit in August 2012, this had not changed. However, a draft of Facility Policy #003.1 (without an effective date) was available at the QA/QI meeting for August to replace the 11/13/09 version of the policy. It will be important going forward, for the Facility to formally adopt the State Office policy, revise its local procedures to conform to the State Office policy, and assure staff are trained on both the policy and the procedures. The Facility had some of the basic infrastructure in place necessary for an adequate QA system. The quality of some of these efforts are discussed in more detail below: ▪ Quality Assurance Director: A Quality Assurance Director was in place; ▪ Communication between Quality Assurance staff and staff of the various sections and disciplines to promote understanding of the requirements of quality assurance and respective roles in carrying them out: The Facility produced monthly notes from meetings between Program Compliance Monitors and Section leads and other staff to indicate on-going communication about the use of monitoring tools. There were minutes of QA/QI Council meetings to attest to the communication between QA and the management of other disciplines. ▪ Collaboration between the QA Director and the Settlement Agreement Coordinator to address the requirements of the Settlement Agreement: At ABSSLC, it appeared that the QA Director and Settlement Agreement Coordinator worked collaboratively on a number of initiatives related to, for example, the self-assessment process. 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 the identification, collection and analysis of key indicators or outcome measures. As indicated in the Monitoring Team's last report, although the Facility had begun to collect 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	Noncompliance

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		improvement, and 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 revealed: ▪ A data inventory that was complete, easy to understand and current was not in place. However, the Facility was able to produce a list of databases upon request that represented a good start toward maintaining a data inventory. The Quality Assurance Department needed to work with each of the programs and departments to identify the data currently being collected, so that decisions could then be made about data that could fairly easily be used to measure key indicators as well as any additional data needed. ▪ A Quality Assurance Plan was in place for monitoring the various sections of the Settlement Agreement and appeared to be implemented. 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. A document entitled "the Quality Assurance Process/Plan," revised 7/18/11, was formatted as a Facility Procedure, but without any clear designation (such as a procedure number, effective date, etc.). The document provided some narrative to describe the overall quality assurance process and to explain how the matrix worked. It was not clear in the narrative how data was entered into the system, how data would be checked for accuracy, and how changes would be made as the system progresses. It was not clear whether this document had been synchronized with the State Office policy, which had not yet been formally issued in the local form. The Quality Assurance Matrix: o Included all Settlement Agreement self-monitoring tools the Facility currently implemented. As noted above, the Facility did not yet implement monitoring tools for Section E or U. o Included data beyond that resulting from application of the self-monitoring tools, but not all data the QA Department was collecting. For example, the Plan of Improvement Data provided monthly to the State Office was not listed, even though the list included some potential beginnings for key indicators of performance and the Facility recorded the data monthly. o Did not include a set of key indicators of performance, selected from	

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		among the various data to serve as the basis for decision-making about the quality of services and supports and to guide in setting priorities for selecting area of systemic performance that need attention or individuals whose array of issues, require coordinated special attention from a high management level. The Facility needed to identify its overall programmatic goals (e.g., individuals will be safe, individuals will lead meaningful lives, individuals will be involved in their communities, etc.). The data then needed to be linked to the Facility's programmatic goals, and data collected to determine if such goals were being met. In developing such a system, key indicators should be developed and monitored regarding the wide range of supports the Facility provides, including areas such at-risk individuals; medical, psychiatric, and nursing issues; infection control; physical and nutritional supports; residential and vocational supports; habilitation and skill acquisition; and outcomes related to transition to the most integrated setting. The data should be used to determine if the Facility is actually reaching clearly delineated benchmarks related to health, safety, and integration. If not, then analysis needs to occur to determine the changes that should be instituted to assist the Facility, and, most importantly, the individuals in reaching the desired outcomes. o Did not reference the satisfaction survey results that were being accumulated. ▪ As a result of these systems not yet being in place, ABSSLC did not yet have a set of monitoring data and key indicators to identify trends across, among, within and/or regarding: program areas; living units; work shifts; protections, supports and services; areas of care; individual staff; and/or individuals receiving services and supports. In interview, the Program Compliance Monitors (PCMs) described their efforts to collaborate with discipline heads to improve the inter-rater reliability of the monitoring tools and to analyze the resulting data. Where some disciplines had been resisting assistance in using the tools, they were requesting additional help from the PCMs in analyzing and trending data. The PCMs noted that several tools had been revised and shortened (i.e., the Restraint-Section C tool), combined to avoid collecting the same data in multiple tools (i.e., Section M: Nursing), or had revisions to guidelines to improve reliability. Where the Facility was producing overall scores of compliance based on the implementation of the monitoring tools, the process needed to be revised since the items on tools were not weighted, and were not designed to produce overall scores. However,	

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		in cases where the individual items on the tools were used to support specific indications of compliance and when inter-rater reliability was established for those individual items, it was helpful in establishing a finding related to compliance. The Facility was not in substantial compliance with this subsection. There had been some progress in the application of the monitoring tools, in work with the disciplines on inter-rater reliability, in refining the tools and guidelines, and in producing data reports. However, much work remained to modify as appropriate and implement the monitoring tools with integrity (this is further discussed in many of the Facility Self-Assessment sections throughout this report); produce a regularly updated list of data sources; and identify, collect, and analyze key indicators of performance.	
E2	Analyze data regularly and, whenever appropriate, require the development and implementation of corrective action plans to address problems identified through the quality assurance process. Such plans shall identify: the actions that need to be taken to remedy and/or prevent the recurrence of problems; the anticipated outcome of each action step; the person(s) responsible; and the time frame in which each action step must occur.	<u>Data Analysis</u> Data in the QA Matrix were not all collected, summarized, graphed, and analyzed by disciplines with oversight and additional analysis by the QA department. The data were not trended across, among, within and regarding program areas by: work shifts, protections, supports and services, areas of care, individual staff, and individuals receiving services. However, a number of activities were underway to accomplish this including: ▪ For most sections listed on the Matrix (as detailed in the list in the Documents Reviewed section above) data from the Monitoring Tools were being collected, analyzed and reported to the QA/QI Council quarterly. Many concerns about the adequacy of these analyses existed. However, it was positive that such reports had begun to be generated. The following provides some examples of the reports reviewed: o The quarterly data summaries included some minimal reviews, such as that for Section O (3rd quarter) in which the sample was described without specifying the total number the sample was based on; the data summary included an overall compliance score that was not relevant since the data was not weighted for importance of the included indicators; and the report specified two indicators that scored less than 70%. The only recommendation was to meet monthly with auditors to assure the tool was being used correctly. There was no recommendation to address the two indicators that scored below 70%, nor any explanation for not addressing them. o Other quarterly data summaries included information about efforts to achieve inter-rater reliability, such as the one for Section Q (3rd quarter), but did not include any recommendations except that department auditors continue to meet monthly with PCMs to assure compliance. o Some summaries such as the one for Section J (3rd quarter) included a	Noncompliance

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		clear description of how the sample was drawn including the population on which it was based. It included revisions to the tool, noted that indicators were not weighted and provided additional information on inter-rater reliability by staff completing the scoring and by indicator scored, making it easy to determine those indicators that were not being measured accurately. o Some summaries such as Section M (3rd quarter) included recommendations for corrective action plans, based on the findings. For example: "Continue focus data analysis and corrective actions on acute injury/illness, hospitalizations and nursing assessments." The summary recommended discontinuation of some nursing monitoring tools, addition of one and development of corrective action plans to address deficient areas found through the analysis of the monitoring data. ▪ None of the summaries appeared to include a set of key indicators or outcome measures, drawn from the monitoring tools and/or from other data collected by the discipline or by the Facility, to measure performance of the Facility across the variety of service and support areas or areas of care. ▪ Trend Reports were completed for: o Restraints for the months of January through June 2012. Data was produced and analyzed for the total restraints, restraints with safety plans, emergency personal restraints, and chemical restraints; o Injuries for the months of January through March 2012 and for the third quarter of FY 2012; o Unusual Incidents for March through May 2012; and o Abuse/Neglect/Exploitation for 1/1/11 through 7/10/12 comparing three years. ▪ The QA Department produced other analyses of data and presented them to the QA/QI Council, including: o A report for March through May 2012 entitled the "Third Quarter Obstacle Report" showing the most frequently identified obstacles to community transition. As is discussed with Section T, this was a good beginning, but further analysis of the data was needed. o An "Aggression Analysis" for March 2012 and May 2012 showing incidents of aggression to be trending downward over time. The reports identified homes where the most aggression was occurring and trended aggression-causing injury and individuals injured due to aggression. These reports could be improved by addition of a clear description of the source of the data and notations of any systemic changes (i.e. a different definition for aggression) that might explain the identified trends.	

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		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. The Monitoring Team does not recommend using aggregate scores, because even if tools are weighted, an aggregate score does not provide the Facility with the information it needs to identify areas of best practice and/or those requiring attention. It was appropriate and necessary for recommendations to include actions related to the monitoring process. However, 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. <u>QA/QI Council</u> The QA/QI Council at ABSSLC was called the Leadership Council/QAQI. The Council's stated purpose was: "To develop or revise and implement quality assurance procedures that enable the Center to assure effective coordination of all Center functions; consistent with regulatory requirements, Settlement Agreement Compliance, and process improvement initiatives throughout the organization…" It was meeting twice monthly with representation from management, the disciplines, and the residential units. Attendance was recorded for each meeting and notes were maintained in an established format. Some subgroups of the Council (Performance Improvement Teams or PITs) had been formed around specific topics, including the Physical and Nutritional Management Team, Medication Variance Committee, and the Polypharmacy Review Committee. These teams reported to the Council. For this report the notes for the two meetings in April (April 12 and April 19, 2012) were examined. The following summarizes the observations resulting from this review: ▪ The April 12th notes included a discussion of engagement monitoring and whether the three years of data were being examined and acted upon. A recommendation was made to convene a committee to propose a plan of action to address concerns with the process and to report back on May 7, 2012.	

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		Minutes of the May 7, 2012 meeting indicated that the "Engagement Monitoring Workgroup" was discussed, and a procedure and action plan were presented. After recommendations were made, Unit III was designated to pilot the new procedure. The action plans were approved and the workgroup was to report back in June. However, no references to the workgroup and the action plan were found in the notes of either of the meetings in June. ▪ The minutes included the preliminary results of the Medical Audit and noted 117 action plans were generated. It was not clear whether these plans were internal follow-up plans and/or whether any of the issues raised was significant enough to suggest a formal corrective action plan for approval by the Council. The notes did not record any discussion, questions, or the raising of possibilities that Corrective Action Plans might be needed. ▪ Three PITs reported on their activities, noting accomplishments, challenges, corrective action plans, monitoring, and priorities for their groups. None included corrective action plans and no discussion was apparent from the notes. ▪ The April 19th notes included reports on restraint, aggression and injury trends, referencing reports given to the Council (but not included in the notes.) No actions to be taken were entered. ▪ The Data Analyst reported on the injury trending database at length. While no discussion was reported, four actions to be taken were listed, but none was designated as a corrective action plan. ▪ Monitoring data results were reported for Sections O, P, R, and T as previously scheduled. Reports were scheduled for Sections E and U but, since the Facility had not monitored Sections E and U, they could not be included. Each section reported on accomplishments, challenges, monitoring tools, policy and next quarter priorities. Some discussion was recorded, and no corrective action plans were assigned for development. ▪ One report on Section T did reference a CAP that was developed in March (3/14/12) as having been completed and being monitored for success. <u>Corrective Action Plans</u> The Facility reported that three formal Corrective Action Plans had been developed: ▪ Section I's CAP addressed competency-based training for the QDDPs on the importance of the Integrated Risk Rating Forms and Risk Action Plans, dated 3/14/12. The CAP listed three people to be responsible for the training, actions to be taken, and an expected outcome of 100% compliance on the filing of IRRFs and plans that occurred after the training. However, there were no steps to achieve the training, no time frame for completion, and no method for measuring the expected outcome. The plan needed to specify what each responsible person was expected to do in a separate step, indicate the timeframes for accomplishing those steps, and how the outcome of the plan would be measured.	

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		▪ Section M's CAP addressed the creation and modification of nursing care plans to address changes in condition. The CAP listed training for case managers using updated Care Plan guidelines as the necessary action and listed four positions as responsible. The CAP needed to contain steps leading to the training, and for each step, one person responsible, with designated time frames. There needed to be an explanation of how the outcome would be measured and a timeframe for completion. ▪ Section T's CAP addressed the development and implementation of a monthly obstacle data spreadsheet for QDDPs to use to record information on obstacles to the transition of individuals to more integrated settings. This CAP had steps, a time frame, and a person responsible. It was not clear whether the assignment of the CAP to the responsible Section Lead included an expectation that the Lead would expand the basic assignment to break the CAP's stated goal into workable steps and return it to the Council for final approval. If that was not made clear, it should be in future. In reviewing the data summaries, the trend reports and the Council notes, there appeared to be numerous areas that would benefit from Corrective Action Plans. For example, the Council notes for 4/12/12 identified the need to make changes to the way engagement data was gathered and used. Some good ideas were put forward and there was agreement on setting up a committee. It was not clear why this was not a CAP. In the same report, the monitoring of medical services generated numerous areas of concern, yet not one CAP was assigned. In the Council notes for 4/19/12, there was a lengthy report and discussion of issues with the data on injuries in the AVATAR data system. The notes included actions to be taken. However, this appeared to be a huge project that needed to be done over a period of time involving corrections to data and training. Yet, it was not considered to need a Corrective Action Plan. On the positive side data was being gathered and some analysis was being completed for most of the sections in the Settlement Agreement. Data was being trended and analyzed for some areas notably abuse, incidents, injuries, and restraints. However, there did not appear to have been much progress in the development of Corrective Action Plans resulting from the data generated by the Facility as part of their internal monitoring processes, and key indicator data was not yet available for analysis. The Monitoring Team found that the Facility was not yet in substantial compliance with this provision due to the need for more extensive analysis and trending of additional information, and the assignment and development of CAPs to address identified issues. The Facility found it was not compliant as well.	
E3	Disseminate corrective action plans	As described with regard to Section E.2 of the Settlement Agreement, the Quality	Noncompliance

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	to all entities responsible for their implementation.	Assurance Plan Process outlined the basic CAP requirements. Three corrective action plans were submitted in response to Document Request TX-AB-1208-IV.7. The QA Plan outlined the responsibilities for each of the Settlement Agreement sections, including responsibilities for proposing and implementing CAPs in response to data analysis. The QA Director maintained a tracking sheet to record the progress on CAPs identified by the Council. The process for disseminating the CAPs involved the Quality Assurance Director sending them via email to the Section Lead for the CAP. The Section Lead was to respond to the QA Director accepting the CAP and assigning responsibility. As long as the QA Director entered the plan and the responsibilities, this appeared to be an acceptable dissemination plan. With only three CAPs to review, which were not broken into the necessary steps with staff assigned to each step, it could not be determined whether those who need to receive a copy of the CAP if fact, did. Thus, it was not possible to determine whether the plan for dissemination was working. As a result, the Facility was not in substantial compliance with this provision. The Facility finding was the same.	
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 timeliness and implementation. Departmental monitors and QA Program Compliance Monitors would monitor the program areas to provide the data to track resulting improvements. 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: ▪ For the Section T CAP: it was marked "completed." However, no information on the results from re-monitoring were entered. ▪ For the Section M and the Section I CAPs, the expected outcomes had been changed, and an update entered to indicate that the schedule for the expected training had been modified. The Presentation Book for Section E indicated that the monitoring of the CAP progress could be found in the QA Council minutes. However, it would be a laborious process to check through minutes to determine if the CAP was making progress. The Tracking sheet should capture and track that progress, and reviewed at the meetings and attached to the minutes.	Noncompliance

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		At the time of this review, there was insufficient experience in the use of the tracking tool to determine whether it met the requirements of this provision. 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. As recommended in previous reports, ABSSLC should continue to revise its monitoring tools to meet the needs of the Facility. 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)
2. 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)
3. The Quality Assurance Department should work with each of the programs and departments to identify the data currently being collected, so that decisions then can be made about data that can fairly easily be used to measure key indicators as well as any additional data needed. (Section E.1)
4. The data referenced in Recommendation #3 should be a core component of what the Quality Assurance/Quality Improvement Council reviews, and the analysis of this data should form the basis for the actions that the Council implements, monitors, and revises, as appropriate, to effectuate positive changes in the lives of individuals the Facility supports. (Section E.2)
5. As recommended in previous reports, data currently being collected and analyzed should be used to identify areas in which improvements are needed. These data should be used to identify problematic trends and/or individual issues, and the Facility should develop, implement, and monitor corrective action plans to address them. (Section E.2)
6. In developing CAPs, the Facility should ensure that the action steps that are identified delineate the detailed steps that will be taken to achieve the desired outcome. Care should be taken not to simply restate the desired outcome, without specifying who will do what when to effectuate change. (Section E.2)
7. CAPs should include measurable outcomes (e.g., decreased in injuries from 1000 to 500, or increase in active engagement from 45% to 75%), 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 Draft Policy Number 004: Individual Support Plan (ISP) Process (Integrated Protections, Service, Treatments, and Supports) with attachments, undated; o Individual Support Plan Planning Circle, dated 4/6/12; o DADS State Supported Living Centers Procedure – Instruction for Preferences and Strengths Inventory (PSI), undated; o Preferences and Strengths Inventory template, undated; o ISP Preparation Meeting instructions, undated; o Individual Support Plan Preparation Addendum, undated; o Draft Annual ISP Meeting Interdisciplinary Team (IDT) Attendance Indicators, revised 6/11/12; o Draft Assessment/Report Schedule – Minimum Requirements, dated 6/14/12; o Assessments/Reports Needed for Annual ISP Meeting and IDT Members Required for the Annual ISP Meeting template, revised 6/14/12; o Instructions for IPS Meeting Guide, undated; o ISP Meeting Guide, undated; o Draft Instructions for Integrated Risk Rating Form (IRRF), dated 5/24/12; o Annual Integrated Risk Rating Form template, dated 5/31/12; 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 8/8/12; o Q Construction: Facilitating for Success Lesson Plan and Content, dated 4/7/11; o Q Construction: Facilitating for Success – Qualified Mental Retardation Professional (QMRP) Facilitation Skills Performance Tool, with instructions, dated 6/7/11; o Annual ISP Meeting Preparation Checklist, undated; o Sign-in Sheets and handouts for ISP training with State Consultant, dated 7/10/12; o In response for the last monitoring tools that the QDDP Coordinator completed and the last 10 the QA Department completed, the following statement: "New monitoring tools developed and implemented in June 2012. Monitoring of ISPs did occur however documentation monitoring tools (sic) still in process;" 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 Total number of ISP annual meetings that occurred more than 365 days after the previous meeting, undated; o Monthly Meeting Notes for Sections F and S, dated 3/13/12, 5/2/12, 5/11/12, 6/13/12, and 8/17/12; o Completed monitoring/auditing forms for seven individuals' annual ISP processes, including two for each individual completed by various monitors on various dates;

	○ ISPs Filed Past the 30-day Timeframe, undated; ○ In response to the request for: "For the last year, aggregate data summary reports on: a) assessments completed for ISPs, including timeliness; and b) team member participation in annual ISP meetings," the response: "No information for TX-AB-1208-V.12;" ○ Individual Support Plans, Sign-in Sheets, Assessments, Individual Support Plan Addenda (ISPAs), Preferences and Strengths Inventory, Community Living Options Information Process (CLOIP) worksheet, skill acquisition and teaching programs, Rights Assessment, monthly reviews, and 90-day ISP planning meeting documentation for: Individual #403, Individual #371, Individual #377, Individual #407, and Individual #170. ○ Handouts from ISP meeting for Individual #542; and ○ Presentation Book for Section F. ▪ **Interviews with**: ○ Kristin Wyrick, QDDP Coordinator; ○ Jolene Willis, Assistant Director of Programs (ADOP); and ○ Haley Savage, Program Compliance Monitor (PCM). ▪ **Observations of**: ○ ISP Meeting for Individual #542, on 8/23/12; and ○ Activities in homes and day programs.
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section F, dated 8/8/12. In its Self-Assessment, for each sub-section, 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. For Section F, in conducting its self-assessment, the Facility: ▪ Used monitoring/auditing tools. At the time of the review, the Facility was in the process of modifying its monitoring tool for Section F. The Facility's progress with this process is discussed in further detail with regard to Section F.2.g. However, based on a review of the Facility's Self-Assessment: ○ The monitoring/audit tool the Facility used to conduct its self-assessment included: the QDDP Facilitation Skills Performance Monitoring Tool. In addition, the Self-Assessment referenced that the QDDP Coordinator had reviewed a sample of 10 ISPs and another sample of 22 assessments, but it was unclear what tool(s) had been used to conduct these reviews. As a result, it also was unclear what criteria had been used, because there were references to documents being completed "according to guidelines," but the specific standards were not stated. ○ As the Facility recognized, the current monitoring/audit tools did not include adequate indicators to allow the Facility to determine compliance with the Settlement Agreement. As the Facility revises its monitoring tools, the Facility is encouraged to review the Monitoring Team's report to identify indicators that are relevant to making compliance determinations. ○ As noted above, the monitoring tool(s) was under revision. However, based on review of the draft tool, it generally included adequate methodologies, such as observations, and

	record reviews. However, these methodologies were not specified with regard to specific indicators. As a result, it was likely that different auditors would, for example, look at different documents, or different portions of documents in conducting their reviews. o The Self-Assessment identified the sample(s) sizes. However, it did not include the number of individuals/records reviewed in comparison with the number of individuals/records in the overall population (i.e., n/N for percent sample size). For ISPs, 10 had been selected, and for assessments 22 had been selected. Based on a census of 411 individuals, it did not appear that these sample sizes were adequate to consider them representative samples. However, it appeared that the ISPs were selected based on the QDDP Coordinator's availability. The sample size could be expanded if data from other monitors/auditors' reviews were included. o As the Facility recognized, the current monitoring/audit tools did not have adequate instructions/guidelines to ensure consistency in monitoring and the validity of the results. The Facility's efforts to develop a revised tool, including guidelines, are discussed in further detail with regard to Section F.2.g. o The following staff/positions were responsible for completing the audit tools: the Program Compliance Monitor, the QDDP Coordinator, and four QDDPs. As noted above, the Self-Assessment appeared to only include the QDDP Coordinator's data. o It was not clear from the documentation provided that the staff responsible for conducting the audits/monitoring had been deemed competent in the use of the tools and/or were programmatically competent in the relevant area(s). o As the Facility recognized, adequate inter-rater reliability had not been established between the various Facility staff responsible for the completion of the tools. ▪ Was in the process of developing other relevant data sources and/or key indicators/outcome measures. For example, the Facility was awaiting development of a database that would allow aggregation of information related to IDT member meeting attendance, as well as assessment timeliness. The Facility also was tracking the timeliness of ISPs, as well as the date the final ISP document was completed and made available for implementation. Although these were important indicators of compliance, the Facility had not used this data in its self-assessment. ▪ Although some improvement was seen, the Facility did not yet consistently present data in a meaningful/useful way. Specifically, the Facility's Self Assessment: o Did not consistently present findings based on specific, measurable indicators. For example, as noted above, at times, it was unclear what criteria had been used, because there were references to documents being completed "according to guidelines," but the specific guidelines were not stated. In addition, at times, indicators combined more than one item, such as "methods for implementation, timeframes for completion, and persons responsible," making it impossible to determine which of these requirements had been met in the ISPs reviewed, and which had not. Another example would be that action plans "reflect the individual's needs for services and supports and are practical and functional at the SSLC and in community settings." o Did not consistently measure the quality as well as presence of items. o Did not distinguish data collected by the QA Department versus the program/discipline.

	▪ The Facility rated itself as being in compliance with none of the sub-sections of Section F. This was consistent with the Monitoring Team's findings. However, of concern, many of the indicators included in the Self-Assessment showed high levels of compliance, which was not consistent with the Monitoring Team's findings. In reviewing the Monitoring Team's report, the Facility should attempt to determine the reason for this discrepancy. ▪ The Facility's data identified areas of need/improvement. However, for these areas of need, the Facility Self-Assessment did not provide an 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.
	Summary of Monitor's Assessment: In July 2012, the State Office provided additional training on a revised ISP format and process to ABSSLC's QDDPs and many other team members. A revised ISP Meeting Guide (Preparation/Facilitation/Documentation Tool) was introduced to assist the QDDPs in preparing for the meetings and in organizing the meetings to ensure teams covered relevant topics. In addition, according to the new procedures, more pre-planning was to begin 90 days prior to the ISP meeting. In addition to the team using a new tool to identify the individual's preferences, strengths, and priorities, at the ISP Preparation Meeting, the team also was to review the previous ISP to determine the status of action plans. If plans had not been completed and/or were not successful, then the team was to decide what action to take. The team also was to make decisions regarding which team members should attend the annual meeting, and the assessments that needed to be completed prior to the meeting. At the time of the Monitoring Team's review, two teams had been selected to pilot the new process. Other teams were using a portion of the process, but had not yet fully implemented the revised Integrated Risk Rating Form or integrated health care plans. Timeliness and quality of assessments continued to be problematic. Although it appeared that teams had begun to review and incorporate more assessment information and clinical data into the decision-making regarding individuals' risk ratings, assessments continued to lack adequate recommendations to appropriately define the protections, supports, and services the individuals required. In addition, even when recommendations were included, teams did not consistently address them in the ISPs. Teams appeared to be talking more about individuals' preferences and strengths, as well as community activities, including sometimes the development of community skill acquisition goals. However, further refinement of these discussions was needed, including expanding the scope and types of preferences and strengths the teams identified, and better incorporating them into the ISP action plans and using them creatively to expand individuals' opportunities or address their needs; and increasing individuals' opportunities for community integration through the inclusion of measurable and meaningful objectives in their ISPs. The Facility identified that the development of action plans was an area in which more work was needed, as well as more training and technical assistance. A review of the ISPs as well as the IRRFs showed that teams were talking more about the various "protections, services and supports, treatment plans, clinical

	care plans, and other interventions provided for the individual." The revised meeting guide prompted the teams to discuss, revise, and approve plans that previously had been viewed as separate plans, such as the PNMP, PBSP, crisis intervention plan, psychiatric treatment plan, and integrated health care plans. Although the Facility was in the beginning stages of implementing this new process, it showed promise for the development of more comprehensive ISPs. In conjunction with State Office, the Facility was in the process of deciding on a new format for monthly reviews. As the Monitoring Team discussed with staff, whatever system is decided upon should provide various team members with responsibility for conducting monthly reviews with a practical method for documenting their reviews, including relevant data. It also should provide the QDDPs with a user-friendly way of pulling these reviews together and making decisions about whether further team review is necessary. Progress was being made in setting up the infrastructure for the quality assurance processes, including development of a monitoring tool that more closely tracked the current ISP process, delineation of guidelines to supplement the indicators in the monitoring tool, establishment of inter-rater reliability amongst auditors, development of a database to aggregate information, and meetings between programmatic and QA Department staff to review and analyze the data, and make recommendations for corrective action plans. However, all of these activities remained in a development stage and required additional work.

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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:	In May 2012, DADS State Office had revised Policy #004.1: Individual Support Plan Process, and had provided the Monitoring Teams with a draft copy. The three Monitoring Teams were in the process of reviewing the policy, and any comments will be provided jointly. DADS State Office recognized the previous ISPs did not meet the requirements of the Settlement Agreement. As a result, using a group of consultants as well as work groups including State Office and Facility staff, the ISP planning and development processes had been revised and reflected in the draft policy. In July 2012, ABSSLC QDDPs and many team members had been provided training on the new process. In consultation with the parties, it was agreed that beginning in August 2012, the Monitoring Teams would only review and comment on the ISP documents that utilized the newest process and format. The new ISP process had only been completed for approximately 10 individuals at ABSSLC, and for some of these individuals, the full process was not reflected due to the pre-planning process that required 90 days to complete. The Monitoring Team requested a sample of five of the newest plans. The intention of limiting the Monitoring Teams' review to newer plans is to provide the State	

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		and Facilities with more specific information about the revised process. Compliance will then be contingent on both the new plans meeting the requirements, and a sufficient number of individuals having plans that meet the Settlement requirements. For the sample of five individuals, the Monitoring Team requested copies of their most recent ISPs, along with related assessments, sign-in sheets, ISPAs, Preferences and Strengths Inventories, Community Living Options Information Process worksheets, skill acquisition and teaching programs, Rights Assessments, monthly reviews, and 90-day ISP planning meeting documentation. This sample included plans for: Individual #403, Individual #371, Individual #377, Individual #407, and Individual #170. It is important to note that only two teams at the Facility were currently implementing the new process, including the revised risk rating process and revised integrated health care plan process. As a result, sample was limited to the work of a couple of teams and QDDPs.	
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 Draft Policy #004.1 in both the definition section and in Section II.F.1.b indicated that the QDDP would assist the individual and Legally Authorized Representative (LAR), as appropriate, in leading the team in an interdisciplinary discussion. ▪ The QDDP Coordinator confirmed that QDDPs facilitated the teams, including team meetings. Observations of team meetings and reviews of ISPs also illustrated that the QDDP was the team leader and responsible for ensuring team participation. For the one meeting the Monitoring Team observed while onsite, neither the individual and/or LAR facilitated the meeting and/or played a role in raising topics and ensuring certain items were discussed. For Individual #542, her guardian had been invited, but could not be present, and Individual #542 did not appear to be interested in facilitating the meeting. The QDDP appropriately took the lead in facilitating the meeting, solicited Individual #542's involvement, and raised questions or comments the guardian had posed in a telephone conversation prior to the meeting. ▪ With regard to staffing, in addition to the QDDP Coordinator, a QDDP Educator remained in place to assist in providing QDDPs with needed oversight and training. Based on the caseload list provided (which was dated 10/28/11, but appeared to have modified since then), a total of 19 QDDPs were in place. Two caseloads were being covered by other QDDPs in addition to their own. This	Noncompliance

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		resulted in a QDDP generally being assigned to each residence. This resulted in an average caseload of 22, with a range of 14 to 29 individuals. ▪ On July 10, 2012, the State Office provided additional training on a revised ISP format and process to QDDPs, and on July 11, 2012, similar training was provided to other team members. A revised ISP Meeting Guide (Preparation/Facilitation/Documentation Tool) was introduced to assist the QDDPs in preparing for the meetings and in organizing the meetings to ensure teams covered relevant topics. Using assessment and other information, the QDDP used this template to draft portions of the ISP prior to the meeting. Copies of the draft were then provided to team members at the beginning of the meeting, and changes were made as appropriate. In addition, more pre-planning began 90 days prior to the ISP meeting. For example, prior to the 90-day ISP Preparation meeting, QDDPs were expected to work with team members who knew the individual best to complete a new Preferences and Skills Inventory. The intention of this document was to identify the individual's preferences and skills, as well as priorities so all team members responsible for completing assessments could utilize this information in the assessment process, as well as in developing the ISP. This document would become a living document that would be updated and revised over time. At the ISP Preparation Meeting, the team also was to review the previous ISP to determine the status of action plans. If plans had not been completed and/or successful, then the team was to decide what action to take. ▪ At the time of the review, two teams had been selected to pilot the new process, including the use of the revised Integrated Risk Rating Form and development of integrated health care plans. The other teams at ABSSLC were using the new ISP Meeting Guide and the 90-Day ISP Preparation Meeting process. The remaining teams were expected to implement the IRRF and integrated health care plan process beginning in September. As noted above, the Monitoring Team's sample included only plans that utilized the new format and process. As is discussed in more detail in the sections that follow, the new process showed some improvements, but as would be anticipated with a new process, more work was needed to continue to make necessary changes and refine the processes. ▪ In an effort to improve the documentation of the IDT discussions and the decisions made at annual ISP meetings, the Facility had taken a couple of steps. Specifically, a QDDP had been assigned to take notes at each meeting, allowing the individual's QDDP to concentrate on facilitating the meeting. The second QDDP's role was to capture the discussion accurately on the computer. This was helpful, but time-consuming for the QDDPs. As a result, other options were being explored to allow an accurate transcription of the meeting to be obtained. Secondly, the Facility had begun to provide a "Ghost" QDDP the day following the ISP meeting to allow the QDDP that had facilitated the meeting the day before to	

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		write-up the ISP. With very limited interruptions, this appeared to be having an extremely positive effect on QDDPs' ability to turn-around the ISP document quickly and accurately, so that implementation could begin. ▪ Based on interview and documentation provided, new QDDPs continued to complete the Q Construction: Facilitating for Success training. The QDDP Coordinator and PCM continued to use the corresponding competency checklist as they sat in on meetings. However, both indicated that a new form, entitled Annual ISP Meeting Preparation checklist, appeared to provide a better assessment of the QDDPs' overall facilitation skills. This form followed the entire process from the 90-Day ISP Preparation Meeting to the annual meeting through to completion of the final ISP document. Based on review of the new form, it included a number of important indicators, but likely would need to be revised slightly to measure specific competencies of the QDDP in the facilitation process. However, it provided a good base on which to build should it be decided that it could replace the Q Construction format. ▪ During the week of the review, the Monitoring Team observed one ISP annual team meeting (i.e., for Individual #542). Progress definitely continued to occur with regard to the facilitation of meetings. Based on this limited observation and review of ISPs, some of the areas in which progress had begun included: o At the annual ISP meeting, an agenda was clearly set forth, along with ground rules. The QDDP politely enforced the ground rules when team members strayed from them. o Efforts were made to include the individual, and focus the discussion on 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. In addition, a note-taker was present to allow the QDDP to run the meeting without needing to maintain detailed notes. o Efforts were made to elicit information from all team members. Some team members participated fully, and offered ideas on a variety of topics, even those outside of their specific areas of expertise. However, not all team members participated to the extent they should have. o During the ISP meeting on site, the team had a more comprehensive discussion than in the past about a wider variety of the protections, supports, and services. o Based on the observation on site, as well as review of ISP documents, QDDPs and teams were using more data to make decisions in relation to individuals' risk areas, although this was as area that required further improvement. In addition, a number of gaps continued to exist, for example with regard to teams' discussions about data related to skill	

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		acquisition programs, PBSPs, and measurable objectives related to risk plans. It was positive, though, that the teams were discussing objective clinical data in a number of areas. o Based on the observations of the ISP meeting, although problems still existed with the specifics included in action plans, teams were observed discussing action plans in more detail, particularly some of the strategies that were in place or would be put in place to address risks. The team discussed functional action plans, and related a number of them back to the individual's preferences. Unfortunately, based on the documents provided, little change was noted. This likely was due to the Facility not providing copies of the integrated health care plans. It was unclear why these were not provided given that they should be part of the ISP document. o During the onsite observation of a team meeting, the discussion about the individual's living options showed improvement, with discussion being linked back to the individual's preferences. Unfortunately, this was another area that was not consistent across the ISPs reviewed. This is discussed in more detail with regard to Section F.1.e. Based on review of ISPs as well as during the observations of a meeting held the week of the onsite review, facilitation of team meetings was improving, but for none of the five plans reviewed or meeting observed was it yet resulting in the requirements of the Settlement Agreement being met with regard to 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. Areas in which improvements should be made in order to achieve compliance, included: ▪ As noted above, the Q Construction: Facilitating for Success training included a competency-based component. Since the previous review, no additional QDDPs had been deemed competent in facilitation. Based on the list provided, seven out of the nineteen QDDPs (37%) had previously been deemed competent in facilitation. Review of a few of the completed tools showed that some important aspects of the facilitation process had been identified as areas in which QDDPs needed to work. ▪ Based on review of ISPs as well as during the observation of a meeting held the week of the onsite review, facilitation of team meetings was continuing to improve, but missed opportunities continued to be noted with regard to: o As is discussed in further detail below, areas in which QDDPs will need to obtain full team participation and facilitate meaningful discussion included, but was not limited to: ▪ Expanding the list of individual preferences to include	

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		preferences related to work, relationships, past experiences, etc. and using the preferences to offer the individual new experiences. ▪ Similarly, identifying a comprehensive list of the individual's strengths, and using them to build upon the individual's current independence, relationships, vocational experiences, etc. ▪ Making sure decisions the team makes are data-based to the extent possible. ▪ Developing measurable objectives. As the QDDP Coordinator indicated during interview, teams continued to struggle to define measurable, functional objectives during team meetings, and, as a result, they often were not included in ISPs. This factored into the overall process of developing adequate action plans, including appropriate methodologies. ▪ Articulating meaningful outcomes for individuals. Often the outcome was expressed as a process (e.g., Individual will attend preferred community outings at least twice a month), rather than as a change in the individual's life (e.g., Individual will make a new piece of artwork at an arts and crafts store in the community, or Individual will participate in a bowling league in the community). ▪ To improve integration of supports, 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. ▪ Although the length of the meetings was somewhat decreased, the majority of the time at the ISP meeting the Monitoring Team observed was spent on the risk rating process, including some discussion of the integrated health care plans related to the risks. Although this was an essential activity in which teams needed to engage, it resulted in little time being spent, for example, on the team defining the measurable outcomes to determine the efficacy of the interventions the team discussed to address the risks, or other important topics. Focus should be placed on the preparation before the meetings, so that meeting time is available for both the clinical discussions that need to occur, but also adequate time is devoted to developing supports to assist individuals to expand their independence, involvement in the community, and in leading meaningful lives. For example, if all team members had familiarized themselves with the information included in the draft IRRF, the team would not have had to review it all in detail, but rather could have discussed any questions and then made decisions. If action plans were presented in draft format, team members could review them prior to the meeting, and discuss necessary changes and additions	

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		at the meeting. 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 Draft Policy #004.1 described the interdisciplinary team as including the individual, the Legally Authorized Representative, if any, the QDDP, direct support professionals, and persons identified as providing services and supports to the individual, as appropriate, including professionals dictated by the individual's preferences, strengths, and needs, and who are professionally qualified and/or certified or licensed with special training and experience in the diagnosis, management and treatment of individuals with intellectual disabilities. With the new process for ISPs, at the ISP Preparation Meeting 90 days prior to the ISP, the team was to make a determination regarding whether a team member's attendance was required or not. Moving forward, this information would be included in the database that was in the initial stages of development and implementation. Data was submitted for individuals in the two pilot homes. The data included an indication of whether or not a team member's presence was required, and if the team member attended the meeting, as well as when the team member was notified that his/her participation was required. Both the Settlement Agreement and State policy required that in addition to the individual, LAR, and QDDP, "other professionals dictated by the individual's strengths, preferences, and needs, and staff who regularly and directly provide services and supports to the individual" should participate. In the training materials the Facility submitted, a draft document was included entitled: "Annual ISP Meeting IDT Attendance Indicators," revised 6/11/12. Recognizing that this was a draft document, it appeared to provide a good basic framework for teams' decision-making regarding attendance. It appeared that the risk levels being established for individuals had been incorporated into these criteria as one mechanism that teams could use to determine which team members should attend an individual's annual planning meeting. This was positive. However, a few areas were unclear, such as how habilitation therapies would provide input at meetings for individuals to whom other staff were providing indirect therapy supports that therapists oversaw, when pharmacy's involvement would be appropriate, when active treatment staff would be involved, and how decisions would be made about which residential staff outside of the QDDP and direct support professionals would attend.	Noncompliance

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		Based on the sample of five ISPs: ▪ For four (80%), at the 90-day ISP Preparation meeting, the team defined the members of the team that should attend the annual meeting. Concerns noted included: o For Individual #403, the ISP Preparation Meeting ISPA indicated that an attached document identified the team members that should attend the annual ISP meeting, but no document was attached. ▪ Four individuals had strengths, preferences, or needs that would have required additional team member participation. For none of these four individuals (0%), the team had adequately justified why such team members' participation was not necessary. The following provides some examples of the problems noted: o Based on Individual #403's needs, no one from vocational or the Seniors' program, which were mentioned as programs she attended, was in attendance. The team discussed a vocational assessment, but without the benefit of a staff from that department. In addition, the Contract Local Authority (LA) was not present, which limited the discussion about community options. o For Individual #377, no justification was provided for the team not requiring the PT's presence. Particularly given that she had an ambulation program, and used a wheelchair as well as numerous other pieces of adaptive equipment, it was unclear how this decision was made. In addition, the team did not identify a pharmacy representative as being necessary. However, Individual #377 was identified as being at high risk for polypharmacy for seizure and constipation medications. As illustrated in the IRRF, the team could not fully discuss the issue o For Individual # 170, no one was required from vocational services despite a clear need for vocational assessment, and there was no justification for not including them. The ISP referenced the need for the presence of the Local Authority at the meeting to permit a discussion of community transition. However, that person had not been on the list of people required to attend. o For Individual #407, according to the Preparation Meeting list, no one from speech, occupational therapy, or physical therapy was required to attend despite the need for a PMNP, and there was no justification for excluding them. No one from psychology was required, although there was a need to discuss a recent PICA behavior. However, those professions were represented at the meeting. ▪ For one of the five (20%), it appeared that a duly constituted team participated in the annual meetings. For Individual #407, all of the team members identified as needed were there. In addition the psychologist, speech and OT/PT professionals, who were needed to discuss the PNMP and PICA issues also	

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		attended. The following provide examples of concerns noted: o For Individual #371, the team met to prepare for the ISP and identified the team members that should be included at the ISP meeting. The following people were identified by the team, but were not in attendance at the annual meeting: 1) the individual was not included on the sign-in sheet. It was unclear from the ISP narrative whether or not she was present, and if not, what the reason was; 2) the Occupational Therapist; 3) the Pharmacist; and 4) a representative from the Dental Department. o For Individual #377, all of the team members the team identified should be present at the ISP were. However, as noted above, no justification was provided for the team not requiring the PT or the Pharmacy Department's presence. o For Individual #170, the pharmacist had been identified to attend, but did not. It was noted in the ISP that no "MRA" was available, but was needed to make some decisions about community transition. However, there was a representative of the contract local authority. It was not clear why the local authority representative was not able to answer questions at the meeting. Some progress had been made in that the Facility had begun using the new 90-Day ISP Preparation process to more systematically identify team members that needed to be in attendance at annual meetings. 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 Draft Policy #004 defined "assessment" as "A formal document that identifies an individual's current level of functioning, preferences, strengths, needs, and recommendations to achieve his or her goals, promote independence, and overcome obstacles to community integration. The assessment is used to identify strengths and needs to support the individual in the development of training, participation, and service objectives listed in the 'Action Plans' section of the ISP." In Sections II.B and III.C, the policy stated: o "Ninety days prior to the annual ISP meeting… The IDT identifies what assessments need to be completed based on the resident's preferences, strengths, needs, and risks, in addition to ICF/ID required assessments. The IDT should use the guidelines outlined in Exhibit A: Assessment/Report Schedule when determining which assessments should be completed or updated. All assessments should incorporate and reflect the individual's preferences, strengths, and needs…	Noncompliance

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		o IDT members complete the recommended and required assessments and place them in the facility computer share drive for the IDT to review no later than 10 working days before the annual ISP meeting. Copies of the assessments will be shared with the resident's LAR, family, actively involved person, or designated representative prior to the ISP meeting…" ▪ Part of the new 90-Day ISP Preparation Meeting process, which was similar to the previous Personal Focus Assessment (PFA) process, was for the team to define the assessments needed for the ISP. Included in some of the training materials was a Draft Assessment/Report Schedule – Minimum Requirements, dated 6/14/12. Although it will be important to ensure that this document addresses the Settlement Agreement as well as regulatory requirements, it appeared to provide a good framework from which teams could work to determine the standard assessments that should be completed, and the timeframes for their completion. ▪ Moving forward, this information would be included in the database that was in the initial stages of development and implementation. Data was submitted for individuals in the two pilot homes. The data included a list of assessments, including an indication of whether or not they were required, and the date they were posted on the shared drive. ▪ 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. The Facility as well as State Office recognized that the quality of assessments was still having a negative impact on the quality of team discussions and the resulting ISPs. 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), 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). Reportedly, the State Office was developing a list of quality indicators for each of the discipline-specific assessments. 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. Based on the sample of five ISPs:	

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		▪ For four (80%) (i.e., Individual #371, Individual #377, Individual #107, and Individual #470), at the 90-day ISP Preparation meeting, the team defined the assessments that were needed for the annual meeting. Concerns noted included: o For Individual #403, the team's list of needed assessments was referenced in, but not attached to the ISPA for the ISP Preparation Meeting. ▪ In reviewing the ISPs for five individuals, the teams for two individuals (40%) had identified the comprehensive assessments necessary to identify the individuals' strengths, preferences, and needs, and/or had provided adequate justification for not requiring such assessments. Examples where this occurred appropriately included: o For Individual #371 and Individual #170 the team identified the assessments that should be completed for the annual meeting. This appeared to be an appropriate list based on the individual's needs. Concerns noted included: o As noted above, it could not be determined what the team for Individual #403 intended based on documentation provided. o For Individual #377, it was unclear why some assessments were not required, including speech (i.e., she used augmentative and alternative communication devices, including a communication book and CheapTalker), or an updated QDRR (i.e., she was on three forms of polypharmacy). The team provided no justification for not requiring these assessments. o For Individual #407, it was unclear why a psychological assessment was not required when the individual was reported to have had a possible PICA episode. The ISP Preparation Meeting documentation should include space for a justification, which teams should complete, particularly when they are not requiring completion of an assessment for which the individual has specific needs. ▪ For none of the five (0%), the necessary assessments were completed and available to the teams at least ten working days prior to the ISP meeting, as ABSSLC required. Concerns noted included: o For Individual #403, the OT/PT assessment was over a year old. This individual had multiple OT/PT needs. The only PT update appeared to be a specific consultation in January 2012 related to positioning in a recliner. Likewise, the nursing assessment, restraint risk, and SLP assessments all were dated after the Facility deadline of 10 days prior to the ISP meeting. o For Individual #371, the following assessments that the team identified	

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		as necessary were not included in the documentation submitted: nursing, psychological, Structured Functional Behavior Assessment, psychiatric, speech, pharmacy, and Self-Administration of medication. Based on the narrative of the ISP, her last speech evaluation was completed in 2002. In addition, the following assessments were dated less than 10 business days prior to the ISP meeting: recreation, vocational, and functional skills assessment summary. o For Individual #371, two assessments that were requested in time for the ISP meeting were not completed, including an updated dental (i.e., the one submitted was over a year old), and an updated vocational assessment, which was not completed until a month after the ISP meeting. In addition, other assessments that were not completed timely included the OT/PT update, nursing, medical, and the Activity Center assessment. All of these were completed less than 10 working days prior to the ISP meeting. o For Individual #170, the nursing, the OT/PT, vocational and pharmacy were not available at least 10 business days prior to the ISP meeting. o For Individual #407, a Preventive Care Flow Sheet was identified, but not provided. Specifically with regard to the identification of strengths, preferences, and needs, according to the revised State Office policy and process, at the 90-day meeting prior to the annual ISP meeting, the team, using the Preferences and Strengths Inventory, was to identify preferences and strengths, as well as the major goals towards which the individual wanted to progress. Assessments then should reflect these preferences and strengths, and, as appropriate, identify any additional ones. The assessments should then incorporate these as appropriate into recommendations, proposed action plans, etc. With most of the assessments reviewed, this was not yet occurring and often the lists of preferences and strengths were weak. For example: ▪ For Individual #403, assessments varied in terms of their inclusion of strengths, needs, and preferences. Interestingly, the FSA included more strengths than what were listed in the ISP or PSI. Except for the FSA, none of the assessments recommended specific programs based on the individual's listed strengths and preferences, or effectively incorporated them into programs. ▪ Based on review of Individual #371's ISP and PSI, the list of preferences and strengths was limited. For example, the preferences related mostly to food and activities (e.g., taking naps, riding on the golf cart, going to work, etc.), and the strengths related mostly to activities of daily living and/or her current job (e.g., toileting independently, dressing on her own, stacking washcloths, etc.). In order to build on the individual's current strengths and broaden the individual's horizons, the team should describe more of the positive	

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		characteristics of the person, as well as the individual's specific skills. For example, describing an individual in terms of having a good work ethic, being persistent, or making friends easily would assist the team in identifying new opportunities or building on current ones to increase the individual's independence or involvement in activities. In reviewing the assessments, some included appropriate strengths and needs, as well as references to preferences. In fact, the vocational assessment included some valuable strengths, but most of these were not included in the ISP. The PSI included no strengths. Except for the FSA Summary, none of the assessments used the strengths and preferences to build programs or address outstanding need areas. The FSA recommended using her preference for Spanish to encourage involvement with her peers, which was an area of need. Unfortunately, this recommendation was not addressed in the ISP. ▪ For Individual #377, it appeared that her Activity Center assessment identified a number of preferences as well as strengths, a number of which were not added to the overall list. Most assessments did not reflect the preferences and strengths identified in the PSI. In addition, the PSI identified some good ideas related to further community integration (e.g., an arts and crafts class at a local store, attendance at college music recitals, and participation in the Arts Walk). However, none of these were included in other assessments or in the ISP. Assessments also frequently did not include adequate recommendations. Some of the issues noted included: ▪ Some assessments typically included no or limited specific recommendations (e.g., nursing, medical, and dental). Others included an incomplete list of recommendations. ▪ Recommendations frequently were not oriented to the development of action plans. In the past, the Monitoring Team had recommended an annual review of incidents, and abuse, neglect, and exploitation allegations. This type of assessment had begun to be included in the ISPs. However, this often appeared to involve a cursory review of the incidents and allegations. It was not clear that the goal had been met of individuals' teams ensuring that all of the protections, supports, and services necessary to reduce to the extent possible such incidents were in place and appropriately incorporated into the ISP. Some examples of where thorough reviews did not appear to have been completed included: ▪ For Individual #377, a header appeared to be missing from the chart with the list of injuries and abuse/neglect allegations. This made the information difficult to interpret. However, the team identified a potential trend related to injuries to her elbow. Although the team had a theory about how the injuries were caused,	

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		no action plan was developed to address the potential cause and/or rule in or out other potential causes. ▪ For Individual #371, the ISP indicated that she had 14 injuries over the last year. They were not listed, so the team's conclusion that there were no trends could not be confirmed. ▪ Similarly, for Individual #542, whose ISP meeting the Monitoring Team observed onsite, the team discussed a list of numerous minor injuries and other incidents, and concluded that there was a trend related to bruising of her lower extremities. The only actions discussed were those currently in place, including keeping her skin hydrated and arranging the furniture to be more open. However, the team did not discuss specifically where the injuries occurred (e.g., was a particular piece of furniture, or particular part of the residence problematic) or circumstances of the injuries (e.g., times of day or levels of staffing). It was particularly concerning that the team did not further analyze these incidents given that Individual #542 was at high risk for osteoporosis. Some progress was noted, because teams had begun to more systematically identify the assessments that the individuals required. Care will need to be taken to ensure that justification is provided when an individual's needs indicate the need for an assessment, but the team decides for a specific reason not to require completion of that assessment. Timeliness and quality of assessments also continued to be problematic. 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 five 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 following are examples of concerns noted: o For Individual #403, generally, the assessments offered few recommendations. Some that were included in the assessments were reflected in the ISP, but other important ones were not. For example, although the OT/PT assessment was old, it recommended continued implementation of exercise and positioning programs, but these were not included as action plans in the ISP, nor was any explanation provided for discontinuing them. The audiology and SLP assessments also included specific recommendations that were not addressed in the	Noncompliance

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		ISP. o For Individual #371, many of the assessments offered limited recommendations. However, many of the recommendations that were included were not addressed in the ISP. For example, dental included a recommendation to improve her oral hygiene, which was rated as poor, and OT/PT recommended a trial of a spin toothbrush. No action plan related to dental care was included in the ISP, and this opportunity for integration between disciplines was lost. The OT/PT update included a number of recommendations that were not addressed. Similarly, none of the recommendations for SAPs included in the FSA Summary were included in the ISP, and no explanation was provided. ▪ Although it appeared that in developing the IRRFs, team had referenced more assessment information, the Facility did not provide the corresponding integrated health care plans, which should have been part of the ISP document. As a result, the Monitoring Team could not determine if this information had been used to develop adequate and appropriate protections, services, and supports. ▪ Some of the overall continuing concerns negatively impacting the Facility's ability to ensure that assessment results were used to develop, implement, and revise, as necessary, an ISP that outlined the protections, services and supports provided to the individual included: o Issues with regard to the quality of the assessments. As noted with regard to Section F.1.c, many assessments included minimal recommendations. As a result, it was not clear what protections, supports, and services, the assessors had determined the individual required. The assessment results were not translated into recommended action plans, including measurable, functional objectives. o A lack of consistent interdisciplinary discussion and coordination in the development of ISPs. Based on review of documentation, it was not clear that team members had read each other's assessments and identified questions and/or recommendations related to the integration of services and supports. This limited teams' ability to utilize assessment information to develop adequate protections, supports, and services. The Facility should address these 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. Although it appeared that teams had begun to review and incorporate assessment information and clinical data into the decision-making regarding individuals' risk ratings,	

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		the Monitoring Team could not fully assess progress in this area because the Facility did not provide complete documentation. Based on the ISPs and related assessments submitted, however, assessments continued to lack adequate recommendations to appropriately define the protections, supports, and services the individuals required. In addition, even when recommendations were included, teams did not consistently address them in the ISP.	
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).	Based on information the Facility provided, the following activities had occurred to provide additional education to QDDPs and IDTs regarding community living options: ▪ On 3/23/12, the Admissions Placement Coordinator provided training to QDDPs and other IDT members on "Essential/Non-Essential Support Identification, Obstacles to Referral/Obstacles to Community Transition, Community Transition Processes." During this training, a number of recommendations the Monitoring Team made in previous reports with regard to Section T were shared with the QDDPs and other IDT members. In addition, the list and rationale for reasons/obstacles to not make a community referral, as well as obstacles to transition were reviewed. The group also reviewed the community transition process, including the process, timeframes, and persons responsible for the various activities. The Admissions Placement Coordinator also reviewed a list of important items related to the referral and transition processes through to the post-move monitoring process. 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 five plans were reviewed including those for: Individual #403, Individual #371, Individual #377, Individual #170, and Individual #407. The following highlights some of the findings: ▪ Progress had been seen. However, teams were not consistently providing independent assessments of individuals' ability to transition to a more integrated setting. In order for the State Office requirement to be met, each discipline's assessment needed to include an opinion/recommendation. In addition, at the ISP meeting, the team needed to make a recommendation to the individual/guardian. Based on the review of records: o Some assessments included the required statements/recommendation, and others did not. However, this was an area in which improvement was seen. Of the five ISPs reviewed, for none (0%) did all of the assessments include the applicable statement/recommendation. The following provides more specific information: ▪ For Individual #403, many of the assessments included specific statements about whether or not the individual could be	Noncompliance

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		supported in a more integrated stetting. Those that did not included Recreation, OT/PT, and Dental. In addition, no formal recommendation was made formally from the QDDP, DSP, or residential staff. This was the case for all of the individuals reviewed. ▪ For Individual #371, many assessments were missing. Those that were present generally included a specific recommendation about the individual's appropriateness for a more integrated setting, with the exception of the dental assessment. ▪ For Individual #377, the assessments that did not include the expected recommendation were dental, medical, and speech (i.e., outdated assessment). o Of the five ISPs reviewed, none of the individuals had been referred for transition to the community. For these five individuals, three individuals' ISPs (60%) included an independent recommendation from the professionals on the team to the individual and LAR (i.e., Individual #403, Individual #407, and Individual #377). However, the following problems were noted: ▪ For two individuals (40%), no independent recommendation was found. Specifically: • For Individual #371, there was no indication in the ISP that individual team members were polled regarding their opinions about whether or not Individual #371 could be supported in a more integrated setting. The sister, who was not the guardian, indicated that she would prefer for Individual #371 to remain at ABSSLC, but was open to receiving further information about options closer to where her family lives. The team concluded: "The IDT agreed that [Individual #371] can live in a less restrictive environment, but we are unable to gauge what she likes and dislikes. The IDT will set more SAPs in place to prepare [Individual #371] by training her in pedestrian safety, proper community etiquette, and personal hygiene. The Home Activity Specialist will take [Individual #371] over to the 2nd Edition store to allow [Individual #371] to pick up what she likes and better determine how to know what she likes and dislikes." In the Rights Assessment, the team had identified that the individual could not	

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		provide informed consent in any of the five areas identified. As a result, the team likely would need to make this decision for the individual. Although it would be important to try to determine her preference, it was unclear how the team intended to do this. • For Individual #170, the ISP did not identify any obstacles to community placement, and determined that the individual should "reside in the least restrictive living option that is available to her," without explicitly making a recommendation. ▪ For three individuals (60%), the assessments and/or ISP narrative included statements showing disagreement amongst the team regarding the individual's appropriateness for community transition (i.e., Individual #403, Individual #407, and Individual #377). For these individuals, the team recommendation was that the individual remain at the Facility. However, it was not clear how the team disagreement about this had been resolved and/or the team had not provided adequate justification for its decision. For example: • For Individual #403, according to the assessments and the ISP, everyone except for the physician indicated she could be served in a less restrictive setting. However, the ISP indicated that: "The **facility discipline members** (independent of the resident and LAR/family) determined that [Individual #403] would not benefit from moving to a less restrictive environment at this time. This determination is based on [Individual #403's] need for 24-hour medical care. The team also identified that [Individual #403] does not like change and has great relationships at AbSSLC." No information was provided regarding how the discrepancies between the physician and all of the other team members were reconciled, and why the other team members changed their minds. In addition, "24-hour medical care" was not defined. The ISP did not include integrated health care plans, and, therefore, no description was provided of the measurable health care supports the individual required. • For Individual #377, most assessments indicated she could be served in a less restrictive environment. The	

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		only assessment that indicated she could not be was nursing. The ISP did not reconcile these differences in opinion. In one section of the ISP, the team indicated: "If everything that is currently provided at AbSSLC could be provided in the community, every represented department believes [Individual #377] could be served in a less restrictive environment." However, in the section in which the team's recommendation was documented, the team stated: "The facility discipline members (independent of the resident and LAR/family) determined that [Individual #377] would not benefit from moving to a less restrictive environment at this time. This determination is based on [Individual #377's] need for 24-hour medical care. The team also identified that [Individual #377] does not like change and has great relationships at the AbSSLC. The IDT is also respectful of [Individual #377's] primary correspondent's wishes for her not to move." The team did not define "24-hour medical care," nor did it describe any efforts to identify such supports in a more integrated setting. In one portion of the ISP, the team made the statement: "The IDT discussed that [Individual #377's] seizure activity is so great that supports are not available for community placement. The only placement with 24-hour nursing is a nursing home, and the team feels that is not an appropriate placement for [Individual #377]." Although the Monitoring Team agrees that a nursing home is not an appropriate placement, the team provided no information regarding how it reached the conclusion that nursing homes were the only settings in which 24-hour nursing was available, nor did the ISP include any health care plan(s) that described the specific roles that nurses needed to play on a 24-hour basis to maintain Individual #377's safety and health. If such supports were being provided, the ISP did a poor job of delineating them. As a result, the team's decision was not adequately justified. • For Individual # 407, the evaluations that included recommendations were split between those who	

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		believed her needs for communication, nutrition, and active treatment could be met in a community setting and those who believed her health needs precluded a community setting. The team agreed that ABSSLC was the least restrictive setting, but there was no indication of how they reached that decision. ▪ 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 obstacles. In summary, the Facility had made some progress with regard to identifying obstacles. However, the Facility was in the initial stages of developing adequate plans to overcome the obstacles. ABSSLC had made some progress in this area. Using the revised ISP Meeting Guide template, it appeared that teams were more frequently making independent recommendations to individuals and their guardians. However, teams were not consistently documenting the resolution of discrepancies between various team members' recommendations and/or adequately justifying their decisions. In addition, more work was needed to develop appropriate action plans to addresses identified obstacles to individuals' transition to the most integrated setting appropriate. The Facility remained out of compliance with this provision.	
F2	**Integrated ISPs -** Each Facility shall review, revise as appropriate, and implement policies and procedures that provide for the development of integrated ISPs for each individual as set forth below:		
F2a	Commencing within six months of the Effective Date hereof and with full implementation within two years, an ISP shall be developed and implemented for each individual that:		
	1. Addresses, in a manner building on the individual's preferences and strengths, each individual's prioritized needs, provides an explanation for any need or	This provision of the Settlement Agreement addresses 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.	Noncompliance

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	barrier that is not addressed, identifies the supports that are needed, and encourages community participation;	DADS Draft Policy #004.1 at II.F.4 indicated that action plans should be based on the individual's preferences, strengths, and needs. The policy further indicated: "The IDT must have a comprehensive, integrated discussion with input from each team member on how he or she will formally or informally support the prioritized action plans." The revised policy included considerable detail regarding the types of action plans teams should develop (i.e., skill acquisition plans, participation objectives, service objectives, and specific objectives to address individual risk factors); the content of action plans; topics that action plans should cover. It also required teams to "consider every opportunity for community integration," as well as ensure that "Outcomes and objectives are expressed in terms that provide measurable indices of performance…" <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 five 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 five of the ISPs reviewed included a listing of individuals' preferences, only three of the individuals' teams (60%) had effectively incorporated their preferences into related action plans. o For Individual #403, there was evidence that the team had attempted to incorporate the individual's preferences to expand her skills as well as her opportunities for socialization and integration in the community. For example, she enjoyed spending time with her sister, and a SAP was being developed to teach her to say her sister's telephone number, so that staff could assist her in making a phone call to her sister. Similarly, she enjoyed having books read to her and liked animals, and action plans that involved going to the library and visiting places in the community that had animals (e.g., pet stores and the zoo) were included. Certainly, more could be done to effectively incorporate her preferences into the ISP, including further expanding her opportunities to grow and develop, but these were good initial steps. o For Individual #407, her ability to reach out for things she liked and her preference for wheelchair dancing to music. One skill acquisition program under development was for her to learn to use an ablenet button to turn the radio on and off. She was reported to like her hair short and this was incorporated into a plan for a "spa day" in the community, where she could get her hair cut and perhaps develop a relationship with the stylist who was known to staff and receptive to meeting her. o Individual #170 had preferences identified that included going to	

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		church, and music. One action plan step called for submitting a consult for including her in a hand bell choir or hand bell activities, effectively including both her interest in music and church. However, generally, the teams had not used these preferences in creative ways to address individuals' needs (e.g., building in incentives for individuals who refused to attend vocational or day programs, or needed to lose weight) or to expand individuals' horizons. Even when work was a preference, teams did not capitalize on this by expanding the individuals' vocational opportunities. Some specific examples included: o For Individual #371, on a minimal level, some of her preferences were incorporated into action plans, such as to address her interest in music, a referral was being made to the choir. However, although others were discussed in the narrative of the ISP, no related action plans were included in the ISP. For example, she liked it when she was spoken to in Spanish. This was not reflected in an action plan(s), and could potentially have been used to expand her horizons. For example, she tended to not want to interact with others or participate in activities. Having staff speak to her in Spanish, while encouraging or incorporating other activities might assist in increasing her involvement in activities. The SLP made some related recommendations, but these were not incorporated into action plans. o Individual #377's action plans minimally included some of her personal preferences, but as identified in the PSI, there were many opportunities to expand these preferences and strengths to offer Individual #377 with new experiences and opportunities for community integration. It was unclear why the team did not include these in the ISP. ▪ As noted above with regard to Section F.1.a, most of the preferences identified for individuals related to items, food, or activities. It will be important for teams to define what it is the individual prefers about such items, foods, or activities to be able to offer the individual new experiences based on this information. It also will be essential to expand the discussion to include preferences related to environments, work, relationships, past or future experiences, routines, interactions with others, etc. ▪ 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 five plans reviewed (0%) included a list of prioritized 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	

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		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. More specifically, in none of the five ISPs reviewed (0%) were barriers identified and addressed, even when they appeared to exist. For example: ▪ For Individual #403, it appeared that a potential barrier to community participation was transportation. However, the team did not specifically identify it as a barrier. The ISP stated: "[Individual #403's] participation in community activities is directly related to the availability of transportation as she utilizes a wheelchair and requires a high top van and staff assistance. The team will consult with Citilink to find out about paratransit services." Although it was positive that the team was looking for alternatives, if transportation and/or staffing currently were barriers to implementation of her plans, the ISP needed to identify these issues. In fact, the summary of the FSA stated: "These vehicles are usually not available for leisure during business hours," but the ISP did not directly address this as a barrier. <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. None of the five ISPs (0%) reviewed included specific skill acquisition action plans for implementation in the community. For one individual (i.e., Individual #371), the ISP included community skill acquisition goals. However, these goals were targeted for completion either in the community or at the Facility. The SAPs did not delineate a frequency for how often they were to be practiced/implemented in the community (e.g., pedestrian safety, bathroom etiquette, and/or seatbelt use). 10. No barriers were identified. This is discussed in further detail with regard to Section S.3.b. In addition, one of the five individuals' ISPs (20%) (i.e., Individual #403's ISP included one measurable objective, but a number of others were not measurable) included a measurable objective for general community participation. Overall, the issues noted included: ▪ Most of the community-related objectives were not written in a manner to actually encourage the integration of individuals with nondisabled peers and/or the expansion of individuals' experiences in the community. ▪ The objectives were written without any specific timeframes, and the start and end dates spanned a year. 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.	

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		▪ The following provide some specific examples to illustrated these points: o For Individual #377, the community participation action steps were not measurable. As a result, no frequency of community involvement could be determined. In addition, although some of her interests were mentioned, none of the goals/action steps were specifically designed to result in more integration with her nondisabled peers. o For Individual #403, although the ISP included a number of opportunities for community integration, the only measurable one was that the individual: "will attend preferred community outings at least twice a month." Other community activities included going to the public library during reading time; going to the zoo, petting zoo at the fair/rodeo, or horse farm, go for a spa day, and "going out into the community with recreation and home staff." None of these were measurable, and it was unclear if they were expected to happen, for example, once during the year. It also was unclear other than attending these community activities what outcomes were anticipated (e.g., greater involvement in specific types of activities, interaction with her nondisabled peers, etc.). o For Individual # 407 the ISP include opportunities for community integration, including participation in a spa day, where a friend of a staff member was apparently open to seeing her and receptive to growing a relationship. However, it was not clear whether this was to be a one-time event in which case it was hard to imagine how a relationship would develop. The completion date was a year away, and again, it was not clear how it would be determined if a relationship had developed if the event did not take place for possibly 12 months. Although progress had been made, because teams appeared to be talking more about individuals' preferences and strengths, as well as community activities, including sometimes community skill acquisition goals, further refinement of these discussions was needed. This included, but was not limited to expanding the scope and types of preferences and strengths the teams identified, and better incorporating them into the ISP action plans and using them creatively to expand individuals' opportunities or address their needs; clearly identifying and documenting barriers to the provision of supports and services; ensuring teams defined the frequency with which community-based skill acquisition plans would be implemented in the community; and increasing individuals' opportunities for community integration through the inclusion of measurable and meaningful objectives in their ISPs. The Facility remained out of compliance with this provision.	
	2. Specifies individualized,	Although some limited progress was seen in this area, this continued to be an area in	Noncompliance

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	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;	which substantial effort was needed in order for ABSSLC to comply with the Settlement Agreement. The Facility self-identified that this was an area in which more work was needed, as well as more training and technical assistance. 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. The following summarizes the findings 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. As noted in the last report, 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. Based on an observation of the ISP meeting for Individual # 542 while the Monitoring Team was on site, it appeared the scope of these action plans, including goals and objectives had begun to increase. This was a positive development. However, this could not be confirmed through document review. As noted previously, for the ISPs submitted, the Facility did not submit the related integrated health care plans. Teams should consider these to be part of the ISP, and it was unclear why the Facility did not include them in the request for individuals' ISPs. As a result, many supports were missing, and it was unclear if the integrated health care plans captured them or not. For example, 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, counseling treatment plans, PBSPs, and physical and nutritional support plans. Other overall concerns related to action plans included: o Objectives were not seen in any of the plans in relation to staff training requirements. o Although monitoring of supports was sometimes defined (e.g., PNMP implementation), this was not consistent. o Rights restrictions were another area in which very limited action plans were identified to assist in potentially reducing the need for the restriction. Although some money management programs were included, most restrictions had no associated plan identified. ▪ However, none of the five plans reviewed (0%) included a full complement of individualized 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. Examples are provided with regard to Section F.2.a.3 of protections, supports, and services that were not integrated into the	

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		ISPs. ▪ In addition, none of the five plans (0%) included a full set of measurable objectives. For example: o For Individual #403, the overall goals/desired outcomes were not measurable, nor were they individualized. For example, the following goals could not be measures: "[Individual] will live in the most integrated setting consistent with their preferences, strengths and needs," or "[Individual] will maintain relationships in the most integrated setting consistent with her preferences, strengths, and needs." Although some service and support objectives were measurable, many were not. The following are examples of objectives that were not measurable: "[Individual #403] will go to the Zoo, petting zoo at the fair/rodeo, or horse farm in order to cultivate [her] love of animals," "[Individual #403] will continue to receive the 1-on-1 attention she desires," or "[Individual #403] will have an informal training objective that allows her to choose books of different genre. If successful, the active treatment coordinator will turn it into a skill acquisition goal," or "Nursing Assessment/Integrated Health Care Plans." o The overall goals for Individual #371 were not measurable, such as: "During the next 12 months, [Individual #371] will increase the quality and quantity of her relationships." In addition to no baseline data being available, no specific goal was set to allow the team to measure whether or not the related action plans were having the desired impact. Many of the objectives included in the action plans referenced implementation of SAPS, and others were not measurable. For example, the following could not be measured: "will mail pictures and receiving (sic) pictures to and from sister," and "will continue to go on community tours." o Although Individual #377's ISP included an action plan related to participation in the activity center and the work center, only one related SAP was included. Due to the lack of measurable goals or objectives, it was unclear what the team expected she would gain from these activities. The overall goal read: "will participate in Employment/Day Hab programs in the most integrated setting consistent with their preferences, strengths and needs." However, none of the objectives or action steps were directly related to this goal. A number of other action steps were not measurable, such as: "will be provided more opportunities for community outings with preferred peers and staff in order to maintain important relationships," or "Ophthalmology follow-up." ▪ In the section below that addresses Section T.1.b.1, there is extensive discussion	

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		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 requires 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. Although based on an observation of an ISP meeting on site, it appeared some progress had been made in the expansion of the scope of measurable objectives, and efforts were being made to improve the measurability and individualization of objectives and action steps, this could not yet be confirmed through record review. As the Facility recognized, these remained areas in which work was needed. 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. However, some action had been taken to improve the comprehensiveness of ISPs. Specifically, after Staff Office consultants provided training, two teams at ABSSLC had begun piloting a new ISP Meeting Guide (Preparation/Facilitation/Documentation Tool). This tool, along with a new process for completing the IRRF and developing integrated health care plans, was designed to assist teams in more comprehensively planning for, discussing, and developing ISPs that addressed individuals' array of needs for protections, supports and services, while approaching this in a person-centered manner and incorporating their preferences and strengths. Although as noted above, the Facility did not provide the integrated health care plans that should have been considered part of the ISP document, review of the ISPs as well as the IRRFs showed that teams were talking more about the various "protections, services and supports, treatment plans, clinical care plans, and other interventions provided for the individual." The revised meeting guide prompted the teams to discuss, revise, and approve plans that previously had been viewed as separate plans, such as the PNMP, PBSP, crisis intervention plan, psychiatric treatment plan, and integrated health care plans. Although the Facility was in the beginning stages of implementing this new process, it showed promise for the development of more comprehensive ISPs. Of note, during the onsite review, the Monitoring Team observed the ISP meeting for Individual #542. Although problems still existed with the detail included in action plans related to the individual's risk ratings, the team had discussed action plans in more detail, particularly in relation to some of the strategies that were in place or would be put	Noncompliance

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		in place to address risks. This included more collaboration and integration. For example, some integration was seen between active treatment and speech and language in relation to the incorporation of the individual's communication book with a skill acquisition program related to appropriate interactions. As the Monitoring Team's observations of an ISP meeting on site indicated, the majority of the time was spent on the risk rating process and discussion about action steps that would be included in the integrated health care plans. Although these were essential activities in which teams needed to engage, it resulted in limited time being spent, for example, on the team defining the measurable outcomes to determine the efficacy of the interventions the team discussed to address the risks, or other important topics, such as the individual's vocational ambitions and plans to achieve them, his/her plans to increase skills leading to greater independence, ways in which greater integration into the community could occur, etc. Additional preparation by the QDDPs as well as other team members before the meetings was an area for improvement. For example, if all team members had familiarized themselves with the information included in the draft IRRF, the team would not have had to review it all in detail, but rather could have discussed any questions and then made decisions. Another consideration would be the development of draft action plans prior to the ISP meeting. Facility staff raised this possibility with the Monitoring Team. As was discussed, it would seem to be a reasonable and necessary process to allow the meeting time to be shortened and adequate time to be spent on other important topics. However, the major caution relates to the concern that this would result in less collaboration between disciplines and the "silo" effect of team members coming to the table with predetermined plans. If action plans were to be drafted ahead of time, QDDPs would need to make clear that they were drafts, and the expectation would need to be set that changes to the drafts would be the norm as opposed to the exception. Again to reduce meeting time, an expectation might also be set that team members review them ahead of time, and come to meetings with mark-ups and/or questions. None of the five 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: ▪ With regard to three of the ISPs that were reviewed, the following provide examples of protections, supports, and services that were not integrated into the ISPs: o For Individual #403, her team included no action plans in the ISP related to IRRF, so many supports and services were missing from her ISP, and the Monitoring Team could not confirm if they were included in	

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		the integrated health care plans. Based on review of the IRRF, a new problem was identified prior to her most recent hospitalization related to low oxygen levels. No specific plan was identified to address or continue to assess this issue, even in ISP addendum upon her return from the hospital. In the IRRF, some items were identified as needing further discussion upon her return from the hospital, but these were not noted in the ISPA documentation. For example, the team cited concerns about staff's proper identification of seizures (i.e., staring off into space, but responding when her name is called). Although the team indicated that this required follow-up upon her return from her current hospitalization, no follow-up to this issue was found in the ISPA. Although the PNMP was discussed during the ISP meeting, no action plans were found integrating it as part of the set of supports the individual would be provided. Similarly, mention was made of a positioning plan, but no corresponding action plan and/or objectives were included in the ISP. o For Individual #371, the ISP did not include integrated health care plans. Therefore, the Monitoring Team could not determine what health care supports were included. As a result, for example, it could not be determined if a support was included to have the Psychiatrist review one of her medications that might have been causing side effects. This discussion was included in the section on injuries, but no corresponding action plan was found. Although the team discussed some strategies to reduce the need for pre-treatment sedation, no corresponding action plans were found. The ISP indicated that the team "reviewed, updated, and approved" the PBSP. However, no indication was provided of the date of the PBSP the team approved, or what updates were made to it. In addition, the action plans did not include the objectives for the target or replacement behaviors, nor did the action plans indicate what data was to be collected, by whom, and/or who would review the data and at what frequency. In one place her ISP stated that she did not have a PNMP: "due to her not being at risk for choking, falls, or anything that the PNMP addresses." However, in the restrictions section, the ISP indicated that she had a chopped low calorie low cholesterol diet, was at risk for choking, and engaged in behaviors such as taking others food, eating rapidly, and putting too much food in her mouth. No action plans were found related to a PNMP and/or dining plan, and the ISP included no indication that psychology staff and/or active treatment staff were involved in developing programs to address her mealtime behavior. A number of the skill acquisition programs submitted did not correspond with what the team agreed to implement (i.e., bathroom skill, and	

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		socialization skill), and some were missing. She had poor oral hygiene, but no dental or related residential plan was included in the action plans. Her diet was not included as an action plan, nor was monitoring of her weight. Although the Vocational Assessment provided limited information, situational assessments had provided some valuable information to potentially expand her vocational opportunities (e.g., adding paper shredding as an option). However, the team only included a SAP related to her current work situation, and did not use the information gained through the assessment to creatively look for ways to expand her skills or experiences. The individualization of action plans also was concerning. o For Individual #377, the narrative of the ISP mentioned certain plans and indicated they were reviewed and approved. However, the dates of the plans were not identified, and in some cases, the specific name of the plan was not indicated. Moreover, no mention was made of the implementation of these plans in action plans within the ISP, so no information was provided about who was responsible for implementing the plans, what measurable outcomes were being tracked to determine their efficacy, who monitored implementation of the plans and/or reviewed related data, who trained staff on their implementation, etc. These plans included the PNMP, health management plans/integrated health care plans, an unnamed plan related to the use and elimination of restraints, and an unnamed plan related to use and/or reduction of the use of protective restraints. Although a reference was made to action plans connected to the IRRF, none were submitted. The only action step related to nursing care plans read: "Nursing assessments/integrated health care plans." It was unclear what this meant. The narrative of her ISP indicated a vocational assessment would be completed within 90 days, but no action plans was included to ensure its completion or set a timeframe for the team's review of the assessment and consideration of potential modifications to her ISP. The narrative of the ISP indicated that she had a communication book and Cheap Talk 8. This was not reflected in her action plans. For example, no action plan was included to ensure that these devices were available to her daily in a variety of settings, or to ensure that staff would encourage their use. Similarly, the role of Habilitation Therapies in maintaining them or monitoring their use was not defined in an action plan. Similarly, Individual #377 had a number of pieces of adaptive equipment, but no action plan was included defining responsibilities with regard to the use, maintenance, or monitoring of the adaptive equipment. The narrative of the ISP identified an ambulation program that Habilitation Therapies	

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		implemented. No related action plan was included that set forth the goals of the program, responsibilities for implementation or monitoring or a schedule for reviewing its effectiveness. ▪ Overall, the medical, psychiatric, counseling, habilitation therapy, PBSPs, and nursing care/health management plans frequently still were separate plans that were 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. ▪ The new format of the ISP included a column for staff responsible for implementation/documentation of plans, as well as one for those responsible for development of the plan, and person(s) responsible for reviewing progress and effectiveness. These were positive additions. Often, this resulted in multiple staff being identified with some level of responsibility. However, as is discussed more below, frequently action plans simply stated what would happen without detailing all of the steps and then, specific roles of the staff who needed to work in an integrated fashion to achieve the stated outcome. ▪ 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. The Facility remained out of compliance with this provision. Although the Facility had begun to implement the revised ISP template and process, it was in its initial stages of implementation. Some limited improvements were seen. However, as noted above, teams will need additional coaching and mentoring to fully implement the process and develop ISPs that meet this requirement of the Settlement Agreement.	
	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, for the five ISPs using the newer format, the timeframes often were confusing, because: 1) teams had completed the "implemented by (Date) column" and the "Completion date" column, but often for items that should not have taken a year (e.g., completing a community tour), the beginning date was the month of the ISP meeting, and the end date was a year later, giving the impression that the team had a year to complete these activities; 2) particularly because the action steps themselves did not define the frequency with which actions should occur (e.g., seeing the neurologist) and the monitoring column was not designed to address implementation, teams had not adequately defined when activities should have occurred, for example, "quarterly," "at every meal," etc.; 3) the ISPs frequently did not distinguish between timeframes for implementation of action steps, and monitoring or oversight of implementation; and 4) at times, action steps were not written in measurable steps, but instead, multiple steps were assumed in one overall objective/action item.	Noncompliance

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		For none of the five ISP (0%), action plans included adequate timeframes for completion. For none of the five ISPs (0%), the roles of the persons identified as responsible were clearly defined. The following provide some examples of concerns noted: ▪ For Individual #403, the objectives included the "Persons Responsible for Implementation/Documentation," "Person Responsible for Plan Development," and "Person Responsible for Reviewing for Progress and Effectiveness." Because the Integrated Health Care Plans were not provided, it was not clear if they included all of these same categories. Often it was not clear who would specifically do what. However, this appeared to be a function of the objectives not being specific or measurable. As a result, an activity or support often included multiple parts, but these were not clearly delineated. Therefore, multiple persons were listed as responsible without any delineation of their responsibilities. For example, the persons responsible for "[Individual #403] will get a library card and go to the public library during reading time" were the Home Activity Specialist, Home Supervisor, and QDDP. However, it was unclear what each of their roles was. Timeframes also were confusing. For example, many action steps that should have been time limited appeared to allow the entire ISP year to complete (e.g., obtaining a consult to determine if she could use paratransit, and obtaining a library card), while others included one timeframe in the written action step and another in the column for completion date (e.g., 14 days versus a year to write a SAP for calling her sister). This too might have been a function of not breaking out different steps necessary to accomplish the overall goal/objective. ▪ For Individual #377, although timeframes were listed in columns marked "Implemented by..." and "Completion Date" these did not always seem to appropriately define the multiple deadlines that might be needed. For example, in the narrative section of the ISP, the team indicated that Individual #377 would see the neurologist at least every three months, and the dermatologist "every few months." However, in the action plan section, the frequency of these visits was not defined. The action steps merely stated: “Dermatology" and "Neurology," with a start date of the day the ISP was developed and the completion date a year later. This provided no indication of the frequency with which these health supports needed to be provided. Generally, direct support professionals were identified more frequently in the action plans (except for the plan for Individual #371 for which no action steps identified direct support professionals as having responsibility). Since the last review, this was an improvement. It will be important, though, as discussed elsewhere to ensure that their roles are clearly defined, as well as the methodologies they should use to implement action steps.	

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		Methods for implementation often were not adequate or present. In other words, the "how" was not provided. In none of the five plans reviewed (0%) was the methodology sufficiently described for the action plans included. For example: ▪ For Individual #371, the action plan related to increasing her and her family's awareness of community options provided few details about methodology. Mailing information to the sister was identified as a methodology, but it was not clear that this would be adequate to answer her questions, and no specific follow-up by the team was identified as part of the methodology. Similarly, Individual #371 was to attend community tours, but the methodology for who would attend with her, what questions would be asked, how the team would review her reaction, etc. was not set forth. Similarly, sending pictures back and forth between her and her sister was included as an action step, but no details were provided regarding with which steps in the process Individual #371 would be involved, how staff would assist with this process, etc. ▪ For Individual #377, Methods also were often missing. For example, action steps related to rekindling relationships with former staff listed a number of staff as responsible, but no methodology was set forth as to who would do what or by when. 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 consistently 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. The Facility remained out of compliance with this provision. In addition to better defining the methodologies in action plans, clear timeframes should be established and specific team members should be identified as responsible.	
	5. Provides interventions, strategies, and supports that effectively address the individual's needs for services and supports and are practical and functional	Although all of the plans included some practical and functional interventions, none of the five 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.	Noncompliance

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	at the Facility and in community settings; and	An area in which some improvements were seen was in developing supports and services that were practical and functional in the community. Although as discussed below, this remained an area of concern, it was positive to see teams making efforts to identify skill acquisition programs that made sense for the individual, addressed an outstanding need, and assisted the individual to function more independently. For example: ▪ Individual #403 had objectives to obtain a library card, learn her sister's telephone number, and use a mitt to assist in bathing. ▪ For Individual #377, the team included some good functional objectives, such as teaching her safety skills while she wheels herself to the Activity Center, learning to use the remote to select the desired station, and once staff added the right amount of thickener, shaking her food to obtain the right consistency. Some of the concerns noted with regard to functionality included: ▪ For Individual #371, the ISP described her work schedule at being from 9:45 a.m. until 11:15 a.m., and then from 1:15 p.m. until 4:15 p.m. No explanation was provided regarding why this individual did not attend the work center all day, including a typical morning start time, and/or why she did not remain at work through lunch with a typical lunch break (e.g., half hour to an hour). Such a work schedule was not typical of and would not be functional in the community. ▪ For Individual, an example of a nonfunctional goal appeared to be one that had Individual #377 learning how to hand her money to the cashier at the diner. However, another action step was to work with the diner to offer food in a consistency that would allow Individual #377 to eat there. It appeared that the only item she could purchase was a drink, and then staff had to thicken it. 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. 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	

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		their residences did not allow opportunities for individuals to learn to either bring lunch and eat at their work sites or in the vicinity of their activity or vocational setting. These low expectations failed to provide individuals with functional skills to allow successful transition to a community setting, where regular participation in a day program or job would be expected. The different set of rules on campus coupled with individuals' limited exposure to the community could become a disadvantage for individuals who decide to transition to the community.	
	6. Identifies the data to be collected and/or documentation to be maintained and the frequency of data collection in order to permit the objective analysis of the individual's progress, the person(s) responsible for the data collection, and the person(s) responsible for the data review.	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. An area in which some regression had occurred was with regard to specifying the frequency for data collection. Due to some of the issues noted with regard to Section F.2.a.4, timeframes were confusing, and contributed to this issue. Similarly, numerous persons responsible often were identified as responsible for "implementation/ documentation." As a result, it was often confusing who was responsible for what documentation. In the new format, the ISP action plans identified the "Persons Responsible for Implementation/Documentation," "Person Responsible for Plan Development," and "Person Responsible for Reviewing for Progress and Effectiveness" were identified. Although this was helpful, the practice of combining many activities into one action step stymied the reader's ability to determine who was responsible for what. 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., integrated health care plans, PNMPs, psychiatric treatment plans, etc.). As a result, appropriate data was not being collected to assist teams in decision-making. Even when plans included objectives, such as PBSPs, individuals' ISPs did not consistently identify the data to be collected, the frequency, and/or the persons responsible for such data collection. To illustrate some of the issues, the following examples from the ISPs reviewed are offered: ▪ Often the data to be collected was inadequately defined. For example, although Individual #377 had "uncontrolled seizures," the ISP did not identify a data collection method, such as a seizure tracking log. Although an action step read: "Neurology," the ISP did not specify that seizure tracking information would be provided to the neurologist, that appointments would occur at least every three months, and that the neurologist would provide a consultation form for each visit. The only documentation requirement for this action step was "Assessment will be filed in the active record." As with other individuals, for Individual #377,	Noncompliance

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		part of what caused confusion with this was the lack of specific, measurable action steps that each defined a person responsible for implementation/documentation, plan development, and for reviewing progress and efficacy. One example of this was an objective that included multiple parts, but was listed as one. It read: "The Active Treatment Coordinator will write a new skill acquisition program for [Individual #377] to learn to bathe herself using the hand-over-hand technique. ATC will consult with OT about obtaining a bath mitt." The persons responsible for implementation included the ATC, Home Activity Supervisor, Direct Support Professional, and Home Supervisor. Everyone's responsibilities would have been more clearly identified, if this had been broken out into steps, including consultation with the OT about a bath mitt, development of the SAP, training of direct support professionals on its implementation, implementation by direct support professionals, and review of progress. ▪ For Individual #403, the new format was used. However, at times, a specific position was not identified, but general groups, such as Habilitation Therapies were listed. In addition, in the data sheet/documentation column, "N/A" was written in for a number of action items. It was unclear how the team expected to review these action steps in any meaningful way if data was not collected. For example, "N/A" was written in for documentation for the objective: "will continue to receive 1-on-1 attention as she desires." None of the five ISPs reviewed (0%) appeared to be driven by a review of data, and the presence or lack of progress on measurable objectives and outcomes. Since the last review, improvement was seen with regard to data being used to inform some of the at-risk discussions, although this was an area that still required improvement. Additional data that should have been included, but was not, related to skill acquisition goal data, data related to the implementation of other plans (e.g., PNMPs, PBSPs, psychiatric treatment plans, etc.), and details regarding individuals' successes or failures, etc. As is discussed below with regard to Sections K and S of the Settlement Agreement processes were not yet in place to determine the reliability of the data, but efforts were beginning in this regard. However, there continued to be some indications that the data being collected was not reliable.	
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	As noted in the previous reports, and based on the current review of ISPs, this was an area that required 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 dental/medical and behavior/psychology; 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	Noncompliance

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	treatments are coordinated in the ISP.	individuals served. As noted above with regard to Section F.1.a, some improvements were being seen with the interdisciplinary discussions that occurred during ISP meetings. However, more work was needed to ensure adequate collaboration and coordination between team members.	
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 Draft Policy #004.1 at I.C.22 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 Facility had implemented the use of an Individual Notebook that included some of the key components of the ISP that direct support professionals might need to quickly access. Improvements were seen in the manner in which plans were written to facilitate direct support professionals' understanding. In an attempt to determine whether the reading level was comprehensible to most staff, the Facility had used a program to estimate reading level. According to the Facility's Self-Assessment, "Of the 10 ISPs reviewed to determine the grade level in which they were written, the grade level ranged from 9.0 to 11.6, with an average grade level of 10.33. This is above the requirements for people caring out programming at ABSSLC." The Facility was working on ways to meet an appropriate reading level, while maintaining the necessary content of the ISPs. Another issue related to comprehensibility of the five ISPs reviewed was the lack of delineation of responsibility for the implementation of the plans. Although some improvements were seen, 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. This in large part was due to the fact that 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. In addition, without clear methodologies, it will continue to be difficult for direct support professionals to consistently implement programs and supports (e.g., "encourage" and other similar terms would be difficult to implement).	Noncompliance

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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.	Based on interviews with staff, the Facility was in the process of deciding on a new format for monthly reviews. This was being done in collaboration with the State Office. The Facility presented two different formats, including one entitled QDDP Program Review Worksheet, and the other entitled Interdisciplinary Support Plan Monthly Review. As the Monitoring Team discussed with staff, whatever system is decided upon should provide various team members with responsibility for conducting monthly reviews with a practical method for documenting their reviews, including relevant data. It also should provide the QDDPs with a user-friendly way of pulling these reviews together and making decisions about whether further team review is necessary. Because all disciplines, as well as QDDPs will be involved in the monthly review process, it will be important to solicit input from a variety of staff on campus. It also might be beneficial to pilot the process with a couple of teams, such as those piloting the new ISP process. The ISPs included in the sample were too new for monthly reviews to be completed. As a result, no monthly reviews were assessed.	Noncompliance
F2e	No later than 18 months from the Effective Date hereof, the Facility shall require all staff responsible for the development of individuals' ISPs to successfully complete related competency-based training. Once this initial training is completed, the Facility shall require such staff to successfully complete related competency-based training, commensurate with their duties. Such training shall occur upon staff's initial 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	As reported in previous reports, training on ISPs had been standardized across the SSLCs. Supporting Visions: Personal Support Planning was the standard training curriculum. As indicated above, since the last review, additional training sessions and resources had been provided to staff at ABSSLC. 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, as noted in previous reports, its implementation provided some valuable information to assist QDDPs in refining their skills. ▪ As noted above, on 3/23/12, the Admissions Placement Coordinator provided training to QDDPs and other IDT members on "Essential/Non-Essential Support Identification, Obstacles to Referral/Obstacles to Community Transition, Community Transition Processes." During this training, a number of recommendations the Monitoring Team made in previous reports with regard to Section T were shared with the QDDPs and other IDT members. In addition, the list and rationale for reasons/obstacles to not make a community referral, as well as obstacles to transition were reviewed. The group also reviewed the community transition process, including the process, timeframes, and persons	Noncompliance

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	updated competency- based training when the plans are revised.	responsible for the various activities. The Admissions Placement Coordinator also reviewed a list of important items related to the referral process through the post-move monitoring process. ▪ As noted with regard to Section F.1.a, in July 2012, the State Office provided additional training on a revised ISP format and process to QDDPs and other team members. A revised ISP Meeting Guide (Preparation/Facilitation/ Documentation Tool) was introduced to assist the QDDPs in preparing for the meetings and in organizing the meetings to ensure teams covered relevant topics. In addition, the new process on which the QDDPs were trained included more pre-planning that began 90 days prior to the ISP meeting. As part of this, QDDPs were trained on the implementation of a new tool/assessment entitled the Preferences and Skills Inventory, as well as the new ISP Preparation Meeting process. Written instructions for the ISP meeting guide also were provided to QDDPs. These instructions provided some helpful hints and direction to QDDPs. Areas in which additional work was needed to reach compliance with the Settlement Agreement included: ▪ As noted above, on 7/10/12 and 7/11/12, QDDPs and other team members, respectively, had undergone additional training on the revised ISP format and process. A State Office consultant provided this training. Anecdotally, it sounded as if both training sessions were well attended. When asked what the expectation was regarding whether or not all QDDPs and all IDT members were required to attend the training, and what methodology would be used to provide training to those that were not in attendance, Facility staff were unsure of the expectation or procedure. ▪ 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 (although this appeared to be an error), the Facility reported that seven of the 19 QDDPs had successfully completed the competency check-off. Unfortunately, as noted in the last report, based on the Monitoring Team's review of ISPs that a number of these QDDPs had developed, it was not obvious from the documents that the QDDPs were competent in facilitation of the meetings. Since that time, QDDPs had undergone additional training and had been provided additional tools to assist with the ISP preparation and completion process. 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-	

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		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 writing of ISPs. However, in developing the new monitoring tool discussed in further detail with regard to Section F.2.g, Facility staff had discussed using it to assist in the measurement of QDDPs' competencies. To use the tool for this purpose, specific competencies would need to be defined, and the criteria for competency clearly identified. ▪ 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, and Facility staff indicated continued to be a need. ▪ 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. 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 should be developed and implemented for the development of the ISP documents, and the Facility should ensure that staff responsible for the implementation of the plans successfully complete 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	Since January 2012, one individual had been admitted to the Facility (i.e., Individual #200). However, at the time of the Monitoring Team's review, she had resided at the Facility for less than 30 days. Therefore, her initial ISP meeting had not yet been held. Based on data the Facility provided, one ISP meeting occurred after the 365-day timeline. This was due to a guardian's request. At the time of the Monitoring Team's review, the Facility's census was 411 individuals. This resulted in a compliance rate of slightly less	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.	than 100%. The Facility tracked the dates that ISPs were completed and filed. For the last one-year period, 156 of the plans were filed more than 30 days after the ISP meeting. Based on a census of 411, this resulted in a compliance rate of approximately 62%. As noted above with regard to Section F.1.a, the Facility had begun to provide a "Ghost" QDDP the day following an ISP meeting to allow the QDDP that had facilitated the meeting the day before to write-up the ISP. With very limited interruptions, this appeared to be having an extremely positive effect on QDDPs' ability to turn-around the ISP documents quickly and accurately, so that implementation could begin. 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.). The Facility remained out of compliance with this provision. However, some progress was noted, and Facility staff were actively pursuing potential solutions to completing the ISP documents within 30 days of the ISP meetings.	
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 Draft Policy #004.1 at V continued to address quality assurance processes to ensure ISPs were developed and implemented consistent with the provisions of the Settlement Agreement. Based on documentation the Facility submitted, it was in the process of developing a revised quality assurance process to identify and remediate problems in order to ensure that ISPs were developed and implemented consistent with the requirements of Section F. The following steps had been taken or were in process: ▪ The Facility determined that the current monitoring tools were not adequate to provide them with the information they needed. In May 2012, instead of completing monitoring using the previous tools, they worked on developing a revised tool. A group, including the QDDP Coordinator, QDDP Educator, other QDDPs, the Active Treatment Coordinator, and the Quality Assurance Program Compliance Monitor met and developed a draft tool. Beginning in June 2012, monitoring began using the revised draft tool. Based on interview with staff, the group continued to meet, and revisions continued to be made, including adding additional information to the guidelines. The revised tool followed the ISP process from the 90-day ISP Preparation Meeting to the ISP annual meeting through to the completion of the ISP document. ▪ The plan moving forward was to sample each QDDP's work once a quarter.	Noncompliance

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		▪ Teams of two reviewers conducted each review. Facility staff with responsibility for monitoring included the assigned Program Compliance Monitor from the QA Department, the QDDP Coordinator, and four other QDDPs. ▪ A group was meeting approximately monthly to review the results of monitoring activities. Since the Monitoring Team's last review, it was positive that the group had begun to maintain minutes. This memorialized actions taken, formalized decisions that the group made, and documented recommendations, including persons responsible for their completion. As discussed above, this group had identified the need to revise the monitoring tools, and was in the process of doing so. Review of the minutes of these meetings showed good collaboration between the QA Department and QDDP Department, and, as appropriate, the Settlement Agreement Coordinator, to identify a monitoring process that would result in the generation of meaningful information that was valid and reliable. By including the Active Treatment Coordinator in the discussions and process, this allowed the group to address the overlap between Sections F and S of the Settlement Agreement. Areas in which improvements should continue to be made in order to achieve compliance, included: ▪ As the Facility recognized, with the introduction of a new monitoring tool, inter-rater reliability would need to be established, but had not been yet. In reviewing the completed monitoring forms for seven individuals, two monitors had completed forms for each of the individuals. For all seven individuals, discrepancies were noted between the two monitors for some indicators. As noted above, the Facility was working to improve the guidelines included with the tools to improve inter-rater reliability. In addition, in the monthly meeting notes for August 2012, the group's decision was documented to have the Program Compliance Monitor complete a review with each of the other monitors, and then discuss any discrepancies. This process should be helpful in determining where further clarification of the criteria for rating an indicator in compliance is needed, and/or further training of the monitors is needed. ▪ With regard to the draft tool, it included a number of important indicators. However, as the Facility recognized, more work was needed to ensure that the tool included a comprehensive set of indicators, and that the indicators and/or guidelines clearly articulated the criteria to be used in assessing compliance. For example, based on the current tool, it was not always clear whether or not the quality of particular indicators was being assessed or the mere presence of an item, and/or which specific characteristics of an item were being assessed. As just a couple of examples, one of the indicators read: "Assessments completed as per ISP Preparation Assessment Checklist (including FSA)…" The guidelines	

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		read: "New document (Look at 3rd Quarterly review for now)." Compliance with the Settlement Agreement with regard to assessments requires multiple criteria to be met, including, for example, timeliness of assessments, completion of the appropriate assessments based on the individual's needs, and adequacy of the assessments. Based on the indicator included in the current tool, it was not clear which of these characteristics the monitor was to assess, and using which criteria (e.g., a definition of "timely"). Other indicators such as: "Does each medium and high risk area have identified triggers?" or "Were plans developed to increase awareness of Living Options for individual and LAR/Family/Advocate?" and their related guidelines did not indicate whether the quality of the teams' efforts would be assessed, and, if so, what criteria would be used to determine that the quality was adequate. ▪ Based on interviews and documents submitted, the Facility did not yet have a database to collect the information gained through implementation of the revised monitoring tools. While awaiting the assistance of the Facility's new data analyst, QA Department staff were in the process of developing an Excel spreadsheet to allow collection and analysis of the information. ▪ Given that the Facility was still in the process of revising its monitoring processes and developing a database to aggregate the data collected, the Facility remained at the beginning stages of utilizing the data collected to identify areas in need of remediation, and to develop action plans to address them. 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 development of a monitoring tool that more closely tracked the current ISP process, delineation of guidelines to supplement the indicators in the monitoring tool, establishment of inter-rater reliability amongst auditors, development of a database to aggregate information, and meetings between programmatic and QA Department staff to review and analyze the data, and make recommendations for corrective action plans. In order for compliance to be achieved, the Facility will need to fully implement these processes, 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/updated 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 draft criteria for determining when a team member's attendance at an ISP meeting is required should be finalized, and incorporated into the attendance database to ensure its reliability. As previously recommended, 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." (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/State should finalize 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. The ISP Preparation Meeting documentation should include space for a justification, which teams should complete, particularly when they are not requiring completion of an assessment for which the individual has specific needs. 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. Now that the ISP process includes an annual review of incidents, and A/N/E allegations, teams should adequately consider how to address whatever themes might be revealed, as an addition to reviewing new allegations or incidents as they arise. (Section F.1.c)
8. 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)
9. 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)
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, integrated 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 the Facility finalizes its revised monitoring tool, it should ensure that the tool includes a comprehensive set of indicators, and that the indicators and/or guidelines clearly articulate the criteria to be used in assessing compliance. (Section F.2.g and Facility Self-Assessment)
26. As the Facility had begun to do, 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. 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 Presentation Book for Section G; o For hospitalizations in prior six months, copies of follow-up ISPAs: o For one individual from each residential home, copies of all consultant reports (i.e., medicine and surgery inclusive of subspecialties) since the Monitoring Team's last visit and all integrated progress notes commenting on consultant reports (i.e., agreeing or reason for not agreeing) and any ISP addendum related to the consultant report, including those for: Individual #138, optometry on 6/19/12, and audiology on 4/3/12; Individual #296, Ear, Nose and Throat (ENT) on 6/14/12, neurology on 4/19/12, and ophthalmology on 3/1/12; Individual #105, gastroenterology on 5/7/12, and ophthalmology on 4/30/12; Individual #476, podiatry on 2/21/12, psychiatry on 6/13/12, and ENT on 5/15/12; Individual #499, neurology on 1/23/12, optometry on 6/22/12, podiatry on 2/21/12, endocrinology on 2/16/12, wound care on 4/25/12, wound care ordered 7/2/12, and dermatology ordered 6/4/12; Individual #460, podiatry on 4/17/12; Individual #426, gastroenterology on 3/21/12; Individual #224, ophthalmology on 4/10/12; Individual #24, ENT on 5/24/12, orthopedics on 5/18/12, and orthopedics on 6/18/12; Individual #210, Physical Therapy (PT) on 4/13/12, Occupational Therapy (OT) on 6/4/12, and audiology on 2/24/12; Individual #274, pediatrics on 4/23/12; Individual #410, optometry on 5/11/12, and podiatry on 2/21/12; Individual #465, ophthalmology on 5/18/12, and podiatry on 2/21/12; Individual #109, ophthalmology on 6/6/12, ophthalmology on 5/16/12, podiatry on 5/29/12, and optometry ordered 6/18/12; Individual #278, optometry on 5/23/12, and podiatry on 2/21/12; Individual #50, optometry on 5/22/12, ophthalmology on 5/8/12, and urology on 2/16/12; Individual #252, cardiology ordered 6/22/12, cardiology on 5/31/12, and dermatology on 6/13/12; Individual #225, neurology on 5/14/12; Individual #142, endocrinology on 3/14/12, ophthalmology ordered 6/28/12, and neurology ordered 6/18/12; Individual #468, allergy on 3/13/12, and ENT on 2/16/12; Individual #510 neurology on 2/27/12, and cardiology on 3/22/12; Individual #510, ophthalmology on 6/29/12; and Individual #264, ophthalmology ordered 6/29/12, and neurology ordered 6/22/12. ▪ **Interviews with**: o Richard Chengson, MD, Medical Director; and o Elizabeth Greer, RN, Medical Program Compliance Monitor. ▪ **Observations of**: o Morning medical meetings on 8/21/12, 8/22/12, and 8/23/12.
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section G, dated 8/8/12. In its Self-Assessment, for each sub-section, 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. The following comments are

	offered regarding the Facility's Self-Assessment for Section G: ▪ In conducting its self–assessment, the Facility used questions from the general medical audit of April 2012 (specifically Questions #27 and #28). Although these questions were used as indicators for Section G.2, they did not include adequate depth or breadth of monitoring to determine compliance with all aspects of the Settlement Agreement. For instance, there was no tracking of consult reports to determine if the IDT received these for review, acted upon them at a follow-up meeting, or developed an ISPA, if applicable, based on the consultant report. Questions #27 and #28 did not monitor this area. ▪ The self-assessment questions addressed five percent of each Primary Care Practitioner's (PCP's) caseload. As each record varied in the number of consultations completed, it was difficult to determine the percentage of consults reviewed. A total number of consultations in the monitored time period would be required to determine if the percentage of consults reviewed was adequate. ▪ Additionally, the external medical peer review audit did not have any inter-rater reliability data, and scoring results appeared to be based on subjectivity and experience of the auditors, without any standardized guidebook or references. There might have been lack of instructions to the auditors, because the internal auditors used different methodologies and interpretation in answering some of the questions. Physician staff completed these questions, both for the external and internal audits. Inter-rater reliability was beginning to be analyzed. The external auditors scored these questions two questions 71% and 50%, respectively, while the internal audit score was 100% for both. This suggested the results could not be analyzed effectively, and effort needed to be focused on why the variability in scores occurred. ▪ The Facility did use attendance sheets to create graphs of departmental attendance at the morning medical meetings. These were an important step toward providing evidence of integrated clinical services. However, no clinical indicators had been developed to measure or monitor integrated discussion at the morning medical meetings. Another potential forum of integrated clinical care was the IDT meeting, both at the ISP meeting and the ISPA meetings when there was a change of status. However, no data was submitted to indicate tracking of departmental attendance or contribution to discussion. There was also no data that tracked morning medical meeting referrals to the IDT, to the development of an ISPA, and subsequently, referral back to the morning medical meeting for review to determine if the concern was resolved/answered. There was a new closure column added to the morning medical meeting minutes to assist in closure, but there was no data available concerning number of requests for closure, percent closure per month, impact on PCP orders or other aspects of care, etc. The Facility rated itself as not being in compliance with Section G. This was consistent with the Monitoring Team's findings. The Facility did observe that there was little evidence of integration by the IDT and the consultant recommendations. However, there was no identification of measures that would provide evidence of measurement of communication between the two forums (i.e., morning medical meeting and IDT meeting) in integrating clinical services.
	Summary of Monitor's Assessment: The morning medical meetings provided a focus of integrated clinical care. They appeared to be well attended. The Facility had begun to record departmental attendance at the

	morning medical meeting as part of the evidence of an integrated approach to clinical services. More recently, a closure column was added to the morning medical meeting minutes to provide documentation when concerns needing resolution were raised. However, several steps were yet to be taken: ▪ To ensure a timely answer was provided to the morning medical meeting committee, once a need was identified, assignment of tasks should have been followed by a due date. ▪ There was no follow-up of concerns when tasks were assigned or recommendations made to the IDT. IDTs should be accountable to answer the concerns identified in the morning medical meeting, and the ISPAs should demonstrate critical discussion reflecting integration of disciplines. The related documentation should be returned in a timely manner to the morning medical meeting for review to determine if the IDT answered their concern. This process had not occurred. ▪ Further, few concerns were identified. Although acute care was timely and appropriate, critical probing to ensure prevention of repeat hospitalizations and ER visits was often absent. There was little evidence the morning medical meeting committee or the IDT met to determine preventive steps for each hospitalization that occurred. There were a few ISPAs that did reflect critical thinking, but there was no tracking of the ISPA process. ISPAs that indicated a preventive approach to care could be used as examples and resources for other teams and the morning medical meeting committee. ▪ Minutes of the morning medical meeting did not have the structure to reflect interdisciplinary discussion of important cases or issues, but appeared to use a nursing morning report format. This was an important start, but considerable documented input from the PCPs and other disciplines was needed in a succinct format. In addition, a format did not appear to exist to ensure the PCPs processed the consult reports in a timely manner in the Integrated Progress Note (IPN), and the rate of compliance of writing an IPN to review the content of the consult remained at 50 percent. No review was occurring of the quality of the IPN to ensure it documented how the plan of care was to be changed or not changed based on this information (i.e., integrating the results into the care plan for the individual). No system was in place to ensure the consult report and PCP response was forwarded to the IDT for review, with interdisciplinary discussion, and ISPA development based on the consult, if indicated. The Monitoring Team determined that the Facility was noncompliant with both sub-sections of Section G.

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G1	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall provide integrated clinical services (i.e., general medicine, psychology, psychiatry, nursing, dentistry, pharmacy, physical therapy, speech	Integrated clinical services require a team approach to health care. Two of the main forums for integration of expertise from different clinical departments were the morning medical meetings and the IDT meetings. These are discussed in further detail below. One of the main meetings in which integrated clinical care should have been demonstrated was the morning medical meeting. To assist in tracking attendance and providing evidence of discussion based on interdisciplinary participation, the Medical Department implemented a signature sheet for attendance at the morning medical	Noncompliance

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	therapy, dietary, and occupational therapy) to ensure that individuals receive the clinical services they need.	meeting. This was started on 4/16/12. An April 12, 2012 email provided a list of attendees that should attend, based on a Medical Directors' meeting at the State Office in Austin held earlier. These included the Chief Nurse Executive (CNE) or designee, QA nurse (weekly), a QDDP representative, psychology, case manager, direct support professional, habilitation services, nutritional services (weekly), hospital liaison nurse, infection control nurse (weekly), and laboratory technician (weekly). It was not clear if the Facility agreed to this list as requirements for attendance at the ABSSLC morning medical meeting. However, the signed attendance roster provided daily evidence of attendance, from which trend analysis of attendance could be completed. Data of attendance was provided for March, June, and July 2012. PCP attendance varied from approximately 54 to 100% in March 2012, to 75 to 100% in June 2012, and 73 to 100% in July 2012. Nursing administration attendance was approximately 45% in March 2012, approximately 45% in June 2012, and 55% in July 2012. Infirmary nursing attendance was 100% in March 2012, 100% in June 2012, and 95% in July 2012. Psychiatry attendance was 95% in March 2012 (90% according to a submitted graph), 70% in June 2012 (80% according to a submitted graph), and 50% in July 2012. Dental department attendance was 90% in March 2012, approximately 85% in June 2012, and 91% in July 2012. Pharmacy attendance was approximately 86% in March 2012, 90% in June 2012, and 77% in July 2012. Psychology attendance was approximately 5% in March 2012, 15% in June 2012, and 23% in July 2012. PNMT attendance was 95% in March 2012, 90% in June 2012, and 91% in July 2012. For March 2012, the QDDP attendance was 0%, 90%in June 2012, and in July 2012 was 86%. Direct support professional attendance was 0% in March 2012, 80% in June 2012, and 45% in July 2012. Other departments tracked included unit director representative, hospital nurse liaison, quality assurance nurse, laboratory, infection control, and facility administration. The data collected provided baseline information for Facility review. It provided a measure of attendance by departments that were considered mandatory by the Facility. Overall, it appeared that attendance for the Medical Department, Infirmary nursing, dental, and the PNMT was over 80 percent in July. However, whether these departments can sustain this level of attendance, and whether other departments can improve attendance are future challenges. The challenge for the minutes was to succinctly record interdisciplinary discussion of topics that arose during review of cases and other business at the meeting. The meeting minutes were to document clinical concerns and active participation of the various departments, as applicable. The Medical Department reported that as of 7/2/12, the minutes had changed to include a closure list component. This was established to track concerns identified at the morning medical meeting that required follow-up at a subsequent morning medical	

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		meeting to ensure closure. Additionally, the weekly PNMT report was attached to the morning medical meeting minutes. Laboratory also provided a list of lab draw concerns for the week. These then were included in the closure list to be tracked. As part of the closure tracking, a list of concerns closed for the month of July 2012 was submitted. Copies of documents were included. In discussion with the Medical Director, it was determined that IDTs did not follow-through on all requests related to concerns raised in the morning medical meeting, including creation of an ISPA and return of that document to the Medical Compliance Nurse. The Medical Director stated that the current system did not include the morning medical meeting members' routine follow-up review of the ISPAs. These should be reviewed, and presented briefly back to the committee to update the committee members on the concern and the IDT's response to ensure the issues were resolved. Such closure monitoring should ensure that the IDT meets to review the concern and develop an ISPA, but that the team also actually addresses the concern with an action plan. The morning medical team then would have an opportunity to learn of the IDT deliberations and the action plan, and determine the adequacy of the response. Other issues requiring closure that would not go through the ISPA process should have a written paper trail that is provided to the Medical Compliance Monitor for review and presentation at the morning medical meeting. For some of these concerns, the examples submitted were not clear. For example: ▪ For the phenobarbital medication variances, the action step was to ensure all orders were converted to match the dose available from the pharmacy so the Medication Administration Record (MAR) would match medication in the drawer. A pharmacy drug order report of individuals with the dosage of phenobarbital was presented. However, it was not clear how to interpret this extensive list in determining if it resolved the concern identified. A brief analysis and interpretation of such documents would help provide clarity to anyone reviewing the closure documents. ▪ For Individual #33, the concern was not clear, so a determination of adequacy of documentation could not be established. "Discharge to home. Check chart for pica history" was written as the concern, but it did not provide the reason for the request. "Pica behavior, unobserved" was written in the active problem list, but without a reason given for the request, it was unclear what issue required clarification. ▪ Individual #107 had an overnight visit to a group home in anticipation of transition, but the IDT members picked him up and returned him home to check his blood sugars. The ISPA brought up several other unanswered issues, as to whether the group home had abilities to check his blood sugar when needed (not just when he visited on an overnight stay), and potential safety mechanisms that	

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		needed to be in place to ensure his health was monitored. The individual's blood glucose was 402, and there appeared to be a need for a close monitoring system to be in place before any visit was conducted. The ISPA did not address future overnight visits, or the reason the home was considered an appropriate placement when the individual had the need for close monitoring of blood glucose. Given that the individual's blood glucose appeared to have wide swings and needed to be rechecked after insulin administration, there was no discussion/determination of the need for staff trained in taking a blood glucose measurement and following a protocol 24 hours a day. Separately, the ISPAs were submitted for individuals hospitalized from January 2012 through June 2012. Twenty-five individuals were listed with 34 hospitalizations. For six individuals, no ISPAs were submitted. For four ISPAs, the discussion and conclusions focused on critical preventive steps for a recurrence. For one individual that underwent planned surgery, there was a comprehensive postoperative plan. For the remaining 14 individuals, there was a range from no discussion concerning preventive steps to some preventive steps considered, but requiring further clinical insight. None of these ISPAs were then shared with the morning medical meeting for review and comment. It would have been helpful for the clinical departments to provide some guidance and return the ISPAs without preventive steps or only preliminary steps to the IDT for further discussion. The ISPAs that included components of critical thinking regarding preventive measures might have been instructive to members of the morning medical meeting. Four of 25 ISPAs (16%) demonstrated critical thinking of steps to prevent a recurrence of the same health issue. Interdisciplinary teams played an integral role in an integrated approach to health care. In part, integration was reflected more in the newer IRRFs. However, overall, the ISP should reflect the contributions of many departments in resolving each issue, but they often still were more compartmentalized with separate department reports and plans. The IRRF could be used as a template for this, because it focused on the individual's problem or area of risk, and each department's contribution to the plan to address the issue. Similar to the documentation of the morning medical meeting, ISP meetings should include evidence such as attendance sheets, with aggregate analysis of attendance, as well as tracking the integrated approach to care by documenting discussions and contributions from each department, as well as the task assignments based on the care plan. However, there was no information concerning attendance per each ISP or ISPA/ISPA, or analysis of ISP documents to reflect the level of integrated discussions and decisions related to clinical care. Analysis of such information would require cooperation of all departments, but the QDDP Coordinator could take the lead.	

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G2	Commencing within six months of the Effective Date hereof and with full implementation within two years, the appropriate clinician shall review recommendations from non-Facility clinicians. The review and documentation shall include whether or not to adopt the recommendations or whether to refer the recommendations to the IDT for integration with existing supports and services.	The Facility submitted consultant reports for one individual from each residence since the Monitoring Team's last visit, as well as any IPNs commenting on the consultant reports. Consultations for 22 individuals were submitted, with a range of one to seven consultations per individual. A total of 55 consultant reports were submitted or were referenced in the documentation. These are listed above in the documents reviewed section. Review of these documents revealed the following: ▪ For 11 of the consultations, a copy of the consult report was not submitted. For these, whether the PCP initialed and dated the consult document could not be determined. For some of the 11 consultations that were referenced, the order was recent and the consultation might not have been scheduled, or if scheduled, had not occurred prior to the Monitoring Team's visit. For 44 consultations, this information was provided. ▪ Of the 44 reviewed, 42 (95%) included the PCP initials, indicating review by the PCP. ▪ Of the 44 reviewed, 35 (80%) included the date on which the PCP conducted the review. ▪ Of the 44 reviewed, 20 consults (45%) included documentation of agreement or not with the consultant recommendations, either on the consult report or in the IPN. o Of the 44 reviewed, two (5%) included documentation of disagreement with the consult recommendations. ▪ Of the 44 reviewed, 22 (50%) included PCP IPN entries. ▪ Of the 44 reviewed, four ISPAs (9%) documented the discussion of the contents of the consultant reports, and the PCP's recommendation. A number of ISPAs were submitted, but either occurred prior to the consult visit, or if dated after the consult report, did not address the content of the report. For these cases, it could not be determined if there was an ISPA which responded to the consultation or not, and whether it could be located in the active record. A separate related internal QA monitoring system the Medical Department used at ABSSLC included specific questions about this topic that were taken from the general medical audit used for both the external and internal medical peer review. Question #27 read: "Are medical and/or surgical consultant recommendations addressed in the integrated progress notes within five business days after the consultation recommendations are received?" Question #28 read: "If consultant recommendations are not implemented, is there a clear explanation on the integrated progress notes as to why the provider has chosen to not implement the recommendations?" The Medical Department used these to monitor progress in this area. The external April 2012 audit determined that the Medical Department was 71% compliant with Question #27, and 50% compliant with Question #28. The follow-up internal July 2012 audit determined	Noncompliance

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		the Medical Department was 78% compliant with Question #27, and 0% compliant with Question #28. It was noted that the inter-rater reliability had not been determined between the external and internal peer reviewers, making analysis of ongoing progress difficult to determine. As of 6/4/12, as part of its QA monitoring, the Medical Department began to develop a database to track consultation reports. This was the first step in implementation of a QA process for this aspect of clinical care. There was little specific information provided concerning the database and specifically the components to be tracked, and the goal and purpose of this database. However, it will be important to monitor the quality of the data being entered to ensure it is complete and accurate.	

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

1. Morning medical meeting minutes should document briefly the interdisciplinary discussion of topics reviewed. (Section G.1)
2. For concerns the morning medical meeting committee identifies, the minutes should clearly define the request in order to determine if the follow up information answers the concern. (Section G.1)
3. All requests the morning medical meeting forwards to the IDT for response to a concern should be followed by creation of an ISPA, which is forwarded back to the morning medical meeting for review. (Section G.1)
4. The Medical Program Compliance Monitor should review the ISPA, and present a summary to the morning medical meeting committee for review. The committee should either accept it, if it resolves the concern, or return it to the IDT for further review, if it does not. (Section G.1)
5. All issues should require documentation back to the Medical Program Compliance Monitor for review and presentation to the committee. (Section G.1)
6. The ISP and ISPA should provide evidence of integrated clinical care. Attendance tracking and documentation of interdisciplinary discussion, decisions, and action plans should lead to trend analysis. (Section G.1)

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 For two individuals from each PCP's caseload, four diagnoses with criteria for justification from active record, with supporting documentation; and o Medical Provider Audit Committee meeting minutes and attendance sheets and forms with changes made. ▪ **Interviews with**: o Richard Chengson, MD, Medical Director; o Edward Craig, MD; and o Elizabeth Greer, RN, Medical Program Compliance Monitor.
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section H, dated 8/8/12. In its Self –Assessment, for each sub-section, 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. For Section H, in conducting its self-assessment, the Facility used auditing tools. Based on a review of the Facility Self-Assessment, the auditing templates, scores, and inter–rater reliability data: ▪ The audit tools the Facility used to conduct its self-assessment included the external medical peer review medical management audit of three diagnoses. These audit tools did not include adequate indicators to allow the Facility to determine compliance with all aspects of the Settlement Agreement. The Facility is encouraged to review the Monitoring Team's report to identify indicators that are relevant to making compliance determinations. The Facility needed to begin to measure all the clinical areas, most of which were not monitored by the external medical management audit. ▪ The medical management audit did identify the percentage of the overall population with specific diagnoses and reviewed three records per diagnosis. Wide variation was noted in the percentage of individuals reviewed with the three diagnoses chosen, from a 33% sample size for those with aspiration pneumonia to a 1.5% sample of all those with osteoporosis. ▪ There was variation in inter-rater reliability for the external and internal reviews. The scores for osteoporosis and pneumonia were similar, but were widely different for diabetes mellitus. ▪ The same data was used for the self-assessment process for Sections H.2, H.3, H.4, and H.6, but for those sections, based on the database utilized, the Facility did not identify specific areas of need/improvement. Other sources of data were listed in the Self-Assessment as assisting to provide evidence for routine assessments and assessment for monitoring changes in health status. However, most of the databases appeared incomplete or needed additional information. Most did not include the time period during which the information applied, or even the title of the database and the reference population. The databases

	appeared unrelated to one another, and the only interpretation of any of the submitted databases in the Self-Assessment was the timely completion of quarterly medical assessments. The Self-Assessment also included a summary statement that annual medical evaluations were completed timely, but no data were provided to confirm this. No information was provided that indicated the Facility measured the quality of the annual assessments for completeness. However, there was the statement that transition information was included, but there was no data to provide verification). There also was no measurement of the quality of the quarterly medical review. The only data used in Self-Assessment for Section H.1, H.5, and H.7 was from the same database for quarterly medical reviews and annuals. The Facility did not identify any other areas needing specific improvement, nor was any information included that further monitoring or auditing tools would be developed to assist in their self-assessment process. The Facility determined that it was not in compliance with any of the sub-sections of Section H. This was consistent with the Monitoring Team's findings.
	Summary of Monitor's Assessment: The Medical Department added a full-time staff member to assist in quality improvement within the department. However, much of Section H remained under-developed, because the PCPs all had clinical care assignments, including the Medical Director. At the time of the Monitoring Team's visit, little development of methods to organize and maintain data had occurred. Many databases appeared incomplete or lacked essential components, and as a result, adequate analysis could not be completed. The database tracking quarterly medical reviews was an important start, but appeared to be user-unfriendly. Section H is also interdisciplinary. Other departments needed to cooperate in providing complete and accurate data concerning routine annual and periodic assessments. Other departments should assist in providing their own interpretation of this data. Overall, there did not appear to be a coordinated system that tracked all clinical departments for timely completion of routine assessments, or assessments based on health status changes and the needs of the individual. In addition, the Facility had not completed an audit to determine if there were criteria (based on clinical guidelines or other sources) to justify the major diagnoses in the active problem list. Clinical guidelines had not been utilized (except through the general medical audit) as a standard in completing record reviews to ensure practice patterns reflected the content of the guidelines. In addition, clinical indicators of success of treatment had not been selected and/or monitoring completed, as a way to guide the PCP and the IDT in determining if treatment was effective or needed to be changed. The Medical Department relied heavily and almost exclusively on the use of the questions in the general medical audit and the medical management audit to attempt to provide evidence of compliance with Section H, but the general audit should have been seen as a start to quality improvement rather than an endpoint. The Facility remained noncompliant with all subsections of Section H.

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H1	Commencing within six months of the Effective Date hereof and with full implementation within two years, assessments or evaluations shall be performed on a regular basis and in response to developments or changes in an individual's status to ensure the timely detection of individuals' needs.	On 4/16/12, a Medical Program Compliance Monitor started in the Medical Department. This was an important step in providing the infrastructure for an internal quality improvement program. Given the large caseload, and complex cases of each PCP, as well as the clinical responsibilities and caseload of the Medical Director, there had been little administrative time allotted to the many requirements of the Settlement Agreement. As a result, significant progress in Section H had been lacking. The role of the Medical Program Compliance Monitor was detailed in a submitted job description. The role involved "planning, developing, coordinating, and evaluating quality assurance/quality enhancement initiatives related to medical care in alignment with the DADS SA [Settlement Agreement]." Duties included developing systems to ensure high quality care, gathering data, providing data analysis, recommending improvements to the Medical Director based on data analysis, and providing education to the PCPs regarding medical components of the Settlement Agreement. The staff person hired had extensive experience with the intellectual and developmental disability (IDD) population, and was familiar with the Facility and State Office organizational structure, and both the individual and systems approaches to care. This was a full-time position with full-time administrative/monitoring duties, which should assist the Medical Director and the other PCPs in achieving compliance. Several lists were submitted in the Presentation Book for Section H, indicating various databases that the Medical Department and other departments had utilized or had access to as part of the departmental monitoring processes. However, a common concern was the lack of titles for the various databases, and the time period the database printouts covered. Although it was self-evident what some of the databases measured, the population base, etc., others were more elusive, and the Monitoring Team was concerned about over-interpreting or misinterpreting the purpose of each of the databases. It is imperative that all database reports provide a title or preface indicating the purpose of the report and the time period covered. Information in databases requires interpretation, and a brief summary of findings by the respective department or the QA Department would be expected as well. There also should be evidence of the departments, committees, etc., with which the analysis was shared. Database reports submitted provided information concerning the dates of completion of the last annual medical assessments, and the due dates for quarterly medical reviews. Additionally, the Facility submitted a series of database reports, such as PNMT reviews for three individuals, a list of those with respiratory illness in the prior three months, habilitation services tracking from January to June 2012, behavioral assessment dates and BSP dates, drug regimen review schedule, MOSES and DISCUS monitoring, and audiology evaluation tracking. There were additional database lists, but the purpose	Noncompliance

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		could not be determined. Overall, without further analysis, the reason for submitting these various reports from the databases was not clear. These lists should be named and dated. More importantly, as opposed to submitting lists, interpretation of findings and action plans based on these findings should be submitted to show the Facility had determined whether or not timely assessment for routine ongoing evaluations and acute illness/change of status assessments were completed. Each department should provide its own internal monitoring data demonstrating timely completion of routine assessments, as well assessments in response to change of health status. Providing the date of the health status change, the date of the notification of the department involved, and the date on which evidence of response was completed would provide a tracking system for timeliness of response. Clinical indicators chosen by each department should be used to measure quality of the response. A quarterly report forwarded to the Facility Administration should include trend analysis and recommendations for or descriptions of quality initiatives based on this information. Some progress was seen with regard to needed tracking and accountability. The Medical Program Compliance Monitor created a spreadsheet to track quarterly reports. The list was divided into thirds, and for each of three months, the PCPs were provided a list of individuals on their respective caseloads that needed a quarterly review completed. On 7/2/12, the closure list of the minutes of the morning medical meeting began to include an assigned staff for each concern. On 8/6/12, the Medical Program Compliance Monitor and the Hospital Liaison Nurse developed an updated tracking spreadsheet for Infirmary admissions, ER visits, and hospitalizations. From the documentation submitted: ▪ 233 of 413 (56%) annual medical assessments were completed within 365 days of the prior annual medical assessment. ▪ 229 of 233 (98%) dental annual evaluations reviewed were completed in a timely manner. ▪ 376 of 422 (89%) QDRRs were completed in a timely manner (defined by State Office guidelines). ▪ 91 of 632 (14%) quarterlies (two quarters aggregated) were completed in the two quarters reviewed. Based on a review of 11 hospitalizations, there was an on-call note or pre-hospital PCP IPN for these assessments indicating health status change in 10 of 11 (91%) records reviewed. Although it was positive that additional resources had been added to the Medical Department to assist in quality assurance efforts, the Facility did not yet have adequate mechanisms in place to determine if assessments and evaluations were performed on a	

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		regular basis and in response to changes in status. However, as is illustrated above, some assessments were regularly being completed in a timely manner, while others were not. As is illustrated in other sections of this report, the quality of assessments also continued to be a concern.	
H2	Commencing within six months of the Effective Date hereof and with full implementation within one year, diagnoses shall clinically fit the corresponding assessments or evaluations and shall be consistent with the current version of the Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems.	To assess the Facility's compliance with this section, a sample of diagnoses listed in individuals' active problem lists was requested. Four diagnoses were to be selected by each PCP, with the evidence in the active record supporting this diagnosis. However, similar to concerns identified with regard to Section H.1, the preliminary information to provide the context of the submitted information was not included. The submitted information did not include the specific four diagnoses chosen from the active problem lists, or a copy of the active problem lists. Test results and other evidence for diagnoses were submitted, but this information needed to be linked to the diagnosis the PCP made, chosen from the active problem list. As a result, this section could not be analyzed. This will be reviewed again during the Monitoring Team's next visit. However, this also would be an excellent internal monitoring tool for the Medical Program Compliance Monitor to implement. To determine compliance with this section, a sample of diagnoses from the active problem lists could be chosen, and an active record reviewed to match diagnoses to specific test results and criteria. This would provide the evidence to justify the diagnosis, and provide evidence for compliance with this section of the Settlement Agreement. Additionally, there was a "Texas ICD-10 Site Visit" training held 4/26/12 and 4/27/12. The Medical Director attended this via Webinar. Content was most applicable to the medical coders that input the medical diagnostic codes for the medical diagnoses provided. Also, as is discussed in further detail related to Section J.5, based on a sample of 20 individuals, approximately 71% of individuals prescribed psychotropic medications had been evaluated and diagnosed in a clinically justifiable manner.	Noncompliance
H3	Commencing within six months of the Effective Date hereof and with full implementation within two years, treatments and interventions shall be timely and clinically appropriate based upon assessments and diagnoses.	The external general audit and medical management audit provided guidance in determining aspects of care needing improvement by the PCPs. A number of clinical indicators focused on appropriate and timely action the PCPs had taken for diagnostic work-ups and treatment interventions. To improve the initial scores from April 2012, one of the PCPs chaired the Medical Provider Audit Committee (MPAC). The goal of the committee was to improve documentation of adequate care at ABSSLC, as well as to make documentation more accessible, and make it easier to find specific facts in the active record.	Noncompliance

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		Through a series of meetings, there was discussion of each of the clinical indicators for the general medical audit, as well as the medical management questions. Discussion included improvements PCPs needed to make, how to resolve gaps in documentation, as well as action steps, such as updating the family history and updating the active problem list. The meetings occurred frequently for a short duration of time, and the goal was completed when all questions/clinical indicators were addressed. When needed there was clarification of expectations in documentation that appeared helpful in improving the documentation process. Several insights were shared among the PCPs as ways to improve documentation. The following lists the date and the topic covered: ▪ 4/18/12 initial meeting, medical management - diabetes questions (six questions); ▪ 4/19/12 review of external/internal audit by the QA Department; ▪ 4/20/12 general medical audit question discussion for Question #2: "Is the active problem list dated and signed when it was last reviewed?"; ▪ 4/23/12 updating the active problem list: "what needs to be included on the active problem list? When to move to the inactive problem list?"; ▪ 4/25/12 steps to take in obtaining additional family history; ▪ 4/26/12 signing the active record copy of the physical exam and problem list. Review of family history discussion; ▪ 4/30/12 general medical audit question discussion for Question #10: "Are the appropriate preventive screening services provided?" Question #11: "Is there documentation present for not providing preventive services?" As part of the plan of improvement for this question, PCPs were expected to complete Section XII: "Preventive Health Services Planned" for the coming year (prior to next annual physical) as part of the annual physical examination summary; ▪ 5/22/12 general medical audit question discussion for Question #18: "Are responses to significant lab values documented in the integrated progress note by the physician?" Question #20: "Are significantly abnormal diagnostic tests addressed by the provider with appropriate follow up documented in the integrated progress note?"; ▪ 5/24/12 general medical audit question discussion for Question #28: "If consultant recommendations are not implemented, is there a clear explanation in IPN why the practitioner has decided not to implement the recommendations?" Question #15: "Did the provider document rationale for not following the pharmacist's recommendation?"; ▪ 6/20/12 general medical audit question discussion for Question #16: "Medication orders for acute conditions must include indication and duration for all medications prescribed." Question #26: "All referrals or consults must include pertinent current and past medical history." Question #27: "Documentation of all medical /surgical consult recommendations in the IPN within five business days of receipt of report." Question #30: "If medical	

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		treatment was ordered during an acute illness or injury was it documented in the progress note?"; ▪ 6/21/12 general medical audit question discussion for Question #13: "Are the current 180 day orders present in the records?" Question #23: "Is the provider's documentation organized in appropriate SOAP format?" Question #27: "Is there documentation of all medical/surgical consult recommendations in the IPN within five business days of receipt of report?" Question #17: "Are the diagnostic tests or therapeutic procedures medically appropriate?"; ▪ 6/26/12, 6/27/12, and 6/28/12 medical management audit – aspiration; ▪ 7/2/12, and 7/3/12 medical management audit – osteoporosis; ▪ 7/10/12 medical management audit – UTIs; ▪ 7/26/12 medical management audit – constipation; and ▪ 7/31/12 medical management audit - seizures. Some of these led to discussions with the State Office for clarification. Other discussions ended with a clear plan for the PCPs to follow in improving documentation and clinical care. Forms were amended to incorporate clinical information that was to be measured by the medical audit process. Although the Facility remained out of compliance with this provision, it was positive that efforts had been placed into reviewing the requirements and findings of the internal and external audits to identify and put into practice mechanisms to assist in achieving compliance.	
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 Medical Department provided a copy of several clinical guidelines that State Office had developed. However, these had not been utilized in developing additional monitoring tools to review quality health care, either by the Medical Department or the QA Department. It is recommended that these guidelines as well as those derived from national professional association guidelines, be used as a source/reference for developing additional clinical indicators. Likewise, the risk action plans or integrated health care plans (discussed with regard to Section I) should identify risks and measurable objectives in achieving a clinical outcome. These measurable objectives could 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

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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.	According to the Facility's Self-Assessment, in June 2012, the PCPs had completed 36 quarterly medical reviews. The number to be completed per month averaged 105. This represented a 34% completion rate. From the Monitoring Team's review of the database information, 91 out of 632 (14%) of the records had quarterly medical reviews over two quarters. In addition, 376 of 422 (89%) QDRRs were current. Except for annual evaluations by the Medical Department and the Dental Department, information was not provided about other routine monitoring evaluations completed. To achieve compliance with this section of the Settlement Agreement, the Medical Department, as well as all other clinical departments, should provide evidence of monitoring the health status of individuals. In addition to information related to ongoing review of individuals' health status, the Medical Program Compliance Monitor and QA Department should begin to choose diagnosis(es) to be sampled and use the clinical guidelines to develop measures to determine if the required minimum common elements of clinical care are being integrated into the care plan, as well as into the care the individual receives. For instance, for an individual with aspiration pneumonia, does the active record reflect involvement of the PCP to coordinate care and timely ordering and interpretation of assessments [e.g., Modified Barium Swallow (MBS), bedside dysphagia evaluation, gastroesophageal reflux disease (GERD) evaluations such as Esophagogastroduodenoscopies (EGDs), radiographic contrast studies for reflux, albumin levels, drug levels, etc.]; is appropriate nursing care provided with, for example, administration of medications and timely assessments; has habilitation services/PNMT been involved to address positioning concerns, and complete Head of Bed Evaluations (HOBEs) evaluation; was dietary involved to determine nutritional needs; has the respiratory therapy department conducted assessments and provided treatments; has pharmacy conducted review to rule out side effects of medications as contributing to dysphagia or obtunded state; and have outside consultants been involved, such as pulmonology, gastroenterology (to rule out reflux), allergy and asthma specialists (e.g., if allergies and bronchospasm from allergies are a consideration), etc.? Analysis and data on a quarterly basis should lead to routine periodic reports and further discussion of areas in need of quality improvement. Acute care concerns for all individuals was routinely discussed at the morning medical meeting. Providing a clear detailed tracking system will ensure the acute illness is tracked to resolution, along with the needed follow-up discussion by the IDT for steps to be taken to prevent a recurrence. This is further discussed with regard to Section G.1 and Section L.1. 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	Noncompliance

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		necessary to minimize long-term sequelae of acute illness, and prevent permanent physical and functional loss when possible. As is discussed in more detail with regard to Section M.1, 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.	
H6	Commencing within six months of the Effective Date hereof and with full implementation within two years, treatments and interventions shall be modified in response to clinical indicators.	Tracking changes in treatment had not occurred at the time of the Monitoring Team's review, but is a future step that should be built into the database process. For example, information could be derived from changes made through the ISPA process to prevent recurrent ER visits and hospitalizations. Recording the change in treatment will begin to measure the effectiveness of the morning medical meeting (i.e., the number of concerns referred to the IDT team, the number of ISPAs written, the number of ISPAs reviewed by the morning medical team and accepted, as well as the number of ISPAs found incomplete and returned for further discussion and decision, and the number of concerns left outstanding each month). As an additional measure of impact of the morning medical meeting, data could be tracked regarding concerns referred to the PCP or to the entire IDT, the number of additional treatments ordered (i.e., medication/non-medication), the number of treatments discontinued, the number of treatment continued but changed in dosage or frequency, etc. As noted in the Monitoring Team's previous report, in addition, the State Office clinical guidelines would provide guidance, along with nationally recognized recommendations from specialty organizations/task forces. The internal audit guidelines included a clinical component of several diagnoses frequently treated in the SSLC populations. These clinical components along with the clinical guidelines provided important guidance in this area.	Noncompliance
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	Noncompliance

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		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. For example, it should tie the morning medical meeting process to the IDT change of health status ISPAs/PSPAs, and also tie these two meetings to the at-risk process in a unified approach. 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.	

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

1. Reports from databases should include a title, a preface indicating the purpose of the database and/or specific report (what it measures), and the time period in which the data was collected. A brief summary of findings/analysis should be included. In addition, the target group(s) that received the analysis for review and education (e.g., department, administration, committees, etc.) should be documented. (Section H.1)
2. Each department should provide its own internal monitoring data demonstrating timely completion of routine assessments, as well as assessments in response to change of health status. Providing the date of the health status change, the date of the notification of the department involved, and the date on which evidence of response was completed would provide a tracking system for timeliness of response. Clinical indicators chosen by each department should measure quality of the response. Quarterly reports should be generated, including trend analysis and a description of quality initiatives based on this information. (Section H.1)
3. To determine compliance with Section H.2, a sample of diagnoses from the active problem lists could be chosen, and an active record reviewed to match diagnoses to specific test results and criteria. (Section H.2)
4. The clinical guidelines, as well as those derived from national professional association guidelines, should be used as a source/reference for developing clinical indicators. (Section H.4)
5. 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)
6. 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)
7. The Medical Program Compliance Monitor and QA Department should begin to choose diagnosis(es) to be sampled and use the clinical guidelines to develop measures to determine if the required minimum common elements of clinical care are being integrated into the care plan, as well as into the care the individual receives. (Section H.5)
8. 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)
9. 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 revised "Risk Guidelines" laminated record, dated 4/17/12; o ABSSLC Presentation Book for Section I; o ABSSLC's Self Assessment; o ABSSLC's Provision Action Information; o ABSSLC At-Risk Individuals list; o Draft of revised At Risk Individuals policy, 006.3; and o The following documents: 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 #451, Individual #162, Individual #541, Individual #215, Individual #407, Individual #348, Individual #527, Individual #59, Individual #396, Individual #146, Individual #327, Individual #324, Individual #542, Individual #381, Individual #376, Individual #64, Individual #519, Individual #418, Individual #517, and Individual #43; and o From the following individuals' active records, selected documents, including: DG-1, most current annual medical assessment and physical exam, preventive care flow sheet, most current nursing assessment, past year of IPNs, past year of lab results, x-rays, scans, MRIs, ultrasound reports, hospital discharge summaries for the past one year, ER report for the past one year, consults and procedure reports for the past one year, DNR forms if applicable, physician orders for the past one year, most recent ISP and subsequent addendums, most recent PBSP, past three medical quarterly reviews, integrated risk rating form(s) for past one year, and risk action plans for past one year, for the following individuals: Individual #30, Individual #26, Individual #55, Individual #76, Individual #545, Individual #53, Individual #88, Individual #109, Individual #385, Individual #40, Individual #535, Individual #409, and Individual #179. ▪ **Interviews with**: o Cathy Northrup, RN, MSN, CPN, Chief Nurse Executive; o Amy Jo Bramlett, LVN, At Risk Coordinator; o Mary Willingham, RN, Program Compliance Nurse; and o Carole Ivy, RN, Nurse Operations Officer. ▪ **Observations of**: o ISP Meeting for Individual #542, on 8/22/12.
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section I, dated 8/8/12. In its Self-Assessment, for each sub-section, 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. For Section I, in conducting its self-assessment, the Facility: ▪ Used monitoring/auditing tools. At the time of the review, the Facility was in the process of

	modifying its monitoring tool for Section I, recognizing that the current monitoring tool did not include all the provisions of the Settlement Agreement for the different subsections of Section I. However, based on a review of the Facility's Self-Assessment: o The monitoring/audit tool the Facility used to conduct its self-assessment included the ABSSLC Monitoring Tool for At Risk Individuals, for the months of March and April 2012. Although the Self-Assessment referenced that for each month, a sample was audited of seven individuals (n) out of a total population of 85 (N), there was no description provided regarding the characteristics of the total population (85) and how the sample of seven for March and April 2012 was selected. In addition, due to the lack of clarity and identification of the specific criteria the Facility used in assessing compliance for the items found on the monitoring tool, the data included in the Self Assessment were uninterpretable. o As the Facility recognized, the current monitoring/audit tool did not include adequate indicators to allow the Facility to determine compliance with the Settlement Agreement. As the Facility revises its monitoring tools, the Facility is encouraged to review the Monitoring Team's report to identify indicators that are relevant to making compliance determinations. o As noted above, the monitoring tool was under revision at the time of the review. However, based on review of the monitoring tool contained in the Presentation Book for Section I, it did not include adequate instructions addressing methodologies to be used with regard to specific indicators, such as observations, and record reviews. As a result, it was likely that different auditors would, for example, look at different documents, or different portions of documents in conducting their reviews. In addition, further definition was needed with regard to the criteria auditors would use to rate the various indicators. Thus, there was a need for clear instructions for all monitoring tools and the establishment of inter-rater reliability to ensure the data generated from the tools were an accurate reflection of the area being audited. o As noted previously, the Self-Assessment identified the sample sizes for March and April 2012. However, without a description of how the total population from which the samples were pulled was determined (e.g., everyone with a completed risk rating tools, individuals identified with high risk ratings, etc.), it was not possible to determine the relevance of the data. In addition, based on a total population of 85 (N), it did not appear that these sample sizes were adequate to consider them representative samples (8%). o The Program Compliance Monitor was responsible for completing the audit tools. From discussions with the Chief Nurse Executive and the At Risk Coordinator, the PCM responsible for conducting the audits/monitoring was not a nurse, and had not been deemed competent in the use of the tools or deemed programmatically competent in the relevant area(s). As noted during several past reviews and in previous Monitoring Team's reports, the quality and adequacy of the assessments conducted by a number of disciplines regarding the at-risk individuals were consistently found to be significantly inadequate. Unfortunately, the Facility's current process of monitoring Section I did not capture this essential issue. The Facility should evaluate who would be best to audit this highly clinical area in order to generate accurate information regarding clinical issues related to the individuals at risk. In order to adequately assess compliance based on critical clinical

	thinking, the auditor for this crucial area should have the appropriate clinical background. o At the time of the review, adequate inter-rater reliability had not been established for the Section I monitoring tool. ▪ Due to the lack of a written procedure addressing the process of developing and implementing monitoring tools, inter-rater reliability, and overall data presentation, the Facility did not yet consistently present data in a meaningful/useful way. Specifically, the Facility's Self Assessment: o Did not consistently present findings based on specific, measurable indicators. For example, as noted above, at times, it was unclear what specific criteria had been used to determine compliance. In addition, at times, items contained on the monitoring tool included more than one item, such as "staff are familiar with the plan and all interventions," making it impossible to determine which of these requirements were found to be in compliance and which had not. o Did not consistently measure the quality of the documentation versus merely the completion of the documentation. o Did not identify who audited the specific area to generate the data collected from the monitoring tool. ▪ The Facility rated itself as being in compliance with none of the subsections of Section I. This was consistent with the Monitoring Team's findings. However, of concern, none of the indicators included in the Self-Assessment appeared to reflect the quality aspect of the indicator. This resulted in higher compliance scores than the Monitoring Team found. In reviewing the Monitoring Team's report, the Facility should attempt to determine how quality will be assessed as well, as identify reasons for any compliance score discrepancies found between the Monitoring Team and the Facility's data. ▪ The Facility's data identified areas of need/improvement. However, for these areas of need, the Facility Self-Assessment did not provide an 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.
	Summary of Monitor's Assessment: Since the last review, the State Office had made revisions to the At-Risk Individuals policy (in draft form at the time of the review). Some of the changes included regrouping the Risk Guidelines so that the risk factors that were clinically inter-related regarding outcomes or provision of services and supports were listed together, and linking each risk factor with specific clinical indicators. In addition, the Integrated Risk Rating Form was revised to follow the same grouping sequence as the Risk Guidelines. Some additional revisions included replacing the Risk Action Plans for the identified high and medium risk indicators with Integrated Health Care Plans designed to provide a comprehensive plan that will be completed annually; different forms regarding IRRF and the IHCP were developed addressing changes in status; the Aspiration Pneumonia Enteral Nutrition was revised as a data collection tool; and Trigger Data Sheets were developed to include observable and measurable clinical signs and symptoms that alert the staff to possible changes in status. In June 2012, two teams at ABSSLC had been trained on the new policy and processes, and had begun to pilot them. It was important that the new system was being piloted with two teams to determine any additional

	implementation steps/changes that needed to be made, or any additional training that would be beneficial before broadening its scope to the entire campus. The many changes that had occurred with regard to the At-Risk system were reflected in the different ISP documents, and the varying quality of the IRRF indicated some confusion amongst the teams with the previous process. Developing a successful program on a small scale that can then be implemented across campus should reduce such issues. Staff from the pilot systems in two residences also could act as mentors to the other teams, another important step in providing consistency across campus and improving the quality of the process. Until now, the quality of the risk reviews and implementation process varied depending on the understanding and expertise of the various IDTs. Hopefully, the process will become more standardized, which should benefit the individuals residing at ABSSLC. From review of the ISP and addendum documentation, individuals' teams were having discussions of the individuals' status, and more pertinent clinical information was being included in the Integrated Risk Rating Forms than previously. However, the overall lack of clear documentation included in the ISPs, the Risk Action Plans, and the associated disciplines' assessments regarding what actions were taken in response to pertinent events or health issues, and the lack of dates and supporting documentation addressing actions and completion of action plans made the Monitoring Team's review of the At-Risk system difficult, and the lack of progress noted was troubling at this juncture of the compliance process.

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I1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, each Facility shall implement a regular risk screening, assessment and management system to identify individuals whose health or well-being is at risk.	Since the last review, interviews with the Facility staff, ABSSLC's Self-Assessment, and Provision Action Information documents indicated that the following steps had been implemented regarding the At Risk process: ▪ Since the Monitoring Team's last review, the State Office had made revisions to the At-Risk Individuals policy (in draft form at the time of the review). Some of the changes included regrouping the Risk Guidelines so the risk factors that were clinically inter-related regarding outcomes or provision of services and supports were listed together, and linking each risk factor with specific clinical indicators. In addition, the Integrated Risk Rating Form was revised to follow the same grouping sequence as the Risk Guidelines that included seven groupings of risk categories. The template of the draft Integrated Risk Rating Form included bulleted items to be addressed for each risk factor, including: data, supports, baseline, discussion and analysis/need for new supports, rationale/risk rating, triggers (trigger sheet indicated/not indicated), and criteria for IDT review. Some additional revisions included replacing the Risk Action Plans for the identified high and medium risk indicators with Integrated Health Care Plans (IHCPs) designed to provide a comprehensive plan that will be completed annually; different forms regarding IRRF and the IHCP were developed addressing changes in status; the Aspiration Pneumonia Enteral Nutrition was revised as a data collection tool; and Trigger Data Sheets were	Noncompliance

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		developed to include observable and measurable clinical signs and symptoms that alert the staff to possible changes in status. Trigger data sheets were to be completed and implemented according to the high-risk category. When there was a change of status (according to the definition provided in the instructions), a change of status integrated risk rating form was to be completed. Each of the risk categories for that individual was to include a log of the monthly review by discipline. There was a separate form to be completed, entitled "Direct Support Professionals Instructions" to be completed for an identified high-risk category. It was to be completed by the home manager/charge and signed off by each direct support professional caring for the individual. ▪ The Facility reported that in June 2012, training was conducted regarding the Enhanced Risk and new Integrated Health Care Plan process. A review of the curriculum found it to be comprehensive and a promising step forward for the Facility's At Risk Individuals. In addition, in May 2012, training was also provided regarding the revised format and purpose of the Aspiration Pneumonia/Enteral Nutrition (APEN). The information contained in the Presentation Book for Section I indicated that as of August 2012, the APEN was "strictly a data collection document to assist with Risk Discussions." Although training rosters were included in the Presentation Book for Section I, 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. ▪ In July 2012, two teams from ABSSLC implemented the "Enhanced Risk Process" described above at Residences 6400 and 6480. Since the system had only been implemented recently at the time of the review, the Monitoring Team was not able to adequately assess any progress made from the system revisions. The Facility's Self-Assessment indicated that based on results from the Section I Facility-specific monitoring tool, the Facility was not in compliance due to the lack of 70% compliance of regular risk screening, assessment and management that occurred in conjunction with the annual ISP; with review of risks in conjunction with change of status in that it was determined that IDTs were not meeting in an adequate and timely manner to review change of status and how the change of status addresses the risks; and the Integrated Risk Action Plans were not completed adequately, implemented in a timely manner or followed up for review. Although the Monitoring Team's findings supported the Facility in finding that it was not in substantial compliance with the Settlement Agreement requirements for Section I, the Monitoring Team's finding was based on a comprehensive review of the clinical quality and adequacy of the current documentation for individuals that were identified as being at risk by their teams. Although the Facility recently had implemented a new pilot At-	

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		Risk system, the Monitoring Team found a significant number of problematic issues as noted below in the existing system at the time of the review. In addition, the Facility's tracking system for recording individuals' who had been hospitalized, including their diagnoses upon discharge, was found to be significantly incomplete and consequently, unreliable. Thus, it was obvious that since the last review, the Facility had not been systematically tracking the individuals' hospitalizations and diagnoses to identify problematic trends affecting individuals, especially those designated as being at high risk. Without an adequate tracking system in place, teams could easily overlook the significance of repeat hospitalizations possibly indicating complications and changes in health status. This could result in critical delays in risk re-screenings, and assessments. The failure of the Facility in not catching this breech prior to the Monitoring Team noting this issue was troubling. Although the Facility updated the list and provided the Monitoring Team a copy, it had been out-of-date for some time. When the hospital liaison is not available, this important duty should be transferred to another staff member. Generally, the recent changes made in the At Risk system appeared to be positive. From review of the ISP and addendum documentation, individuals' teams were having discussions of the individuals' status, and overall, there was more pertinent clinical information being included in the Integrated Risk Rating Forms than previously. However, the overall lack of clear documentation included in the ISPs, Integrated Risk Rating Forms and revisions, the Risk Action Plans, and the associated disciplines' assessments regarding what actions were taken in response to pertinent events or health issues, and the lack of structure, dates and supporting documentation addressing actions and completion of action plans made the Monitoring Team's review of the At-Risk system difficult. The lack of progress noted was troubling at this juncture of the compliance process. Although the Monitoring Team agreed that changes to the at-risk system needed to occur for substantial compliance to be achieved, the numerous changes to the At-Risk system had resulted in fragmented documentation that made it difficult, if not impossible to sequentially follow the assessment and action plan processes for a sample of 20 individuals who the Facility determined to be at high risk regarding health and/or mental health issues. To assess the Facility's revised risk screening process, members of the Monitoring Team observed one individual's ISP meeting (Individual #542) while on site. Although there were other ISPs conducted during the week of the Monitoring Team's review, the ISP observed was reflective of the new ISP format and process the Facility had implemented, and thus was chosen for that reason. Specifically, the observations of the ISP indicated that: ▪ All appropriate disciplines were present at the observed ISP.	

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		▪ The staff present at the ISP meeting were the actual staff that worked with the individual, and not substitute staff sitting in for other staff members for the ISP. ▪ The individual was present for part of the ISP meeting observed, and left based on her choice. ▪ The IDT consistently used the Risk Level Guidelines when determining risk levels at the ISP meeting. ▪ The IDT did not consistently use supporting clinical data when determining risks levels for the ISP observed. Although improvements were seen with regard to the use of clinical data, the Monitoring Team noted that there was limited information contained on the IRRF for some of the health indicators, such as fractures and constipation. ▪ Overall, most of the risk levels the IDTs designated appeared appropriate for most of the health categories. However, due to the limited clinical information discussed from the content of the IRRF for some of the health categories, the Monitoring Team was not able to determine if those risk levels were appropriate. ▪ Due to the limited information noted above, there needed to be more adequate and appropriate clinical discussion among appropriate team members in decisions regarding risk levels for the ISP meeting observed. ▪ Team disagreements regarding risk levels were not noted at the ISP meeting for Individual #542, and thus, the Monitoring Team did not observe the process of resolving issues. In evaluating this indicator, when team 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 the ISP observed, the ISP facilitator kept the team focused. Areas for continued focus included time management since the ISP observed was lengthy, presenting justification for risks levels in alignment with the Risk Guidelines and individual-specific clinical information, and continuing to increase team discussions of risk indicators. In addition, other positive observations of the ISP for Individual #542 included: ▪ Efforts were made to elicit information from all team members. Some team members participated fully, and offered ideas on a variety of topics, even those outside of their specific areas of expertise. However, not all team members participated to the extent they should have. ▪ During the ISP meeting, the team had a more comprehensive discussion about a wider variety of the protections, supports, and services. ▪ Based on the observation, the QDDP and team used more data to make decisions in relation to individuals' risk areas, although this was an area that required further improvement. However, a number of gaps continued to exist, for	

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		example with regard to teams' discussions about data related to skill acquisition programs, PBSPs, and measurable objectives related to risk plans. It was positive, though, that the teams were discussing more objective clinical data in a number of areas. ▪ Based on the observations of the ISP meeting, although problems still existed with the detail included in action plans, teams were observed discussing action plans in more detail, particularly some of the strategies that were in place or would be put in place to address risks. In addition, the team discussed more functional action plans, and related a number of them back to the individual's preferences. ▪ The frequent input by the physician provided the team with some clinically sound parameters by which to set criteria for further and future team meetings regarding the individual's health issues. ▪ The team came up with ideas to engage the individual's sister for a possible visit during Family Day and the possibility of providing overnight lodging due to the distance she would have to travel. ▪ The team made a good attempt to integrate a skill acquisition program from issues raised by the Individual's sister and a community goal. ▪ During some of the team's discussions for Individual #542, a number of the team members remained cognizant of the individual's finances, her need to maintain as much independence as possible, and her long employment history (since 2006) in her current job. Areas in which more work was needed to obtain full team participation and facilitate meaningful discussion included, but was not limited to: ▪ Making sure decisions the team makes are data-based to the extent possible. As noted above, improvement was seen in this area, but further attention to relevant data was necessary. ▪ The Active Record was not brought to the ISP. This precluded the team from verifying pertinent clinical information. For example, the team's attempt to discuss the individual's enhanced supervision was hampered without having the data available in order to make an adequate decision regarding this issue. From comments made by the Facilitator during the ISP regarding not having the Active Record present during the meeting, the Monitoring Team got the impression that its presence at the ISP was somehow discouraged, or the team saw it as a point of pride that they did not need to refer to the record. It is crucial that the team have all the needed information to ensure that decisions are based on accurate information. The ever-changing record should be viewed as a resource, not something that needs to be committed to memory. ▪ Limited information was contained in the IRRF regarding some of the health indicators. For example, the health indicator for constipation did not include the	

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		specific number of additional laxatives/stool softeners that had been administered each month during the year, with a comparison to the previous year's numbers to accurately determine the level of risk. In addition, the team needed more information regarding a choking incident in 2010, and the results of a Modified Barium Swallow that was conducted in 2009 to adequately assess the risk of choking. Also, the information addressing falls and fractures only included limited data regarding the past year's events which did not accurately reflect the individual's overall risks related to her history of fractures, falls, and diagnosis of osteoporosis. ▪ Although the nurse generically referenced some nursing protocols during the meeting, she did not individualize them or translate them into specific action steps within the Integrated Health Care Plans the team developed for the individual. Consequently, most of the nursing interventions discussed at the ISP were not adequate in addressing the health risk indicators and did not address the needed clinical assessments to ensure the health indicator was actually being monitored. ▪ Overall, the Integrated Health Care Plans discussed during the ISP did not reflect the needed clinical intensity in alignment with the designated risk levels determined by the team. ▪ In setting the future criteria for the team to meet regarding the health risk indicators, most consisted of reactive events in that the individual had to experience an illness in order for the team to meet rather than proactive criteria that focused on the prevention of an acute event. ▪ It was unclear to why the team decided that Individual #542 should have sedation for future diagnostic tests when they reported that she had not needed it in the past, and did not have supporting data indicating that past diagnostic testing could not be completed without sedation. ▪ Regarding the development of measurable objectives, the team did not define adequate measurable, functional objectives during the team meeting. As a result, the team did not have a mechanism to determine whether the individual was doing better, worse, or remaining the same. This limited their ability to evaluate whether the supports that were in place were working, or if they required revision. For 13 records reviewed (i.e., Individual #30, Individual #26, Individual #55, Individual #76, Individual #545, Individual #53, Individual #88, Individual #109, Individual #385, Individual #40, Individual #535, Individual #409, and Individual #179), the submitted documents from the active record were reviewed along with the integrated risk rating form. The attendance sheet from the ISP also was utilized in determining the following information. ▪ For five out of 13 individuals (38%), the appropriate disciplines were present at	

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		the ISP. ▪ For four out of 13 (31%), the individual was present at the ISP. ▪ For 11 out of 13 individuals (85%), the IDT used the Risk Level Guidelines when determining risk levels. ▪ For 11 out of 13 individuals (85%), the IDT used supporting clinical data when determining risk levels. ▪ For eight out of 13 individuals (62%), 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 #55 was noted to cough after feeding and wheeze when bathed, but she was considered low risk for gastrointestinal concerns even though it was unclear if she experienced reflux, and moderate risk of aspiration and respiratory compromise. The IRRF was not consistent with the active record review findings. o Individual #40 required a pureed diet with liquids thickened to pudding consistency. He required special techniques for safe swallowing and developed fatigue as meals progressed. However, he was considered low risk for choking and aspiration, and no risk for respiratory compromise. According to the submitted document, the severe dysphagia identified through an MBS, pudding consistency liquids and need for close supervision during meals would indicate high risk in these categories. o Individual #385 was rated as low risk for aspiration despite a tracheostomy, gastrostomy tube (G-tube), and GERD. He would appear to be high risk for aspiration. o Individual #179 was placed at medium risk for skin integrity, but had only a cyst on her back. The documentation provided did not indicate any complicating factor. Clinically, this would be low risk. From the Monitoring Team's limited observations and review of documentation, there had been some positive steps made regarding the structure and format of the ISP meetings and documents, specifically the increased use and team discussions of supporting clinical data when assessing risk levels. However, significantly more efforts are needed to ensure that the appropriate risks levels are assigned based on the clinical data, that the action plans reflect the needed clinical intensity in alignment with the appropriate designated risk levels, that objectives are functional and/or measurable, that adequate preventative measures are discussed and are included in the action plans, and this process is clearly documented. In addition, the Facility should implement a system to address the reassessment of risk factors for individuals experiencing significant changes in status, including acute changes in status for at-risk individuals. Such a system	

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		should not only be activated in response to hospital admissions. ABSSLC should continue to provide training and mentoring for the IDTs 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 #451, Individual #162, Individual #541, Individual #215, Individual #407, Individual #348, Individual #527, Individual #59, Individual #396, Individual #146, Individual #327, Individual #324, Individual #542, Individual #381, Individual #376, Individual #64, Individual #519, Individual #418, Individual #517, and Individual #43), 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 none of these (0%) individuals. Problematic issues that resulted in noncompliance included: ▪ Integrated Risk Rating forms (IRRFs) did not consistently include specific clinical data to support the risk ratings for the health indicators, such as including the number of bowel medications and supplemental laxatives/stool softeners regarding constipation risks, or dates and the types of injuries/fractures when addressing falls and fracture risks. Thus, the Monitoring Team was unable to determine if further assessment was needed; ▪ Due to the lack of documented dates on the various forms, the Monitoring Team was unable to consistently determine what new information was added to a revised Integrated Risk Rating form, and what additional assessments were needed and/or conducted in response to the revised information or possible change of status; and ▪ When recommendations for further assessment were found on the Risk Action Plans, the date of completion was frequently left blank, or the dates that were listed on the Action Plans did not correspond to dates on the Integrated Risk Rating forms, ISPs, or ISP addendums. Thus, it was not possible to determine what precipitated the recommended assessment, and if it was timely completed. <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 #451, Individual #162, Individual #541, Individual #215, Individual #407, Individual #348, Individual #527, Individual #59, Individual #396, Individual #146, Individual #327, Individual #324, Individual #542, Individual #381, Individual #376, Individual #64, Individual #519, Individual #418, Individual #517, and Individual #43. In addition, consistent with previous findings from the Monitoring Team, a review of the most current quarterly or annual Comprehensive Nursing Assessments for the above 20 individuals found that none of them (0%) contained an adequate assessments of the	Noncompliance

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		specific high-risk health indicators or provided any type of analysis of the high-risk health indicators in the Summary Section of the Comprehensive Nursing Assessment form. Unfortunately, the Comprehensive Nursing Assessments the Monitoring Team reviewed were noted to have regressed from the previous review in that some of the nursing assessments did not reflect any clinical information regarding the health risk indicator while others merely listed the entries from the IPNs or physician orders. As noted from the previous five reviews, nursing continued to have no specific procedure in place regarding the nursing assessment process and the analysis of the identified risk indicators. As noted from past reviews, the nursing assessments for the At Risk individuals were not adequate in addressing the health risks of the individuals reviewed. Regarding the Integrated Risk Rating forms, although overall more specific clinical information was contained on the forms, for some of the areas that nursing was responsible for assessing and/or providing information, such as constipation, cardiac, osteoporosis, and dates of injuries/fractures, a decrease in this individual-specific information was noted from the previous review. In addition, when reviewing some the Integrated Risk Rating forms that included dates of revisions, the areas that contained deficits in individual-specific information remained unchanged. As previously recommended, the Facility, in conjunction with the State, should specifically define the nursing assessment and documentation process regarding at-risk individuals. <u>Medical Assessments</u> Based on the submitted documentation reviewed for 13 records for individuals determined to be at risk (i.e., Individual #30, Individual #26, Individual #55, Individual #76, Individual #545, Individual #53, Individual #88, Individual #109, Individual #385, Individual #40, Individual #535, Individual #409, and Individual #179), for areas identified as needing further assessments, there appeared to be no system to record evidence of the date of initiation of the assessment process. In addition, there was no document that logged the steps completed for easy review to ensure compliance with the Settlement Agreement, and easy review by the QDDP and IDT. Based on a review of 13 individuals' records, two records indicated a significant change in status in one or more clinical areas. There was documentation that the IDT started the assessment process as soon as possible, but within five working days of the individual changes in an at-risk condition for none of two individuals (0%) (i.e., Individual #545, and Individual #385). Based on a review of 13 individuals' records for whom assessments had been completed to address the individuals' at risk conditions, eight (62%) 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 #55, Individual #545,	

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		Individual #76, Individual #385, and Individual #535. The following provides an example of an assessment that was not comprehensive: ▪ Individual #535 had an intermittent history of anorexia, meal refusal, and weight loss. Since 12/2011, he was placed in the Infirmary three times for this concern. There did not appear to be a consideration of cyclic depression and the need for a psychiatric assessment. Additionally, it was noted he was prescribed Keppra, which might contribute to irritability and difficulty in compliance. Both these assessments/areas would be helpful in determining/ruling out various reasons for the cyclic anorexia. In 7/11, he was recently referred to the neurologist for a review of seizure medication side effects. However, it would have been an appropriate and aggressive approach to complete these assessments after his first Infirmary admission. The individual also was challenged with constipation, and his lack of fluid intake added to the problem. Further assessment of the constipation might be indicated, because it might also be a sequelae of depression. There did not appear to be any bowel motility studies completed or work-up except an abdominal x-ray. On 5/27/12, an EGD was completed, with the findings of gastritis and H. pylori, but it was difficult to determine from the submitted documents whether the H. pylori was treated. A review of events and documentation prior to the onset of the anorexia through an open record review might also be beneficial to review other psychosocial aspects that might contribute to the meal refusal, as well as aspects that would increase his cooperation with oral intake (e.g., food choices, likes and dislikes, times of day that the individual normally had a larger appetite, etc.). A pharmacy review of medications might assist in determining those that could be contributing to anorexia, gastritis, or noncompliance with meals. When there are repeated events of the same issue, such as anorexia and meal refusal, at each episode, the PCP and team need to convene and provide additional steps (i.e., diagnostic steps, consults, second opinion consults, treatments). The lack of early assessment in this case has not been helpful to the team, nor had it benefited the individual. The Facility indicated that it was not in compliance with the requirements of the Settlement Agreement for this area. This was consistent 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	Based on a review of 20 records for individuals determined to be at risk (i.e., Individual #451, Individual #162, Individual #541, Individual #215, Individual #407, Individual #348, Individual #527, Individual #59, Individual #396, Individual #146, Individual #327, Individual #324, Individual #542, Individual #381, Individual #376, Individual #64, Individual #519, Individual #418, Individual #517, and Individual #43), there was	Noncompliance

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	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.	documentation that the Facility: ▪ Established an appropriate plan within fourteen days, for each individual, as appropriate, in none of the cases reviewed (0%). ▪ Implemented a plan within fourteen days for each individual, as appropriate in none of the cases reviewed (0%). Although the Action Plans reviewed usually 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 so nonspecific and generically written, it would not be possible to verify their implementation. ▪ 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%). Although there were some generic interventions found in some ISPs addressing the need for increases in exercise or fluids that would have lead to a preventative intervention, because these interventions were not written in measurable terms as to actually be implemented and tracked, they were found not to be in compliance with this indicator. ▪ When the risk to the individual warranted, took immediate action in none of the cases (0%). ▪ Integrated the plans into the ISPs in 12 of the cases reviewed (60%). Individuals who had not had their Risk Action Plans integrated in to their ISPs included: Individual #451, Individual #407, Individual #59, Individual #146, Individual #64, Individual #418, Individual #517, and Individual #43. ▪ 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. The significant problematic issues that resulted in noncompliance with the above compliance indicators included: ▪ The Facility indicated that there were no Risk Action Plans for some individuals who had high and/or medium health risk indicators; ▪ Some of the Risk Action Plans included in the ISPs appeared to be incomplete; ▪ The Monitoring Team was unable to determine what information on the Integrated Risk Rating Forms was actually revised when additional dates added	

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		to the form indicated revisions were made, which in turn, made it impossible to determine if there had been appropriate and timely associated changes made to the Risk Action Plans; ▪ Since many of the dates on the Risk Action Plans did not coordinate with any of the revision dates on the Integrated Risk Rating forms, the ISP date, or an ISP addendum date, it was not possible to determine exactly when and in response to what event the Action Plan was developed, and implemented; ▪ The Risk Action Plans that were reviewed generally were found to be generic, and non-specific in addressing the health risks of the individual; ▪ Specific and measurable preventative interventions were not included in the Risk Action Plans; ▪ Interventions listed on the Risk Action Plans did not include specific clinical indicators to be monitored or the specific frequency included; ▪ Often the interventions listed on the Risk Action Plans were not in alignment with the designated risk rating of high or medium risks; and ▪ There was no supporting documentation indicating that interventions contained in the Risk Action Plans were actually implemented. In addition, general observations from the Monitoring Team regarding Section I that should assist in guiding the IDTs and in interpretation of the documents by all reviewers include the following: ▪ There needed to be a system to document timeliness of steps outlined in the Settlement Agreement (i.e., beginning the assessment process within five days, proof of implementation within 14 days, etc.). ▪ For several individuals, there were numerous revisions of the IRRF and risk action plans in the past year. It is important to differentiate new information (with date that paragraph or statement was updated) from prior information. It was difficult to determine what had changed from one version to the next version. ▪ Teams needed to clearly define the assessments being requested to create a final risk action plan. For most IRRF documents, it was difficult to determine if additional assessments were being requested, and when the request was made. This is especially important to identify the five-day time period in which the assessment process should begin. ▪ It would be helpful to have a chart at the end of the document listing the assessments with columns to indicate when it was requested, when it was completed, when it was received by the IDT, when it was discussed at an IDT meeting, and the date of the ISPA at which it was discussed and acted upon. ▪ The IRRF and risk action plan were inconsistent about including monthly/quarterly updates in the documents. There should be consistency	

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		across the campus about whether to include these in the reports or not. ▪ The ISP did not capture interdisciplinary discussion for most risks defined for the individual, but simply copied the risk from the IRRF. For many entries, the focus was on a contribution of a department to the ISP (i.e., medical, nursing, etc.), as opposed to a focus on the risk and how each department could contribute to preventing or minimizing the risk. ▪ The ISPs did not appear to reflect the process for health status change, or the questions raised at the morning medical meeting that resulted in an IDT meeting followed by an ISPA. Documentation of the health status change and the effectiveness of any steps taken as a result of implementation of the ISPA would be expected to be part of an amended or future ISP for that particular risk. For each hospitalization/ER visit, the goal would be to have a discussion of preventing a recurrence, with action steps that can be measured. At the time of the review, the Facility indicated it was not in compliance with the requirements of the Settlement Agreement for this provision. This was consistent with the findings of the Monitoring Team. Although the Facility was in the beginning stages of implementing a new pilot addressing the At-Risk system, it was concerning to note the increase in the inconsistent and fragmented documentation regarding the At-Risk individuals. These problematic issues made determining the chronological clinical sequence of events, and the Facility's response to these events confusing and complicated. Clear documentation, especially during revisions and changes in the At-Risk system is essential. ABSSLC should continue to focus its efforts on the process of appropriately rating health risks and developing specific and clinically appropriate risk action plans for each individual by the next review. These 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. PCPs should be encouraged to attend the risk rating meetings. They should be sufficiently prepared to discuss the work-ups or completed aspects of the work-up, interpret lab and test results for the IDT, provide details regarding the history as well as current health status of the individual, and recommend next steps. They should play an instrumental role in assisting the team to finalize measurable objectives and determine clinical indicators for each of the high and medium risks for the individual. (Sections I.1, and I.2)
2. 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)

3. Additional training and/or technical assistance 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)
4. When the team convenes about an individual, the departments responsible for background information concerning a risk category should be sufficiently knowledgeable about that category to explain the risk to the remainder of the team. (Section I.1)
5. Each IDT member should obtain all relevant information ahead of the meeting, especially information on which the team will base a risk rating. 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)
6. There should be evidence to confirm the team's rationale for each category of risk reviewed. The team should ensure updated information is provided as documentation. (Section I.1)
7. 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 address any changes in health and functional status. (Sections I.1, I.2, and I.3)
8. 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)
9. The Facility, in conjunction with the State, should define specifically the assessment process regarding at-risk individuals for all disciplines. (Section I.2)
10. Given that IDTs, at times, do not realize when more assessment is indicated, and department heads should review IDTs findings relevant to their department to ensure appropriate guidance is provided to the teams in determining needed assessments. (Section I.1, and I.2)
11. 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)
12. 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)
13. The Facility QA Department should track a hospitalization or ER visit or Infirmary admission from the morning medical meeting discussion, to the IDT meeting, to an ISPA meeting, including, as appropriate, revised risk categorization with changes in the risk action plan(s). All of the related documents should be sent to the morning medical meeting committee for wrap-up discussion and closure. (Sections I.1, I.2, and I.3)
14. To meet the timeline requirements of the Settlement Agreement, the Facility should develop a database system and oversight tracking to provide evidence that the requirement to begin assessments within five working days of risk identification and the 14-day requirement of implementation are successfully carried out. (Sections I.2, and I.3)
15. As the Facility's self-assessment processes evolve, additional data should be analyzed, addressed, and included in the Facility 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)
16. Regarding the Facility's monitoring system addressing Section I, the Facility should evaluate who would be best to audit this highly clinical area in order to generate accurate information regarding clinical issues related to the individuals at risk. (Facility Self-Assessment)
17. Consideration should be given to standardizing the presentation of data across the Facility for consistency in interpretation, using, for example, tables to report monitoring findings rather than a narrative format that would be better for the presentation of the analysis of the data. (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 intra-class 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 #226, Individual #333, Individual #458, Individual #265, and Individual #53; o List of individuals who were prescribed each of the following: a) anti-epileptic medication being used as a psychotropic medication; b) Lithium; c) Tricyclic antidepressants; d) Trazodone; e) Beta-blockers being used as a psychotropic medication; f) Clozaril/ Clozapine; g) Mellaril; and h) Reglan; o List of new admissions within the last six months, and whether a Reiss screen was obtained; o Spreadsheet of all individuals who 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 within the last six months, inclusive of the Reiss Scoring Sheet and the results of the Comprehensive Psychiatric Evaluation (CPE) that was performed as a result of any elevated Reiss Screening Scores; 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 Psychiatric Clinics: 5962 Walnut Avenue on 8/21/12, and 6760 Circle Drive on 8/22/12;

	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 #231 on 6/5/12; Individual #163 on 6/6/12; Individual #304 on 5/20/12; Individual #137 on 5/20/12; and Individual #120 on 5/25/12; o List of all individuals age 18 or younger who were prescribed psychotropic medication; o Documents reviewed in the context of the 8/21/12 Psychotropic Polypharmacy Meeting; o Minutes reviewed and discussed at the 8/22/12 Pharmacy and Therapeutics Committee Meeting; o Spreadsheet of oral pre-treatment sedation medications used for medical and dental appointments for the past six months; o List of individuals with completed CPEs and the date of completion; o Dental Pre-Treatment Sedation Log for the prior six months; o Medical Pre-Treatment Sedation Log for the prior six months; o Emergency Chemical Restraint spreadsheet maintained by the Pharmacy Department; o Data on percentage of oral sedation and general anesthesia used for dental appointments over the prior six months; o Desensitization Tracking Worksheet for July 2012; o List of individuals who had been psychiatrically hospitalized over the last six months; o Documentation of training the Living Unit RNs received with regard to the administration of the DISCUS; o List of Individual Support Plan meetings attended by a member of the Psychiatry Department during the prior year; o The following sections of the active medical records were requested: a) Data Record; b) Social History Evaluation; c) Individual Support Plan section; d) PBSP, including addendums; e) Annual Medical Summary; f) Active Problem List; g) Inactive Problem List; h) Psychiatric Problem List; i) Hospital Admissions; j) Health Risk Assessment Rating, only most recent tool and team meeting sheet; k) Psychiatry section, inclusive of the most recent Comprehensive Psychiatric Evaluation; l) MOSES/DISCUS screenings; m) Quarterly Drug Regimen Reviews (QDRRs); n) Neurology Consultation(s); 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 Committee (HRC) section, including a copy of the signed consents for the following three samples of individuals who were receiving psychotropic medication: 1. The Facility selected the records of the following ten individuals and submitted them as part of the pre-review document request: Individual #190, Individual #355, Individual #462, Individual #518, Individual #4, Individual #534, Individual #168, Individual #460, Individual #320, and Individual #461; 2. The records of the following ten individuals were chosen as they were reviewed during the 8/21/12 and 8/22/12 Psychiatry Clinics: Individual #395, Individual #464, Individual #120, Individual #369, Individual #126, Individual #103, Individual #388, Individual #373, Individual #540, and Individual #151; and

	3. The records of the following eight individuals were selected because of their psychiatric acuity: Individual #94, Individual #163, Individual #392, Individual #439, Individual #274, Individual #465, Individual #455, and Individual #97. ▪ **Interviews with**: o Toni Wilson, R.N., Psychiatric Nurse; Kevin Copeland, Psychiatry Assistant; and Marcus Perez, Psychiatry Assistant, on 8/22/12; o Michael Murray, M.D., Chief Psychiatrist, on 8/20/12, 8/21/12, and 8/22/12; o Richard Chengson, M.D., Medical Director, on 8/20/12; o Jerry Griffen, D.D.S., Director of Dental Services, on 8/20/12; o Marla Knight, Pharm. D., Clinical Pharmacist, on 8/20/12; o Ron Manns, Director of Behavioral Services, on 8/20/12; o Shae Butts, Human Rights Officer, on 8/22/12; o Brian Luster, Program Compliance Monitor, in conjunction with Michael Murray, M.D. to review Facility Self-Assessment, on 8/23/12; o Stephen Milstead, R.N., D.M., M.H.N.P., on 8/20/12 and 8/23/12; and o John Crowley, M.D., on 8/22/12. ▪ **Observations of**: o Psychiatric Clinic for Residence 5962 Walnut Avenue, on 8/21/12; o Psychiatric Clinic for Residence 6370 Seventh Street, on 8/22/12; o HRC Meeting, on 8/21/12; o Psychotropic Polypharmacy Committee Meeting, on 8/21/12; o Participation in the Monitoring Team's review of the Community Living Discharge Plan meeting for Individual #272, on 8/22/12; o Observations of the following individuals in the context of the Psychiatric Clinic at 5962 Walnut Avenue, on 8/21/12: Individual #237, Individual #347, Individual #395, Individual #388, Individual #373, Individual #392, and Individual #519; o Observations of the following individuals in the context of the Psychiatric Clinic at 6370 Seventh Street, on 8/22/12: Individual #126, Individual #464, Individual #120, Individual #369, Individual #103, Individual #11, and Individual #154; o Observations of the following individuals in the context of the tour of the Vocational Workshops, on 8/23/12: Individual #136, Individual #544, Individual #197, Individual #325, Individual #178, Individual #87, Individual #300, Individual #99, Individual #495, Individual #34, Individual #152, Individual #115, Individual #8, Individual #104, Individual #523, Individual #180, Individual #481, Individual #167, Individual #308, Individual #158, Individual #363, Individual #327, Individual #411, Individual #269, Individual #453, Individual #462, Individual #179, Individual #321, Individual #286, Individual #301, Individual #22, Individual #280, and Individual #494.
	Facility Self-Assessment: The review of the Facility Self-Assessment was facilitated by an interview with the Program Compliance Monitor and the Chief Psychiatrist, on 8/23/12. The Presentation Book for Psychiatry also was reviewed with the Chief Psychiatrist at that time. The Program Compliance Monitor indicated that he reviewed two individual records per month, which were selected randomly from a list of

	individuals who were reviewed in the Quarterly Psychiatric Reviews during the prior month. These two individual records were reviewed 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 related to 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 for that diagnosis had been provided. However, he did participate in a monthly meeting with the entire Psychiatry Team, during which they reviewed the results of their inter-reliability data. The Program Compliance Monitor noted that this process was increasing his knowledge of clinical quality indicators. During these monthly meetings, a discussion occurred of the independent reviews in order to improve inter-rater reliability in the future. At the time of the prior review, the "QA/QI 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 produced by the internal psychiatry review process. The Data Summary also provided information on specific items that were consistently scored as being below a preset score of 70 percent. Since the last review, the QA/QI monitoring system had been modified. Specifically, overall compliance scores were replaced with indicator-specific scores. The current work product of the QA/QI review reported on 27 indicators related to 11 provisions of Section J of the Settlement Agreement. The ones that were not covered were Sections J.1, J.5, J.7, and J.11. Section J.1 related to the qualifications of the Psychiatrists, while Section J.5 addressed the number of Psychiatrists necessary to provide services to the individuals who reside at ABSSLC. Section J.7 concerned the status of the Reiss Screenings, and Section J.11 related to the use of polypharmacy at the Facility. Both of these issues were addressed through separate databases. During the 8/23/12 interview, the Chief Psychiatrist indicated that each month the Psychiatry Department reviewed six individual records, two each of which were distributed to the Psychiatry Support Staff (i.e., two Psychiatric Assistants and one Psychiatric Nurse). The Chief Psychiatrist and the Program Compliance Monitor provided reviews of two of the six described above to assess for inter-rater reliability. The principal author of the Facility Self-Assessment was the Chief Psychiatrist. During the 8/23/12 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 with the Chief Psychiatrist and the Program Compliance Monitor. At the time of the prior review, two primary strategies were employed, including a data-based approach and the sampling strategy, as described above. For example, for provisions such as Sections J.2 and J.6, the Facility used information from its databases to assess progress in completing the CPEs, and for Section J.11, they analyzed their progress in decreasing the rates of polypharmacy using data as opposed to a sampling methodology. However, the sampling of individual records, as described above, was used to assess compliance for the majority of the provisions. This description continued to be accurate with the qualification that the sampling technique had been expanded to include indicators from Sections J.2 and J.6, to augment the data-based methodology for those provisions.

	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 percentages for the compliance rates differed from those of this external review, this could, to some extent, be explained by the statistical differences that would be expected by the different composition of the two sample sets. In light of the similarity in the statistical methods utilized on both the internal and this external review, it is not surprising that there was almost complete congruence between the compliance results of both reviews pertaining to the 15 provisions contained in Section J. The one exception to this was Section J.7, for which the Facility rated itself as being in "Substantial Compliance," and this external review found that the designation of "Substantial Compliance" could not be carried over from the Monitoring Team's previous review, due to significant omissions, as described below. 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 also should contribute to the overall reliability of the self-assessment process in the future.
	Summary of Monitor's Assessment: At the time of the Monitoring Team's previous review, ABSSLC had three full-time Psychiatrists, who were supported by one Psychiatric Nurse and two Psychiatry Assistants. The Chief Psychiatrist completed an analysis of the workload distribution among the Psychiatrists, which took into account the requirements of the Settlement Agreement, and it appeared that this number of Psychiatrists should be adequate. Two of these Psychiatrists left the Facility in the spring of this year, but the Psychiatry Department has since added a half-time Psychiatry Consultant, as well as a full-time Psychiatric Nurse Practitioner. The progress with regard to the completion of the CPEs had continued. The data available indicated that there had been progress in completing the CPEs, which the Facility believed complied with the criteria set forth in the Settlement Agreement. The progress in completing the CPEs had been disrupted by the departure of the two full-time Psychiatrists noted above. The current plan was to complete these in conjunction with the annual ISP. The annual updates also would be completed to coincide with the annual ISP, which would make the process self-sustaining. The Psychiatrists or a member of the Psychiatry Department Support Staff also had begun to attend the ISPs of individuals who were receiving psychotropic medication. It will be important for the Psychiatry Department to ensure that the documentation that concerns psychiatric treatment, which appears in the ISP, conforms to the requirements the Settlement Agreement specifies. At the time of the Monitoring Team's previous review, the Facility had ceased performing routine monthly Psychiatric Clinic Reviews for individuals that 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, as the Settlement Agreement only specified quarterly reviews, including a direct observation. Observation of the Psychiatric Clinics of the two 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, attended the clinics. The Living Unit Supervisor represented the direct support professionals. The documentation that accompanied the Quarterly Psychiatric Reviews, which had been expanded to four pages at the time of the Monitoring Team's previous review, was recently updated. The Quarterly Psychiatric Reviews now 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. There was also an expanded Risk versus Benefit section. The teams had made progress in implementing this new section, which initially had been difficult to implement. The Psychiatry Department, working in conjunction with the Psychology Department and HRC, had completed the process allowing 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 (PPMTP), which served as a Treatment Plan for the psychotropic medication, because this information no longer appeared in the PBSP. This system was fully operational at the time of the Monitoring Team's August 2012 review. Members of the Monitoring Team attended an HRC meeting, during the onsite review, and it was clear that the system was more functional than it had been at the time of the previous review. The Chief Psychiatrist had been attending HRC meetings, when possible, and this had contributed to the improved operation of the process. Progress continued in decreasing the rates of polypharmacy at ABSSLC, which had been reduced to approximately 24 percent of those prescribed psychoactive medications. In addition, a number of individuals had active tapering schedules in process. 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. For individuals in the latter group, the Facility had made additional progress in assembling the necessary documentation to justify the efficacy of psychotropic medications. At the time of the current review, a plan recently had been approved to have all of the individuals followed by both Psychiatry and Neurology reviewed in a distinct Neuro-Psychiatry Clinic. This should provide improved coordination of clinical care by both specialties. Thus, in summary, the Facility had made significant progress in a number of areas. However, the impact of many of these positive initiatives was not fully reflected in the current review, due to the time lag before the new procedures were fully assimilated into the ongoing clinical processes and were documented in the individual records. The full impact of these initiatives should be reflected in 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.	Dr. Michael Murray, who was Board Certified in Adult and Adolescent Psychiatry and had completed an accredited Residency in Child Psychiatry, had continued as the Chief Psychiatrist. 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 residing in community residences in his catchment area. Dr. John Crowley, who was previously a Psychiatry Consultant to the Facility, had returned after a brief absence. As discussed in the Monitoring Team's previous reports, Dr. Crowley was Certified by the American Board of Psychiatry in both Adult Psychiatry and Child and Adolescent Psychiatry. He initially began working at ABSSLC as a Consultant approximately four years ago as the Child Psychiatrist for the adolescents living at the Facility. His caseload quickly expanded to adults as well, and he continued to provide services to all age groups. Dr. Trina Cormack, who was a full-time Staff Psychiatrist at the time of the Monitoring Team's previous review, terminated her employment at the Facility in April of this year. Dr. Robert Brimmer, who was also a full-time Staff Psychiatrist at the time of the Monitoring Team's previous review, left the Facility in March of this year. Stephen Milstead, who had functioned as a Psychiatry Nurse at ABSSLC, recently received his Master of Science in Nursing degree from the University of Texas San Antonio, and also had passed the credentialing examination to practice as a Psychiatry Nurse Practitioner with prescribing privileges. The licensure process had just been completed as well. Mr. Milstead indicated that the Texas licensing requirements stipulate a supervising relationship with a licensed Psychiatrist, and Dr. Murray would fulfill that role for his work at ABSSLC. Mr. Milstead's primary exposure regarding clinical work with individuals who have developmental disabilities had been limited. However, as noted above, he would be working with Dr. Murray, who had extensive experience with this population. The Facility remained in substantial compliance with this provision, because the Psychiatrists were all Board Certified by the American Board of Psychiatry and Neurology, and the Nurse Practitioner was expected to be working under the supervision of a Psychiatrist certified by the American Board of Psychiatry and Neurology.	Substantial Compliance
J2	Commencing within six months of the Effective Date hereof and with full implementation within	As noted above, at the time of the review, the Psychiatrists who diagnosed and treated the individuals 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	Noncompliance

#	Provision	Assessment of Status	Compliance
	one year, each Facility shall ensure that no individual shall receive psychotropic medication without having been evaluated and diagnosed, in a clinically justifiable manner, by a board-certified or board-eligible psychiatrist.	the diagnosis and treatment of psychiatric disorders in individuals with ID/DD. The documents in the individual records that provided the most complete description of the psychiatric evaluation process required by this provision of the Settlement Agreement were: a) the Psychiatric Quarterly Reviews; b) the PPMTP, which functioned as a Treatment Plan for psychotropic medication; and c) the CPE. The newly formatted psychiatric Quarterly Review Forms contained sections that discussed: ▪ The diagnosis (including the DSM criteria for that diagnosis); ▪ Past psychotropic medication trials; ▪ Non-psychiatric medications the individual received; ▪ Pertinent laboratory and/or other medical information; ▪ The results of the most recent MOSES and DISCUS side effect monitoring; ▪ The mental status examination performed by the Attending Psychiatrist 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. Graphs the Psychology Department had prepared augmented the tables reporting the frequency of the monitored behaviors. These graphs provided dose response data for the prescribed psychotropic medication, with phase lines to demarcate major environmental or pharmacological changes. The PPMTP contained a comprehensive list of the symptoms of psychiatric disorders, which were organized into seven sub-groups that represented common Axis I Psychiatric Disorders seen in individuals with Intellectual Disability and Developmental Disorders (ID/DD). These included: Depressive Disorder, Bipolar Disorder, Anxiety Disorder, Psychotic Disorder, Pervasive Developmental Disorder, Impulse Control Disorder, and Stereotypic Movement Disorder. The symptom list included check boxes by each listed symptom. The Psychiatrist, working in conjunction with the Treatment Team, could indicate which symptoms the individual manifested. The subsequent two pages were devoted to sections that described the rationale and justification for the medication, as well as the risk versus benefit considerations, which will be discussed later in this report. The PPMTP was completed when treatment with a new medication was initiated, and then annually in conjunction with the individual's ISP. The CPE also contained a listing of the psychiatric diagnosis for the individual, as well as the	

#	Provision	Assessment of Status	Compliance
		Bio-Psycho-Social-Spiritual formulation. It discussed the differential diagnosis and provided more detail concerning the rationale for the diagnosis of record, as well as important information that described the impact of the individual's psychiatric diagnosis on his overt behavior. This was essential for differentiating those behaviors that were derived from the psychiatric disorder from those that were present due to environmental and/or learned factors. Thus, when evaluating the records of the 28 individuals out of 190 individuals prescribed psychotropic medication (15%), all three of the aforementioned sources of clinical information were taken into account, because they complemented each other in the manner described above. Although the CPE was the closest to a stand-alone document, a comprehensive diagnostic profile of the individual generally required the presence of all three to fully support the diagnosis of record. Given that there were very high rates of completion for the psychiatric quarterlies (as discussed with regard to Sections J.9, J.10, and J.13), which the PPMTP accompanied, the limiting factor for this review became the completion rate of the CPEs (as is discussed with regard to Section J.6). That review indicated that 20 of the individuals in the sample of 28 (71%) had CPEs that had been completed within the past year, and met the criteria specified in the Settlement Agreement. Therefore, based on this sample, approximately 71% of individuals prescribed psychotropic medications had been evaluated and diagnosed in a clinically justifiable manner. This is also the completion rate for the CPEs that meet the requirements of the Settlement Agreement and have been completed or updated within the past year. As noted above, the reason for this is that although there is documentation of the psychiatric symptoms that support the Psychiatric Diagnosis in other sections of the record, it is primarily the material in the CPE (especially the Bio-Psycho-Social-Spiritual Formulation section) that pulls everything together into a comprehensive discussion of the primary psychiatric diagnosis. The specific individuals who met this criterion are identified in the discussion regarding Section J.6. ABSSLC did not use either "Deferred," "Rule Out – R/O" or "Not Otherwise Specified - NOS" qualifiers when establishing an individual's psychiatric diagnosis. They did not maintain a list of individuals who had had a change in their psychiatric diagnosis, but indicated during the onsite review that they had the capability to establish a mechanism to accomplish this. As noted above, the Facility had created an impressive mechanism for documenting the clinical rationale for an individual's psychiatric diagnosis, which was primarily constructed through three inter-related documents. However, the finding of noncompliance for this provision derived from the completion rate for the CPEs, which were a crucial component of the psychiatric diagnostic process. This was a deficit that the Psychiatry Department was well aware of and was actively addressing.	

#	Provision	Assessment of Status	Compliance
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 28 individuals prescribed psychotropic medication, did not reveal any evidence that psychotropic medication was being used overtly 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 was able to directly observe approximately 21 percent of the 190 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 with regard to Sections J.2, J.6, and J.13. However, in summary, although improvements were seen, a number of individuals did not yet have clinically justifiable diagnoses. The 28 records reviewed included an active PBSP for each individual prescribed psychotropic medication. However, the Monitoring Team's prior reviews indicated that the behaviors that were identified as the "target behaviors" of the psychotropic medication also often were identified in the Functional Analysis and related Positive Behavior Support Plan as being present on a behavioral basis and/or related to environmental factors. The dual classification of behaviors suggested that, for these individuals, the prescribed psychotropic medication could be construed as having been utilized to suppress behaviors not directly derived from a psychiatric diagnosis, which would not be consistent with the terms of this provision 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 "as a substitute for a treatment program." The Facility had made progress in this area, and the current status of this finding is discussed in greater detail below with regard to Section J.9 of the Settlement Agreement. This factor is also relevant to Sections J.2, J.6, and J.13, as it also relates to the integrity of the psychiatric diagnostic process. In addition, concerns related to the quality of PBSPs are discussed with regard to Section K.9 of the Settlement Agreement. The use of chemical restraint also could be construed as punishment, because it frequently involved the 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 chemical restraint at ABSSLC, the following sample of chemical restraint data was reviewed:	Noncompliance

#	Provision	Assessment of Status	Compliance

INDIVIDUAL #	DATE	TIME	MEDICATION AND DOSAGE	ROUTE OF ADMINISTRATION
Individual #231	6/5/12	12:00 hrs	Zyprexa 10 milligrams (mg)	IM
Individual #163	6/16/12	20:05 hrs	Thorazine 50mg	IM
Individual #304	5/20/12	10:30 hrs	Haldol 5mg	IM
Individual #137	5/20/12	13:10 hrs	Zyprexa 10mg	(Not specified)
Individual #120	5/25/12	20:50 hrs	Thorazine 5mg	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" which precipitated this behavior for four of these individuals: Individual #231, Individual #163, Individual #304, and Individual #120. The corresponding documentation for Individual #137 adequately described the antecedent events. Thus, the documentation was completed correctly for only one of the five individuals (20%). However, subsequent documentation in the post-restraint debriefing section of the report contained an adequate description of the antecedent events for all of these individuals. This finding is consistent with the interview with the Director of Behavioral Services that occurred during the course of the onsite review. Specifically, he expressed concern that the direct support professionals would be able to adequately provide this information in the context of the restraint episode. Accordingly, the Psychologists had been asked to provide more information concerning the antecedent conditions that led to the restraint, in the post-restraint debriefing section of documentation. As indicated above, the review of this sample indicated that these descriptions adequately described the antecedent events.
2. The section that followed the prompt to describe: "Interventions attempted to avoid restraint" was also reviewed. This section had been completed for all five of these individuals (100%).
3. The portion of the documentation in which the physiological post-restraint monitoring was recorded was completed for three of the individuals in this sample (60%): Individual #231, Individual #163, and Individual #304. The exceptions were: Individual #137 and Individual #120, for whom there was either no (or very limited/inadequate) documentation of physiological monitoring.

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		4. The face-to-face post-restraint debriefing was not present in the documentation for Individual #120, but was completed for the following four individuals: Individual #231, Individual #163, and Individual #304, and Individual #137 (80%). 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 present in the documentation for only the following three individuals: Individual #120, Individual #137, and Individual #304 (60%). It was not present for Individual #231 and Individual #163. 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 two days for three of the individuals (60%): Individual #304, Individual #137, and Individual #231. The interval for individual #163 was five days, and for Individual #120, the interval before the Pharm.D review was five days, and it was over one week before the Psychiatry Review occurred. Thus, although this information was completed for all five individuals, there was a delay in the completion of the documentation for two individuals. Accordingly, these essential elements of the documentation needed to verify the appropriate utilization of the involuntary administration of chemical restraint was fully completed for only one of the five individuals in this sample (20%): Individual #304. Thus, it was not possible to definitively reach the conclusion that chemical restraint was not being used for punishment at ABSSLC, and/or for the convenience of staff in responding to a difficult situation. However, it should also be noted that there was no definitive information that would indicate that psychotropic medication was being utilized as a punishment or for the convenience of staff. As noted above, the chemical restraint documentation was deficient, and without this, it was impossible to conclude that chemical restraint was not being inappropriately used for punishment or, in some cases, for the convenience of staff. The timely review of the chemical restraint documentation by the both the psychiatrist and the clinical pharmacist are crucial to determining both the safety and appropriateness of the intervention. In addition, problems continued to exist with regard to PBSPs and their implementation, as well as the existence of clinically justifiable psychiatric diagnoses. Thus, the overall rating for this provision was that of noncompliance.	
J4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, if pre-treatment	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. The Dental Services Department had been maintaining data on the frequency with which	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	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 2012	Total # Appoint-ments	% No Sedation Required	# Oral Pre-Treatment Sedation Required	% Oral Pre-Treatment Sedation Required	# General Anesthesia Utilized	% General Anesthesia Utilized
January	294	98%	2	0.68%	4	1.36%
February	324	97.5%	4	1.23%	4	1.23%
March	203	95.5%	6	2.96%	3	1.48%
April	264	98.4%	3	1.14%	1	0.38%
May	282	98.2%	4	1.42%	1	0.35%
June	259	99.2%	1	0.39%	1	0.39%

The review of the Facility Restraint and Dental Pre-Treatment Sedation Log, dated 8/20/12, indicated that during the time period between January and June 2012, the orders were primarily for Halcion 0.5 mg. The other medications that were used were Ativan, Chloral Hydrate, and Valium. During the Monitoring Team's previous reviews, 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 data contained in the aforementioned log was consistent with this description, as the dosages appeared to be appropriate. The Consultant who actually administered the anesthesia performed the general anesthesia monitoring, which was very detailed.

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 in the Monitoring Team's previous report, the Facility had devoted a great deal of attention to minimizing and monitoring the use of pre-treatment sedation for dental

#	Provision	Assessment of Status	Compliance
		procedures. However, the documentation that detailed the utilization of pre-treatment sedation for medical procedures from 2/1/12 to 5/31/12 indicated that the majority of pre-treatment sedation at ABSSLC was utilized for medical appointments. The number of oral pre-treatment sedations for dental procedures during this time period was 17. The corresponding frequency of pre-treatment sedation for medical procedures during this time period was 51. The status of the 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 there was an initiative to develop Desensitization Plans for medical appointments for selected situations, but there was no organized Facility-wide initiative similar to that for dental procedures. Obviously, the situations that required pre-treatment sedation for medical procedures were much more diverse than the specific nature of a dental appointment. Nevertheless, the discrepancy between the frequency of the utilization of pre-treatment sedation for medical and dental procedures suggested that the issue of pre-treatment sedation for medical procedures required more attention. The ABSSLC Desensitization Tracking Worksheet indicated that as of 7/30/12, 49 individuals had been evaluated, and there were 36 "formal written plans" as well as "several written strategies." These numbers and descriptors have been reproduced, as written at the top of the spreadsheet, which was complicated and difficult for an external reviewer to fully comprehend. However, it did appear to be useful to those within the Facility who were monitoring the progress of this initiative. The quality of these plans is discussed in further detail with regard to Section C.4. The Facility should address the assessment of the need for, as well as the development of Pre-Treatment Sedation Desensitization Plans for medical procedures in the near future. Thus, although the Facility had put a great deal of effort into the development of Pre-Treatment Sedation Plans, only 49 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 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	At the time of the August 2012 onsite review, 190 individuals were receiving psychotropic medication at ABSSLC, and this number continued to decline. For example, the Monitoring Team previously reported the following: **NUMBER OF**	Noncompliance

#	Provision	Assessment of Status	Compliance
	board eligible psychiatrists to ensure the provision of services necessary for implementation of this section of the Agreement.	**INDIVIDUALS** **DATE** 199 February 2012 219 August 2011 222 February 2011 225 August 2010 The Psychiatry Department currently had one full-time Psychiatrist. At the time of the Monitoring Team's previous review, the Chief Psychiatrist had performed an analysis of the time allocation that would be required to meet all of the requirements specified in the Settlement Agreement, and determined that three full-time Psychiatrists would be required. The current part-time Consulting Psychiatrist essentially worked full-time (i.e., four 10-hour days) for two weeks each month. Thus, this equated to one half-time Staff Psychiatrist. 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. At the time of the Monitoring Team's previous review, the Facility was found to be in substantial compliance with this provision of the Settlement Agreement based on the finding that the Facility had employed a sufficient number (three) of skilled Psychiatrists to provide the appropriate clinical services to the individuals at ABSSLC. At the time of the most recent review, the number of full-time Psychiatrists was currently 1.5. The Facility recently had added a full-time Nurse Practitioner (with prescribing privileges), who will function under a supervisory relationship with the Chief Psychiatrist. However, that individual had only recently received the necessary licensure, and was just beginning his work in this capacity (as discussed with regard to Section J.1). Thus, the finding of substantial compliance could not be carried forward due to the less than adequate number of full-time equivalent Psychiatrists to meet the requirements of the Settlement Agreement. ABSSLC was aware of this deficit, and was working to recruit the necessary number of Psychiatrists to comply with this provision of the Settlement Agreement. During the course of the onsite review, a member of the Monitoring Team suggested that the Facility consider undertaking a more detailed analysis of the time requirements that would be required to fulfill the requirements of the Settlement Agreement, which should also take into account the contributions of the Psychiatry Support Staff and the newly added Nurse Practitioner.	
J6	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement	As indicated above, ABSSLC 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 28 individuals (15% of the 190 individuals receiving	Noncompliance

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	procedures for psychiatric assessment, diagnosis, and case formulation, consistent with current, generally accepted professional standards of care, as described in Appendix B.	psychotropic medication) identified a CPE that had been completed within the prior year and met the criteria set forth in the Settlement Agreement for 20 of the 28 individuals in the sample (71%). The individual records that contained this documentation were those of: Individual #540, Individual #320, Individual #168, Individual #461, Individual #460, Individual #4, Individual #462, Individual #355, Individual #190, Individual #94, Individual #103, Individual #388, Individual #151, Individual #455, Individual #464, Individual #97, Individual #395, Individual #369, Individual #439, and Individual #534. The record of Individual #126 contained a CPE that had been completed within the past year, but did not meet the standards of the Settlement Agreement, in that several sections specified in Appendix B were missing. The record of Individual #465 contained a CPE that met the standards, but it was dated 3/14/11 and, thus, would need to be updated. The records of the following individuals contained a CPE that was both out-of-date, and did not meet the requirements of the Settlement Agreement: Individual #120, Individual #392, Individual #163, Individual #274, Individual #518, and Individual #373. As noted these CPEs had been completed over one year ago and were also missing sections of the document that are specified in the Settlement Agreement. In addition, the very important Bio-Psycho-Social-Spiritual Formulation contained in these documents was either missing or rudimentary in nature. The more recently completed CPEs were of a much higher quality. The Facility's internal compilation of individuals with completed CPEs indicated that, to date, these documents had been completed for 153 individuals (81%) of the 190 individuals prescribed psychotropic medication. However, a tabulation of the number of CPEs that had been completed and updated within the last 12 months indicated that 127 (67%) of the 190 individuals receiving psychotropic medication had been completed or updated during this timeframe. The Facility's current plan was to update the CPEs in conjunction with the individuals' annual ISPs reviews. The Facility remained out of compliance with this provision of the Settlement Agreement due to the fact that these evaluations had not been completed for a substantial enough number of the individuals prescribed psychotropic medication, and that some of the evaluations that had been completed did not meet the standards of the Settlement Agreement.	
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	A spreadsheet produced in conjunction with this review listed the individuals who had been administered the Reiss Screen for Maladaptive Behavior. 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.	Noncompliance

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	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.	The current review focused on those individuals for whom the Reiss Screen had been administered since, or shortly before, the Monitoring Team's previous review. The individuals who had been administered the Reiss Screening instrument within the timeframe described above were as follows: <u>Individual #126</u>: Reiss Screen administered 5/11/12 (Total Reiss Score = 5) Outcome: This score was below the clinical cut-off score of nine, which would have prompted a CPE. However, a CPE was performed on 6/11/12, because the IDT continued to have concerns about "persistent threatening behavior," which had been increasing in frequency and severity. As a result of this evaluation, the individual was begun on a low dosage of psychotropic medication and was scheduled for follow-up in the Psychiatry Clinic. However, the CPE did not meet the standards of the Settlement Agreement, because it omitted several of the required sections specified in Appendix B of the Settlement Agreement. <u>Individual #187</u>: Reiss Screen administered 5/7/12 (Total Reiss Score = 4) Outcome: The Reiss Screen was administered due to concerns about a change in the individual's behavioral status. The Reiss Score was below the clinical cut-off score of nine and there were no extenuating circumstances that would have precipitated a CPE, and, thus, he was not referred for a CPE. <u>Individual #80</u>: Reiss Screen administered 5/1/12 (Total Reiss Score = 2.5) Outcome: The Reiss Screen was administered due to a concern about the individual's behavioral status. The Total Reiss Score was well below the clinical cut-off score, and a CPE was not performed. <u>Individual #476</u>: Reiss Screen administered 5/1/12 (Total Reiss Score = 11) Outcome: This individual's score was above the clinical cut-off score of nine, and the Reiss Screen report stated that: "this individual exhibits behaviors that may include a need for mental health supports. Please arrange for professional evaluations to better determine this individual's needs." During the onsite review, a request was submitted for the name of any individuals who had undergone a CPE as a result of an elevated Reiss Score, as well as a copy of the actual CPE. This request only yielded the documentation for Individual #126, as noted above. A CPE for Individual #476 was not produced. <u>Individual #124</u>: Reiss Screen administered 3/8/12 (Total Reiss Score = 1.5)	

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		Outcome: The Reiss Screen was administered due to an unspecified change in status. The Total Reiss Score was below the clinical cut-off score that would have precipitated a CPE. <u>Individual #142</u>: Reiss Screen administered 2/17/12 (Total Reiss Score = 12) Outcome: The Reiss Screen was administered following this individual's admission to ABSSLC. The total score was above the clinical cut-off score. The Psychiatry Team indicated that a CPE was not performed, because the individual's guardian did not consent to further psychiatric assessment or treatment, and the IDT did not feel that the individual's psychiatric presentation was of sufficient magnitude to challenge the guardian's opinion in court. For the last review, the Facility was found to be in substantial compliance with this provision. However, the due to a decline in the Facility's performance, the finding of substantial compliance could not be carried forward for this review. More specifically: ▪ The CPE that was performed for Individual #126 did not meet the criteria specified in the Settlement Agreement; ▪ A CPE was not performed for Individual #476, despite a Total Reiss Score of 11, which was above the clinical cut-off score of nine, nor was there an explanation as to why a CPE was not performed. A CPE also was not performed for Individual #142, who had a Reiss Score of 12, which was also above the clinical cut-off score of nine, but the rationale for not pursuing a CPE was clarified. Specifically, the Psychiatric team had explained the results of the screen to the guardian, who still maintained that psychiatric intervention was not to be utilized. The team did not feel that the seriousness of the situation was sufficient to seek court intervention to attempt to overturn the guardian's position. ▪ In addition, the change in status that precipitated the administration of the Reiss Screen for the other individuals was not identified. The Facility should develop a mechanism to record the nature of the change in status that precipitated the decision to pursue a Reiss Screen, as well as any pertinent follow-up if the Reiss Score was above the clinical cut-off score. As stipulated in this provision of the Settlement Agreement, a Reiss Score above nine should precipitate a CPE that meets the criteria specified in the Settlement Agreement, or there should be a plausible explanation as to why a CPE was not performed for the individual.	
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	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 two 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.	Noncompliance

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	pharmacological treatments with behavioral and other interventions through combined assessment and case formulation.	The observations of the Psychiatry Clinics and the related documents that were produced illustrated the active collaboration between the two disciplines. A prior 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, provided 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. However, in summary, improvements were seen in this area. Section J.8 also contains the terminology "integrate pharmacological treatments with behavioral and other interventions through combined assessments and case formulation." The primary setting during which the active collaboration between the Psychiatry and Psychology Departments was the most visible occurred within the context of the Psychiatry Clinics. The subject of the collaboration between Psychiatry and Psychology also is discussed with regard to Section J.9. The primary disciplines that attended the Psychiatry Clinics were nursing, psychiatry, psychology, direct support professionals, and the Qualified Developmental Disabilities Professionals. The Psychologist played an active role in this process, and it was clear that the Psychiatrist and other members of the IDT relied heavily upon the Behavioral Data and other information the Psychologist provided. Other disciplines, such as Occupational Therapy and Physical Therapy were, of course, not able to attend the Psychiatry Clinics, because there were several every week. However, these disciplines often attended the individual ISP meetings. At the time of the prior review, the full-time Psychiatrists at ABSSLC had considered attending the ISP meetings to the extent possible in the future. The attendance at these meetings, as well as the content, was reviewed for the 28 individuals in this sample. This review indicated that a member of the Psychiatry Department had attended a recent individual ISP meeting for four of the 28 individuals (14%). The specific records that contained this documentation were those of: Individual #439, Individual #97, Individual #460, and Individual #190. Although the Psychiatry Department recently had begun an initiative to attend the individual ISP meetings, the documentation from the ISP section of these four records did not fully reflect the psychiatric aspects individuals' treatment, nor did the documentation contained in the other 24 records in this sample. The ISPs reflected some discussion of the Psychology 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' contributions to the	

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		meetings, and also contains a reference to the primary components of the psychiatric medication treatment plan. The Facility remained out of compliance with this provision. Although the Psychiatry Department had begun an initiative 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 treatments were not yet integrated into ISP documents.	
J9	Commencing within six months of the Effective Date hereof and with full implementation within two years, before a proposed PBSP for individuals receiving psychiatric care and services is implemented, the IDT, including the psychiatrist, shall determine the least intrusive and most positive interventions to treat the behavioral or psychiatric condition, and whether the individual will best be served primarily through behavioral, pharmacology, or other interventions, in combination or alone. If it is concluded that the individual is best served through use of psychotropic medication, the ISP must also specify non-pharmacological treatment, interventions, or supports to address signs and symptoms in order to minimize the need for psychotropic medication to the degree possible.	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 in the documentation that was found in the sample of 28 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, which had been identified in Monitoring Team's previous reports, 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 Psychological Behavioral Treatment Plans were developed through parallel processes that were not fully integrated. ABSSLC had been developing systemic approaches to rectify these deficits. These were integrated into the Quarterly Review documentation, as well as the PPMTP, which essentially functioned as a Treatment Plan for the individual's psychotropic medication. The latter document was created when the consent process and HRC review of the psychiatric medications was separated from the PBSP last year. The issue of the differentiation of the behaviors that were related to the psychiatric diagnosis, as opposed to being related to a purely behavioral etiology, as well as the discussion of those behaviors that are co-determined, was now reviewed in a distinct section of the psychiatric quarterly documentation. This section provided a checklist to indicate if no overlap existed between the behavioral and biological factors, or if the behavior was co-determined. There was also a narrative section in which the Psychiatrist described the basis for this decision. This issue was also discussed in the PPMTP. This document was to be completed when a new individual was admitted to the Facility or an individual began receiving psychiatric services, and then annually, in conjunction with the individual's ISP. The Psychotropic Medication	Noncompliance

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		Initiation form (PMI) served as an addendum to the PPMTP when a new medication was started for an individual already in psychiatric services, unless the initiation of the new medication coincided with the annual treatment planning. The first page of the PPMTP contained a listing of the symptoms of the primary Axis I psychiatric disorders grouped into seven categories, which parallel the major Axis I psychiatric disorders. The identification of the primary symptoms of the individual's psychiatric disorder provided a major contribution to the differentiation of learned behaviors from those that were derived from the individual's psychiatric disorder. The third page of this document contained a distinct narrative section entitled: "Discussion of the behavioral support plan and proposed least restrictive interventions," which was followed by another narrative section that prompted a specific discussion of the differentiation of psychiatric symptoms from learned behaviors. The review of 28 records contained in this sample (with the exception of that of Individual #126, which was missing documentation) showed that these areas were completed in all of the documents reviewed, in a timely manner that was responsive to the prompts. The Psychology documentation did not contain a discrete section that discussed this issue, but the language of the PBSPs had been modified so that there were references to the contributions of the psychiatric disorders to the individual's maladaptive behaviors, which differentiated them from those that were primarily due to environmental or behavioral factors. The interaction of the biological and behavioral-based aspects of the individual's presentation also was discussed in the Bio-Psycho-Social-Spiritual formulation section of the CPEs. That information primarily summarized the material that was contained in the aforementioned documents, which were the primary source for these determinations. Thus, although the presence of a CPE enhanced these points, it was not essential to the process. The observation of the Psychiatry Clinics during the current and prior onsite review indicated that the discussions upon which the documentation in the Psychiatry Quarterly Reviews and PPMTP were based, occurred in the context of the individual Psychiatry Clinics and represented contributions from all of the disciplines that were present, including the direct support professionals. The review of the sample of the records of 28 individuals receiving psychotropic medication identified 26 individuals (93%) for whom there was an adequate differentiation of the behaviors that were primarily related to the psychiatric diagnosis, or were co-determined by both. This included those for: Individual #461, Individual #534, Individual #168, Individual #465, Individual #190, Individual #4, Individual #373, Individual #540, Individual #320, Individual #462, Individual #274, Individual #355, Individual #460, Individual #94, Individual #120, Individual #103, Individual #97, Individual #369, Individual #395, Individual #392, Individual #439, Individual $455, Individual #464, Individual #388, Individual #151, and Individual #163. This represented a significant improvement over the 40 percent (13 of 30) reported in the Monitoring Team's previous report.	

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		The individuals' records that were identified as containing a dual reference to maladaptive behaviors were those of: Individual #518 and Individual #126. The psychiatric section of the record for Individual #126 was not present and, thus, was scored as not containing this information. The differentiation of the maladaptive behaviors that the individual presented with is directly related to the concluding comment in this provision, which addressed "the need to minimize the need for psychotropic medication to the degree possible." The appropriate differentiation of behaviors greatly decreased the risk that the individual would be prescribed psychotropic medication that was not necessary, and also increased the likelihood that they would receive the behavioral supports that were appropriate to address the problem. The contributions of this process to the determination of the least intrusive interventions are obvious. However, this issue is also discussed in more detail in Section J.10. The Chief Psychiatrist also recently 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 maladaptive behaviors. These newly formatted Quarterly Review documents only recently had been incorporated into the records of the individuals prescribed psychotropic medication and, thus, the addition of this information was not fully reflected in this review. As noted above with regard to Section J.8, the ISP documentation was not adequate to show that teams had conducted the necessary review, and made the decisions that this provision of the Settlement Agreement requires. Specifically, teams should determine: ▪ The least intrusive and most positive interventions to treat the behavioral or psychiatric condition; ▪ Whether the individual will best be served primarily through behavioral, pharmacology, or other interventions, in combination or alone; and ▪ If the team determines the use of psychotropic medication is necessary, 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. Accordingly, the Facility was found to be in noncompliance with this provision. However, the progress of the Psychiatry Department in addressing these issues through the methods described above was significant.	
J10	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, before the non-	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 initial reviews indicated that the discussion of these factors primarily occurred in the HRC section of the record, as well as the PBSP. These	Noncompliance

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	emergency administration of psychotropic medication, the IDT, including the psychiatrist, primary care physician, and nurse, shall determine whether the harmful effects of the individual's mental illness outweigh the possible harmful effects of psychotropic medication and whether reasonable alternative treatment strategies are likely to be less effective or potentially more dangerous than the medications.	reviews also 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. The Facility had responded to the recommendations related to these observations by developing a new system for documenting the risk versus benefit considerations. The Facility's system appeared to have been derived from 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. At the time of the Monitoring Team's previous review, this revised process had just been implemented, and the IDTs were experiencing some problems with the implementation of this complex system. The observations of the Psychiatry Clinics, HRC Meeting, and interview with the Chief Psychiatrist during the current review indicated that the process had been fully integrated into the clinical review process and was operating more efficiently. The current review found an adequate discussion of the risk versus benefit analysis in 23 of the 28 individual records in the sample (82%). The records that contained an adequate risk versus benefit analysis were those for: Individual #190, Individual #4, Individual #462, Individual #518, Individual #460, Individual #168, Individual #534, Individual #320, Individual #461, Individual #540, Individual #465, Individual #373, Individual #392, Individual #439, Individual #369, Individual #395, Individual #97, Individual #464, Individual #151, Individual #120, Individual #163, Individual #103, and Individual #94. The records that did not contain an adequate discussion were those of the following individuals: Individual #126, Individual #455, Individual #388, Individual #274, and Individual #355. These individuals were all receiving multiple psychotropic medications, which greatly complicated the risk versus benefit ratio from a purely mathematical standpoint as well as clinically. It becomes much more difficult to determine the efficacy for an individual medication when multiple medications are prescribed, which also usually results in more dosage changes to account for. In addition, the side effect risk was increased because of the increased possibility of drug interactions. Supporting documentation for these decisions was contained in the newly expanded Quarterly Psychiatric Review, as well as the PPMTP. The Quarterly Psychiatry Review form contained specific sections related to: ▪ The evidence that the prescribed medication was effective; ▪ The current side effect profile, as indicated by a review of the MOSES/DISCUS findings;	

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		▪ A checklist of commonly experienced side effects, including a space for "other" and a global rating of severity; ▪ Another sub-section that provided a framework for rating the realized and potential side effects on a scale from low to high; ▪ A similar scale for rating the severity of the psychiatric symptoms and derivative behaviors; ▪ A scale for determining the efficacy of the psychotropic medication(s) along a continuum that ranged from "no, or little response" to "very good response," and also included "undetermined." This scale also included general definitions of these categories; ▪ A grid on which the Treatment Team could record the answers for each medication after their discussion; and ▪ A concluding section, which prompted a narrative discussion of the above considerations with the heading of "Team Discussion/Deliberation of Psychotropic Medication(s) as a restrictive intervention." Observations of the Psychiatry Clinics during the onsite review indicated there was an active discussion of these issues during the Quarterly Review, in which many of the IDT members participated, including the direct support professionals. The Psychiatrist then recorded the results of these deliberations. The discussions between the Psychiatry teams and members of the HRC during the Monitoring Team's previous review revealed that there was some confusion regarding the implementation of the new risk versus benefit analysis system. This confusion was not observed during the HRC Meeting on 8/22/12. This improvement appeared to be due both to the HRC Committee members' increased familiarity with the material, and the periodic attendance of the Chief Psychiatrist at the meeting. The Chief Psychiatrist attended the 8/22/12 meeting. This matter was also discussed with the Chief Psychiatrist during the onsite review. The Facility's Self-Assessment, dated 8/8/12, indicated that their internal review of 24 randomly selected individual records (12.6 percent of those receiving psychotropic medication for the third quarter) identified 78 percent compliance with regard to documenting the overall risk versus benefit determination, and 62 percent for an adequate discussion of less intrusive alternate interventions. Particular attention to these issues was noticed in each of the Psychiatry Clinics observed during the onsite review. The finding of noncompliance for this provision was related to the finding of adequate documentation in 82 percent of the sample of individual records, which is remarkably similar to the 78 percent rate described in the Facility's Self-Assessment for an overlapping time period. As noted above, significant progress had occurred in refining and improving the risk versus benefit assessment process.	

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<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td>J11</td><td>Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall develop and implement a Facility- level review system to monitor at least monthly the prescriptions of two or more psychotropic medications from the same general class (e.g., two antipsychotics) to the same individual, and the prescription of three or more psychotropic medications, regardless of class, to the same individual, to ensure that the use of such medications is clinically justified, and that medications that are not clinically justified are eliminated.</td><td>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 prior six months. The Chief Psychiatrist, Consulting Psychiatrist, Director of Pharmacy Services, Director of Behavioral Services, Clinical Pharm. D., Psychiatric Specialty Nurse, and the Medical Director attended these meetings, which were facilitated by the Pharm.D. 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. On 8/21/12, a member of the Monitoring Team observed the August meeting of this Committee. In addition to the individuals described above, the newly employed Psychiatry Nurse Practitioner at the Facility also attended the meeting.

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 8/21/12 meeting provided a summary of the Facility’s progress toward minimizing polypharmacy as of that date. The total number of individuals who met the criteria for polypharmacy was 45 (24%) of the 190 individuals receiving psychotropic medication.

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 that 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>11</td></tr>
<tr><td>Number of individuals receiving three or more medications regardless of class or indication</td><td>108</td><td>42</td></tr>
<tr><td>Total number of individuals on polypharmacy</td><td>108</td><td>45*</td></tr>
<tr><td>Total number of individuals receiving psychotropic medication</td><td>224</td><td>190</td></tr>
<tr><td>Percentage of individuals receiving psychotropic medication whose medication regimen met the criteria for polypharmacy</td><td>48%</td><td>24%</td></tr>
</table>
*This number is less than the sum of the preceding two numbers due to individuals who are receiving three or more psychotropic medications and two medications from the same class. Individuals that met both of these criteria for polypharmacy were only counted once.

This section of the Settlement Agreement also stated that it is necessary “to ensure that the</td><td>Noncompliance</td></tr>
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		use of such medications is clinically justified, and that medications that are not clinically justified are eliminated." Thus, this section also relates to the documentation that all prescribed medications could be empirically demonstrated to be effective. During the 8/21/12 Polypharmacy Committee Meeting, the discussions of the individuals whose psychotropic medication regimens continued to meet the criteria for polypharmacy indicated that the psychiatric team believed that many of these medications were essential for the individuals' stability. The Facility had begun to make a distinction between those individuals for whom the efficacy of all of the medications had not yet been determined, and/or they were not clinically stable. Thus, changes in their psychotropic medication were occurring (active polypharmacy = AP), as opposed to those who were thought to require their current medications to maintain their continued stability (stable polypharmacy = SP). At the time of the Monitoring Team's previous review, the total number of individuals who the Facility placed in the AP classification was 40, as compared to 11 in the stable polypharmacy group. As of the conclusion of the 8/21/12 Polypharmacy Meeting, the number of individuals in the AP category was 26, while 19 were classified as SP. Thus, the Facility felt that there was adequate information to support the efficacy of the existing medication for 19 of the 45 individuals (42%) who were prescribed medication regimens that met the criteria for polypharmacy. For the remaining 58%, they were still in the process of either actively adjusting the individual's medication or assembling the necessary historical data to support the medication's efficacy. During the onsite review, there was an extensive discussion between a member of the Monitoring Team and the members of the Polypharmacy Committee regarding the type of evidence that would generally be required to substantiate efficacy. ABSSLC 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. 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 Facility was continuing to organize historical data to support the efficacy of the psychotropic medications for those individuals in the SP group, and continued to actively challenge the medications for the individual in the AP group. The current finding of noncompliance for this provision primarily related to the continued number of individuals who received multiple psychotropic medications whose efficacy had not yet 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. During the onsite review, a member of the Monitoring Team suggested the Psychiatry Team consider developing tapering strategies for the medications prescribed to the individuals in the AP group that had not already been empirically determined to be effective. These tapering schedules would only apply to those medications that the Facility	

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		was optimistic could be removed and were not considered essential.	
J12	Within six months of the Effective Date hereof, each Facility shall develop and implement a system, using standard assessment tools such as MOSES and DISCUS, for monitoring, detecting, reporting, and responding to side effects of psychotropic medication, based on the individual's current status and/or changing needs, but at least quarterly.	This provision of the Settlement Agreement mandated 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 MOSES every six months. The Facility actually performed the MOSES every three months, in conjunction with the DISCUS. This was not due to a specific policy, but rather, represented an internal mechanism that linked the performance of both evaluations to a quarterly schedule. This was, in turn, aligned with the Quarterly Review of the individual in the Psychiatry Clinic. An additional component of this process was also the latency between the time that the nurse completed the exam, and the documentation was reviewed and signed by the prescribing physician. The review of the sample of the records of 28 individuals prescribed psychotropic medication showed the documentation the MOSES evaluation was current (completed within the last three months) and had been performed at least every three months for the prior year, was present for all, with the exception of Individual #355, for whom there was a gap of greater than three months between the 5/2/11 and 10/6/11 evaluation. However, this interval was still within the six-month parameter (by one month) specified in the Settlement Agreement. Thus, timely documentation could be identified for 28 of the 28 individuals (100%). The records of 23 of the 28 individuals (82%) contained documentation that the prescribing physician had reviewed the MOSES evaluation in a timely manner, which had been defined as ten days prior to this review, but was now calculated based on 14 calendar days. Those individuals whose MOSES documentation was not reviewed in a timely manner (latency between dates) were those of: Individual #540 (5/1/12 – 5/23/12); Individual #168 (12/2/11 – 12/20/11); Individual #355 (10/6/11 – 10/24/11); Individual #97 (4/30/12 – 5/23/12); and Individual #151 (5/1/12 – 5/23/12). Thus, the evaluations of 23 individuals had been reviewed in a timely manner, resulting in the overall completion rate of 82 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 28 individuals indicated that the Facility carried out quarterly evaluations with the DISCUS of all individuals receiving psychotropic medications, regardless of whether or not one of these medications was an antipsychotic agent. This was similar to the findings of the Monitoring Team's previous review, which indicated that the Facility's practice was to perform the DISCUS for all individuals who received psychotropic medication. The January 2012 guidelines from the Executive Formulary Committee, which addressed this issue, only specified that the DISCUS be used to monitor for the side effects of the antipsychotic agents and Reglan. Thus, the rationale was similar to that related to the quarterly evaluations with the MOSES and was not	Noncompliance

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		mandated by an internal policy, but rather reflected an internal mechanism to routinely administer these evaluations to ensure completion for all of those requiring them. In regard to the DISCUS, it also provided a baseline of evaluations if an individual should be started on antipsychotic medication in the future. Documentation that the DISCUS was current, and had been performed quarterly for the past year was identified for all but the following individuals: Individual #168 (most recent evaluation 3/23/12), and Individual #518 (interval of greater than 90 days between 12/12/11 and 6/1/12). Thus, the DISCUS had been performed as specified for 26 of the 28 individuals (93%) that the Facility included in their protocol for monitoring with the DISCUS, which set a higher standard than that required by the Settlement Agreement. 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 prescribing physician reviewed it. Those seven individuals whose records indicated that there was a significant delay between the date the Nurse completed the DISCUS evaluation, and the prescribing physician reviewed and signed it (latency before review), were as follows: Individual #51 (5/1/12 – 5/23/12), Individual #97 (4/30/12 - 5/23/12), Individual #465 (2/16/12 – 3/6/12), and Individual #540 (5/1/12 – 5/23/12. Thus, the prescribing physician reviewed the DISCUS in a timely manner for 24 of the 28 individuals (86%). 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 similar to those of antipsychotic agents. A list was obtained from the Pharmacy of all individuals receiving 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. There were a total of 19 individuals receiving Reglan, only two of which were also prescribed psychotropic medication. The following sample of five individuals (29% of the 17 individuals who fit the above criteria) was selected: Individual #226, Individual #333, Individual #458, Individual #265, and Individual #53. Review of the records of these individuals related to the MOSES indicated the examination had been performed quarterly for all five individuals (100%). The evaluations also were reviewed with regard to the elapsed time between when the nurse completed the evaluation and the PCP reviewed it. This analysis indicated that the review by the prescriber had been completed in a timely manner for all five individuals (100%). With regard to the completion of the DISCUS for the individuals in the sample, these evaluations were completed as specified for four of the five individuals (80 %): Individual #333, Individual #458, Individual #265, and Individual #53. Once completed, the	

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		prescribing practitioner had reviewed the DISCUS evaluations in a timely manner for all five individuals in the sample (100%). During the Monitoring Team's prior reviews, the subject of the latency between the completion of the MOSES and DISCUS and the date the prescribing physician reviewed and signed them had been discussed with the Psychiatry Department, because there had been considerable deficiencies. ABSSLC had responded to this problem with interventions that have considerably improved the results. The coordination of the timing of the quarterly MOSES/DISCUS evaluations with the Quarterly Psychiatry Reviews appeared to have been a key intervention. During the Psychiatry Clinics observed during the onsite review, the Unit Nurse that performed these evaluations brought the newly completed reviews to the prescribing Psychiatrist for their review, and the results were discussed. During the 8/21/12 Psychiatry Clinic, a member of the Monitoring Team discussed this process with the Nurse who had completed the MOSES and DISCUS evaluations. She indicated that linking of the evaluations to the Quarterly Psychiatry Reviews had been helpful, because she had to prepare other documentation for these reviews, and this served as a prompt to also complete these evaluations. The scheduling of these evaluations, in conjunction with these meetings, also facilitated the timely review with the Psychiatrist at the time of the meeting. During this discussion, the nurse also was asked about the training the nurses received related to the administration of the DISCUS. Her response was that the training was thorough and included an instructional video, as well as a post-test related to that video. Following this meeting, a request was made for documents related to this training, and the Psychiatry Department provided an example of materials used in these trainings, but did not produce attendance logs, or dates of trainings. In the future, ABSSLC should maintain a log of these activities. The timely review of the MOSES and DISCUS evaluations was also the subject of a detailed internal audit the Clinical Pharmacist conducted. Specifically, this audit entailed the review of every MOSES and DISCUS evaluation performed at ABSSLC from December 2011 through mid-August 2012. The spreadsheet that reported this data provided monthly results and quarterly summaries. The results of the quarterly summaries from March through May of 2012 were as follows: 12/11 through 2/12 293/374 (78%) 3/12 through 5/12 381/512 (74%) 6/12 through 8/12 481/529 (91%) This data was consistent with the results of this review in terms of both the significant improvement and the current status.	

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		Because the Facility had expressed confusion as to whether the ten-day requirement referred to ten business days or ten calendar days, which would be complicated by weekends and holidays, the Monitoring Team discussed the definition of what constitutes a "timely review" of the MOSES and DISCUS evaluations by the prescribing physician. The consensus decision was to utilize a standard of 14 calendar days, because this would greatly simplify the process and be flexible enough to allow for weekends and holidays. This was communicated to both the Psychiatry Department and the Clinical Pharmacist. ABSSLC had made significant process in both the completion of the MOSES and DISCUS evaluations on schedule, and the timely review by the prescribing practitioner. The Facility remained out of compliance with this provision. Some problems continued to be noted with the timeliness of the prescribing practitioners' timely review. As both the Monitoring Team's review and the Facility's Clinical Pharmacist internal review indicated the full effect of the positive changes that the Facility has implemented had only been fully realized in recent months. Hopefully, the full effects will be firmly in place at the time of the Monitoring Team's next review.	
J13	Commencing within six months of the Effective Date hereof and with full implementation in 18 months, for every individual receiving psychotropic medication as part of an ISP, the IDT, including the psychiatrist, shall ensure that the treatment plan for the psychotropic medication identifies a clinically justifiable diagnosis or a specific behavioral-pharmacological hypothesis; the expected timeline for the therapeutic effects of the medication to occur; the objective psychiatric symptoms or behavioral characteristics that will be monitored to assess the treatment's efficacy, by whom, when, and how this monitoring will occur, and shall provide	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 related to the integrity of the psychiatric diagnosis is 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 28 individuals (15%) of the 190 individuals receiving psychotropic medication indicated that adequate documentation that would support the psychiatric diagnosis of record could be identified for 20 individuals (71%). This subject is discussed in more detail in Sections J.2 and J.6. The criteria for this Section also addressed the need to identify "the objective psychiatric symptoms or behavioral characteristics that will be monitored to assess the treatment's efficacy." These "symptoms or behavioral characteristics" were referred to in 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 ABSSLC records had been 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. There had been significant improvement in this area, which was discussed in detail with regard to Section J.9. The objective symptoms of the psychiatric disorder and the related behavioral characteristics were detailed in each of the Quarterly Psychiatric Review notes that were contained in this sample, as well as those that were observed during the course of the onsite review. The Psychologist led this aspect of the discussion during the meeting, but there was active input from all of the professional	Noncompliance

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	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.	disciplines that were present. The Psychologist was ultimately responsible for assembling the objective behavioral data and ensuring the integrity of that information. The composition of the members of the psychiatric treatment team that routinely attended the quarterly psychiatric reviews is detailed with regard to Section J.8 of this report. The format of the meetings was not strictly formalized, but generally followed the outline of the four-page psychiatric quarterly review notes, which the Psychiatrist completed during the course of the meeting with input from the other team members. Thus, the discussion included a review of the individual's current status, as well as any potential changes in his/her medication based on the behavioral data presented by the Psychologist during the meeting. The risk-versus-benefit considerations were also the subject of an extensive discussion. Based on observations of the meetings, each individual review lasted for greater than 30 minutes, and there was ample time for additional discussion, if necessary. There was no sense of time pressure to complete the discussion, or pre-set allocation of time during which each review would have to be completed. The individual that was the subject of the review either attended the meeting or was seen by the Psychiatrist before the meeting. The related observations were documented in the mental status section of the quarterly review document, which consisted of both a checklist and an area for a narrative description of the individual's presentation. The Facility's policy was to review each individual on a quarterly basis. However, they also reviewed individuals more frequently if their status was unstable, and/or if there were changes in the individual's psychotropic medication that required more frequent reviews. This Section also addressed the question of the efficacy of the prescribed psychotropic medication. In 23 of the 28 records reviewed (82%), empirical evidence was found that the prescribed psychotropic medication had produced a significant diminution in the frequency of the monitored target behaviors. The five individuals for whom this evidence could not be found were: Individual #126, Individual #455, Individual #388, Individual #274, and Individual #355. The record for Individual #126 was missing the section of the record that contained the Psychiatric Quarterly Review Notes and, thus, was scored negatively. The other individuals tended to be receiving multiple psychotropic medications. The prescription of multiple psychotropic medications greatly complicated the determination of efficacy, primarily because of the mathematical difficulties in sorting out the effects of multiple medications, coupled with the changes in dosages of each of these medications. The final requirement of this provision is related to the frequency with which the Psychiatrist reviews individuals receiving psychotropic medication. The current review of the sample of the records indicated that Quarterly Reviews were performed as specified in this provision for 27 of the 28 individual records reviewed (96%). The single individual record that did not contain this information was that of Individual #126, for whom the psychiatric section of the record was missing. Documentation was also present to show that the Psychiatrist had	

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		directly observed the individual in conjunction with the Quarterly Review for 26 of the sample of 28 individuals (93%). The individuals whose records did not contain documentation of direct observation were those of Individual #163 (no observation noted in 3/8/12 review), and Individual #126. The Psychiatry Department had made progress in several of the factors that were specified in this Section of the Settlement Agreement. Much of this progress was related to the expanded Quarterly Review documentation for those individuals prescribed psychotropic medication, as discussed in detail with regard to Sections J.2 and J.10. The Facility remained in noncompliance with this provision. This is due to the lack of documentation necessary to demonstrate that the psychotropic medications had been effective. In addition, although significant improvement was noted in the justification of the psychiatric diagnosis, 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.	
J14	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall obtain informed consent or proper legal authorization (except in the case of an emergency) prior to administering psychotropic medications or other restrictive procedures. The terms of the consent shall include any limitations on the use of the medications or restrictive procedures and shall identify associated risks.	The review of the Rights/Consents sections of the medical records for the sample of 28 individuals indicated that 17 individuals (61%) had a Guardian of the Person. Those individuals without a guardian relied on the Facility Director to review the material concerning risk versus benefit considerations related to the utilization of psychotropic medication, and then provide the necessary consent. Review of the individual records indicated that consents for the use of psychotropic medications had been obtained in a timely manner for 26 of the 28 individuals in the sample (93%). The record of Individual #355 was missing the relevant section of the record. With regard to Individual #168, there was a letter to the guardian dated 2/2/12, indicating that the relevant side effect materials and other documents were being sent, but the signed consent (which would have been returned in response to this communication) could not be located. However, as discussed with regard to Section J.10, an adequate risk-versus-benefit documentation could only be identified in 82% of the 28 individuals contained in the review sample, which was a key component of informed consent. As indicated with regard to Section J.10 of the Settlement Agreement, the risk-benefit analysis contained in the Psychiatry section of the record demonstrated the Facility had implemented an initiative that significantly improved the risk versus benefit analysis as it related to the utilization of psychotropic medication. This system had now been fully implemented for several months, and this process had been extended to the Informed Consent process. The current process for obtaining consent for a new medication involved the Psychiatrist placing a call to the guardian during the Psychiatry Clinic, during which the decision to use	Noncompliance

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		the medication was made. Although no actual statistics were available for review, both Psychiatrists independently estimated that this initial call was successful in contacting the guardian, explaining the rationale for the medication as well as the risk versus benefit considerations, and then securing the verbal consent if the guardian approved, approximately two out of three times (66%). If the guardian could not be contacted directly with this telephone call, then a message was left and the guardian was asked to call the Psychiatrist and/or nurse on the individual's Unit. The QDDP also placed a call to the guardian after the meeting, not to pursue the consent, but rather to serve as a quality control check to make sure the guardian had all of their questions answered, and to relay and address any additional concerns the guardian might have had, but did not express to the medical team. The QDDP was the staff member on the IDT that usually had the most consistent ongoing contact with the guardian, and, thus, it was felt that a guardian might be more comfortable expressing any additional unspoken concerns to this member of the IDT. ABSSLC should develop a system to formally document who actually secured the initial verbal consent, including when the initial call was made, and when the verbal consent was actually received. Following the verbal consent, the approval process proceeded to the next HRC Meeting. Following their approval, the Medical Record Department would send out the detailed side effect information as well as an explanatory cover letter to obtain the final written consent. The Monitoring Team's previous report documented a discrepancy between the information the Facility indicated was supplied to the guardian, and the corresponding material that actually appeared in the consent section of the record. This was discussed with the Chief Psychiatrist again during this onsite review. During that meeting, he produced an impressive amount of detailed side effect information, which he indicated was routinely provided to the guardian as part of the consent process. This information was sent to the guardian, along with a cover letter, which provided an overview of the information that was enclosed. Thus, although the information found in the records was identical to that described in the Monitoring Team's previous reports (which consisted of a brief generic listing of both the most serious and most common side effects), the documents actually sent to the guardian included a comprehensive description of the potential side effects. The cover letter also made it clear that the Psychiatrist would be available to discuss this information with the guardian if he/she had any addition questions after reading the material. If the individual did not have a guardian, this information would be referred to the Facility Director, who would then provide the informed consent. In order for the record to be accurate, a full copy of what is sent to the guardian and/or Facility Director should be maintained in the record. On 8/22/12, members of the Monitoring Team attended the HRC Meeting. The discussions 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. The Monitoring Team's previous report described significant difficulties the	

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		Committee was experiencing in understanding and reviewing the risk versus benefit analysis that, at that time, had been newly developed. The Chief Psychiatrist had been periodically attending the HRC Meetings over the past six months and attended the meeting on 8/22/12. The observations of the Committee Meeting, and the review of the meeting minutes, indicated that the HRC was now much more proficient in understanding the risk versus benefit process. The HRC review of the psychotropic medication had previously been performed in conjunction with their approval of the PBSP. Following the Monitoring Team's last review, the process of reviewing the psychotropic medications separately from the PBSP had been fully implemented. 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. The finding of noncompliance for this provision of the Settlement Agreement was related to the observation that adequate risk-versus-benefit documentation could only be identified in 82% of the 28 individuals contained in the review sample, and the risk-versus-benefit determination process in an essential component of the consent process. In addition the signed consent documentation for two individuals could not be located in their records. However it should be noted that the Facility had made substantial progress in both the risk-versus-benefit determination process and the documentation of the informed consent	
J15	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall ensure that the neurologist and psychiatrist coordinate the use of medications, through the IDT process, when they are prescribed to treat both seizures and a mental health disorder.	In order to address this provision of the Settlement Agreement, the Chief Psychiatrist began attending the Neurology Clinics at the time of the Monitoring Team's previous review. ABSSLC also had added a section to the Quarterly Review documentation indicating the date of the last Neurology Consult and, depending on the complexity of that Consult, would either provide a very brief summary, or simply document its occurrence. A Neurology Clinic with the Consulting Neurologist at ABSSLC did not occur during this onsite review. However, it had been possible to observe these clinics during each of the prior reviews. The Chief Psychiatrist and the Facility Medical Director routinely attended the Neurology Clinic. Prior observations indicated the Neurologist was responsive to questions from both the Chief Psychiatrist and/or other clinicians and would spontaneously comment on findings of significance. The individuals with 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. There was adequate time for discussion and the clinics, which were scheduled to begin in the late afternoon, essentially remained in operation until all of the scheduled individuals were reviewed. This could take as long as three hours. During the Monitoring Team's previous	Noncompliance

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		reviews, the Facility indicated that if, in the future, more Neurology consultation time was required, the contract could be expanded. 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. Documentation that the individual had been seen in a Neurology Clinic during the past year was present in 15 of the 28 individuals (54%). The total percentage of individuals receiving psychiatric services that also were followed in the Neurology Clinic was 61 percent (115/190). Thus, the 15 individuals contained in this sample represented 13 percent of the total number of individuals Psychiatry and Neurology both followed (115). The documentation that the Neurology Clinic had occurred appeared in the Psychiatric Quarterly Review Notes for 14 of the 15 individuals in this sub-sample (93%). The only exception was Individual #126, for whom the section of the record containing the documentation of the Psychiatry Clinics was missing. The Neurology Notes also referenced the psychotropic medications for all 15 individuals (100%). However, there was little or no discussion of other aspects of the individual's psychiatric status, such as whether there had been a recent change in their psychotropic medication and/or a significant change in their overall psychiatric stability. The Facility's internal Self-Assessment, dated 8/8/12, indicated that, through their QA/QI review process, they had reviewed 24 randomly selected records (21% of the 115 followed in both Clinics) and found a compliance rate of 78 percent "with documented evidence that the Psychiatrist and Neurologist are coordinating the use of medications…." Although the specific criteria utilized was not described. It is also important to note that the Psychiatry Department had received approval to institute a separate Neurology Clinic for those individuals jointly followed by both Neurology and Psychiatry. This joint Neurology-Psychiatry Clinic should allow for more collaboration between the Neurology and Psychiatry Departments, as well as the immediate dissemination of that information, and a fuller discussion of both the neurological and psychiatric aspects of the individual's care. It will be important to develop a mechanism to ensure that there is a brief description of the individual's psychiatric status, as well as their psychotropic	

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		medication(s) in the Neurology Note that parallels the summary of their neurological status that appears in the Psychiatric Quarterly Review Notes. The rating of noncompliance for this provision is related to the finding that, although the Neurology Consultation Notes always referenced the individual's psychotropic medication, the degree to which other aspects of the individual's psychiatric status were discussed were often either not present or very brief. However, the considerable progress that the Facility had made in addressing the requirements of this provision was 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 will also need to 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 should also 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 intramuscular injection of a psychotropic medication during crisis situations should be fully completed, (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 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 procedures. (Section J.4)
6. The Facility should continue its efforts to recruit additional Psychiatrists to receive a staffing level of three full-time equivalents. (Section J.5)
7. The Psychiatry Department should maintain a list of individuals for whom there has been a change in their diagnosis during the past year. (Section J.6)
8. The Psychiatry Department should ensure that all individuals with a Reiss Screening score above the clinical cut-off undergo a CPE that meets the criteria specified in the Settlement Agreement, and also that this evaluation is completed in a timely manner. (Section J.7)
9. The Psychiatry Team should maintain a list that identifies the change in status or other rationale that precipitated a Reiss Screen, the results, and any pertinent follow-up. (Section J.7)
10. The documentation for the individual ISP meetings should delineate clearly both the attendance of the Psychiatrist, as well as any contributions that the Psychiatrist made to the deliberations. (Section J.8)
11. The documentation for the individuals' ISPs should include a discussion of the individual's psychiatric status and Treatment Plan, as well as the deliberations concerning the least intrusive intervention, as specified in the Settlement Agreement. (Sections J.8 and J.9)
12. The newly developed risk versus benefit discussion that appeared in the revised Quarterly Review documentation should be consistently carried over to the CPEs, the HRC review, and the Guardian Consent process. (Section J.10)
13. The discussion of the risk-versus-benefit determination process that considers the potential side effects of the medication, as well as those that have actually been experienced, and then weighs them against both the potential and realized benefits of the medication in diminishing the morbidity related to the underlying psychiatric disorder should also be discussed at the individual's ISP meeting and incorporated into the related ISP documentation. (Section J.10)

14. The Facility should improve the collection and presentation of the empirical data to document the efficacy of psychotropic medications that teams assert must be continued to maintain an individual's psychiatric stability. (Sections J.11 and J.13)
15. Individuals for whom the challenge of a specific medication provided valuable information concerning its efficacy should have this information carried forward on a continual basis in the Psychiatric Review Notes. (Sections J.11 and J.13)
16. 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)
17. The Facility should maintain a list indicating which member of the IDT actually obtained the verbal consent from the guardian to begin a new medication, and the date on which this occurred. (Section J.14)
18. In order for the record to be accurate, a full copy of what is sent to the guardian and/or Facility Director in requesting consent for psychotropic medication should be maintained in the record. (Section J.14)
19. The Psychiatry Department should implement its plan to develop a distinct Neurology Clinic devoted to the large number of individuals who were jointly followed by both Neurology and Psychiatry. (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 8/20/12; o Section K Presentation Book; o Table outlining coursework completed towards behavior analyst certification, dated 7/12/12; o Behavior Support Committee (BSC) minutes, including members in attendance, from 2/1/12 to 8/20/12; o Psychology Department meeting minutes, dated: 1/27/12, 3/6/12, 4/20/12, 5/17/12, and 6/22/12; o Psychology Procedures – Development of Behavior Supports, revised 3/8/12; o Psychology Procedures – Assessing the Implementation of Positive Behavior Support Plans (PBSP) and Safety Plans, revised 3/13/12; o Personal Support Team (PST) Review of Repeated Restraints, template; o Psychology Procedure – Repeated Aggression, revised 3/12; o Psychology Monthly Progress Note from 3/12 to 5/12 for: Individual #87, Individual #213, Individual #533, and Individual #525; o Psychology Monthly Progress Note from 4/12 to 6/12 for: Individual #517, Individual #540, Individual #61, Individual #95, Individual #120, Individual #48, Individual #315, Individual #89, Individual #231, Individual #274, Individual #320, and Individual #46; o Psychology Monthly Progress Note from 5/12 to 7/12 for: Individual #267, Individual #216, Individual #518, Individual #218, Individual #197, Individual #49, Individual #201, Individual #318, Individual #355, Individual #268, Individual #252, Individual #67, Individual #397, and Individual #150; o PBSP Data Sheets for: Individual #87, Individual #267, Individual #213, Individual #517, Individual #540, Individual #61, Individual #95, Individual #216, Individual #518, Individual #375, Individual #218, Individual #156, Individual #145, Individual #120, Individual #48, Individual #315, Individual #49, Individual #89, Individual #201, Individual #318, Individual #355, Individual #268, Individual #231, Individual #274, Individual #533, Individual #461, Individual #320, Individual #46, Individual #252, Individual #67, Individual #397, Individual #525, Individual #142, and Individual #150; o Behavioral Assessment for: Individual #87, Individual #23, Individual #267, Individual #164, Individual #517, Individual #540, Individual #61, Individual #216, Individual #518, Individual #218, Individual #120, Individual #315, Individual #49, Individual #89, Individual #127, Individual #355, Individual #231, Individual #56, Individual #461, Individual #252, Individual #67, Individual #397, Individual #525, Individual #103, and Individual #39; o Brief Behavioral Assessment for: Individual #144; o Abbreviated Functional Assessment for: Individual #95, Individual #156, Individual #145,

	Individual #318, Individual #274, Individual #533, Individual #320, Individual #142, and Individual #150; o Admission ISP and Behavior Protocol for: Individual #200; o Inventory for Client and Agency Planning (ICAP) Roster, dated 6/12; o List of individuals involved in counseling provided by Associate Psychologist, dated 6/12; o Psychotherapy Progress Note for 6/12 for: Individual #43, Individual #95, Individual #478, Individual #156, Individual #81, Individual #197, Individual #374, Individual #268, Individual #301, and Individual #136; o Psychotherapy Progress Note template; o Counseling Referral Form, dated 5/3/12; o ABSSLC Guide for PSTs: Requesting Counseling, dated 10/09; o Behavior Support Plan for: Individual #87, Individual #267, Individual #517, Individual #540, Individual #61, Individual #95, Individual #216 (draft), Individual #518 (draft), Individual #375, Individual #218, Individual #156, Individual #145, Individual #120, Individual #197, Individual #315, Individual #49 (draft), Individual #89, Individual #127, Individual #318 (draft), Individual #355, Individual #268, Individual #274, Individual #533, Individual #56, Individual #461, Individual #320, Individual #252, Individual #67, Individual #397, Individual #525, Individual #142, Individual #144, Individual #150 (draft), Individual #103, and Individual #39; o Human Rights Committee meeting minutes: from 2/7/12 through 7/10/12; o CLDP Psychological Discharge Report, dated 3/22/12, for Individual #272; o Individual Support Plan addenda for Individual #87; o Consent/Approval Procedures, revised 2/12; o Monthly Monitoring and Tracking the Guardian Consent Forms for Behavior Support Plans, dated 7/11/12; o Tracking of Behavioral Assessment, Behavior Support Plan, ISP, consents, and in-service training; o Instructions for PBSP I/R Monitoring, revised 12/10/11; o PBSP Integrity/Reliability (I/R) Monitoring report, dated 7/11/12; o Staff Training and Program Implementation Efforts; and o Memoranda from R. Manns to Associate Psychologists regarding Behavior Support Plans due in 9/12. ▪ **Interviews with**: o Shae Butts, Human Rights Officer, on 8/21/12; o Ron Manns, Director of Behavioral Services, on 8/21/12 and 8/23/12; and o Jeff Branch, Active Treatment Coordinator; and Ron Manns, Director of Behavioral Services, on 8/22/12. ▪ **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, Activity Center 6380, Activity Center 6460, and Activity Center 6700; o Senior Center; o Workshop 1, Workshop 2, and Workshop 3; o 5th Street Diner; o Re-admission meeting for Individual #94, on 8/20/12; o Center Incident Management Review Team meeting, on 8/20/12; o Behavior Support Committee meeting, on 8/20/12; o Human Rights Committee meeting, on 8/21/12; o Daily Incident Monitoring meeting, Unit IV, on 8/22/12; o Psychiatric Clinic (Dr. Murray), on 8/22/12; o Participation in Monitoring Team's review of Community Living Discharge Plan for Individual #272, on 8/22/12; and o Restraint Reduction Committee meeting, on 8/23/12.
	Facility Self-Assessment: The Facility provided the Monitoring Team with a copy of its Self-Assessment, dated 8/8/12. Section K.1 included a review of current Associate Psychology staff and their progress towards professional certification. Although significant progress was noted, this section was rated out of compliance, because the majority of the Associate Psychologists had not yet completed the requirements for certification as behavior analysts. For this same reason, the Facility rated itself as being in noncompliance with Section K.13. The Facility found itself to be in substantial compliance with Section K.2, because the Director of Behavioral Services met the requirements outlined in the Settlement Agreement. The Facility also rated itself as being in substantial compliance with Section K.3, but for reasons noted below, the Monitoring Team did not agree with this rating. For all other sub-sections of Section K, the Facility had developed a Section K Self-Monitoring Questionnaire to assess compliance with the Settlement Agreement. Below is a summary of the information gathered based on a review of the Facility Self-Assessment, the monitoring tool, and staff interview: ▪ The monitoring questionnaire used to complete the self-assessment addressed the following sub-sections of the Settlement Agreement: K.1, K.4, K.5, K.8, K.9, K.10, K.11, and K.12. The form was designed to indicate whether or not the indicator had been met and to provide comments as necessary. This included a review of data collection and monitoring of progress, the functional behavior assessment, counseling services, and the behavior support plan, including measures of staff training and understanding, data accuracy, and fidelity of treatment implementation. ▪ The monitoring tool was a good step in ensuring compliance with the Settlement Agreement. For additional indicators, the Facility is encouraged to review the Monitoring Team's reports. ▪ The Facility Self-Assessment identified a sample size of 76 individual records reviewed between 1/1/12 and 6/30/12. As the Facility served 411 individuals at the time of the visit, this sample size represented 18% of the population. ▪ As noted in the Self-Assessment, Behavioral Services staff members completed the audit. To assess

	for inter-rater reliability, the Director of Behavioral Services reviewed a sub-set of 13 individuals from the sample and Quality Assurance staff reviewed a sub-set of 28 individuals from the sample. ▪ A total of 86 indicators were identified for sub-sections K.4 through K.12 in the Facility Self-Assessment. Of these, inter-rater reliability scores were reported for 67, or 78% of the indicators. It was unclear why inter-rater reliability was provided for only a portion of the indicators. Scores of inter-rater reliability ranged from 14% to 93%, with 14 of the scores (21%) equal to or greater than 80%. ▪ The Facility did not provide guidelines for the use of the Monitoring Questionnaire. As such, it was not always clear how compliance was measured. Clearly identified criteria for measuring compliance with the requirements of the Settlement Agreement would enhance the self-assessment process. Examples are provided below: o For sub-section K.4.2.c, the Facility reported that records reflected input from direct support professionals. As Section K.4 relates to data and monitoring of progress, it was not clear how DSPs participated. o Sub-section K.9.4.h referenced the adequacy of schedules of reinforcement in behavior support plans. Criteria used to determine adequacy would be helpful in assessing compliance. ▪ Although Section K.6 was not included in the Monitoring Questionnaire, information related to this section was included in the Facility Self-Assessment. Here, too, there were questions about the criteria used to determine that information contained in a psychological assessment was current, accurate, and complete. ▪ The quality of information provided in assessments, behavior support plans, progress notes, and other documents was not reviewed. ▪ Monitoring tool guidelines and continued training will likely result in improved inter-rater reliability scores. ▪ The Facility rated itself as out of compliance with all but two sub-sections of Section K. This was consistent with the findings of the Monitoring Team with the exception of Section K.3 noted above and explained in detail below. The Facility identified broad areas of deficiency in Section K, but did not identify potential causes. The Self-Assessment did not make connections to any action plans that had been developed to address such issues.
	Summary of Monitor's Assessment: The Facility continued to make good progress in supporting staff to obtain professional certification. Several members of the Psychology Department had completed the required coursework and supervision required by the Behavior Analyst Certification Board. One staff member had achieved professional certification and another recently had been hired. Peer review continued to evolve. Internal peer review occurred on a regular basis through meetings of the Behavior Support Committee. Monthly external peer review involving staff from other State Supported Living Centers had been initiated. Expansion of these activities to include regularly scheduled opportunities for review of particularly challenging cases is recommended.

	Data collection and monitoring of Behavior Support Plan implementation remained a challenge, yet the Facility had initiated steps to improve both. Staff were beginning to gather monthly data regarding staff knowledge of plans as identified through interview, were collecting measures of inter-observer agreement, and were initiating methods to ensure high levels of treatment integrity. As this monitoring was completed, measures of engagement also were being recorded. This information was reported in the individual's Psychology Monthly Progress Note. Work continued on developing comprehensive behavioral assessments and behavior support plans for individuals. Review of all assessments and plans continued through the Behavior Support Committee and templates for self-assessment had been developed. Although progress was being made, a number of concerns identified in previous report still existed. A pilot project had been implemented to test specific staff training strategies. Plans were discussed to use the information gained from this experience to develop training programs in additional homes and other areas of the Facility.

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K1	Commencing within six months of the Effective Date hereof and with full implementation in three years, each Facility shall provide individuals requiring a PBSP with individualized services and comprehensive programs developed by professionals who have a Master's degree and who are demonstrably competent in applied behavior analysis to promote the growth, development, and independence of all individuals, to minimize regression and loss of skills, and to ensure reasonable safety, security, and freedom from undue use of restraint.	At the time of the Monitoring Team's visit, there were a total of 17 Associate Psychologists working in the Behavioral Services Department. One of these individuals was resigning in early September. Of the remaining 16 psychology staff members, one Associate Psychologist had taken and passed the exam, becoming the newest BCBA department member in March of 2012. A new Associate Psychologist had been hired who had already obtained her credentials as a BCBA. Seven other Associate Psychologists had completed the necessary coursework and supervision requirements with at least four of these expected to take the exam this fall. Of the remaining seven Associate Psychologists, one was providing counseling services and was not expected to obtain certification in Applied Behavior Analysis, five had completed some of the required coursework, and one was expected to enroll in the near future. As noted in the Facility's Presentation Book, participation in coursework required for professional certification was included in performance evaluations. The Director of Behavioral Services provided supervision to those enrolled in classes. There were plans to expand supervision to include the other BCBA staff members. Additionally, three new Associate Psychologists had been hired to begin work in the fall. One of these individuals already had completed the coursework necessary for board certification. This provision continues to be rated as being in noncompliance because the professionals in the Behavioral Services Department were not yet demonstrably competent in applied behavior analysis as evidenced by the absence of professional	Noncompliance

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		certification, as well as by the quality of the programming observed at the Facility. Since the Monitoring Team's last visit, there had been good progress made by the psychology staff in meeting the requirements necessary for board certification as behavior analysts. However, only three members of the department held professional certification. Issues related to the quality of behavioral programming are discussed in further detail below with regard to Section K.9 of the Settlement Agreement.	
K2	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall maintain a qualified director of psychology who is responsible for maintaining a consistent level of psychological care throughout the Facility.	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 held 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. Mr. Manns had completed the necessary continuing education requirements to renew his certification in August of this year. Throughout the week of the onsite review, the Monitoring Team observed many interactions between Mr. Manns and psychology and administrative staff. Observations would suggest that Mr. Manns maintained a positive relationship with staff members and offered consistent support to the psychology staff. Additionally, he continued to provide supervision to Associate Psychology staff who were pursuing board certification as behavior analysts. 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.	At the time of the Monitoring Team's visit, the Behavior Support Committee (BSC) continued to review all completed behavioral assessments, and newly developed or revised behavior support plans. A rubric was employed to provide feedback to the author of these assessments and plans with specific suggestions provided when items did not meet expectations, when the required information was not included, or when changes were recommended to strengthen the assessment/plan. As the rubrics did not list the staff in attendance at the BSC meeting, the Monitoring Team requested documentation that would provide this information. In response, the Facility provided minutes from the BSC meetings, held between 2/1/12 and 8/20/12. A review of these documents indicated that each meeting was chaired by the Director of Behavioral Services and attended by two Associate Psychologists, one of whom was identified as the alternate. Also in attendance at 23 of 26 meetings were members of the speech/occupational/physical therapy departments, a registered nurse, and/or the Director of Pharmacy Services. The information provided suggested that over 26 meetings of this committee, 11 of 18 Associate Psychologists were in attendance at least once. Although it is the Facility's practice to have the author of the assessment report or behavior support plan present at the BSC meeting, there was no documentation to indicate that the other seven psychologists had participated in this peer review activity.	Noncompliance

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		The Facility should provide documentation of all staff in attendance at BSC. As peer review provides a valuable opportunity for staff to expand their knowledge and skills regarding effective behavioral supports, ongoing attendance by all department members is encouraged. There also was no evidence of direct support professionals' involvement with this review process. As these are the staff who will be responsible for the day-to-day implementation of behavior support plans, the Facility is encouraged to schedule meetings to allow for participation by home staff, in particular, and activity center and workshop staff, as appropriate. At the time of the Monitoring Team's visit, the BSC continued to review all completed behavioral assessments, and newly developed or revised behavior support plans. A rubric was employed to provide feedback to the author of these assessments and plans with specific suggestions provided when items did not meet expectations, when the required information was not included, or when changes were recommended to strengthen the assessment/plan. There remained no format for regular peer review of current behavior support plans. This is an important role for internal peer review to ensure timely response to problem behaviors that are resistant to change or that display worsening trends. The Director of Behavioral Services noted that he was planning on having the staff who had acquired professional certification (i.e., BCBA) begin to hold regularly scheduled meetings with psychology staff. This added training and supervision would certainly strengthen the ongoing review and revision process. In previous visits, the Facility had been working with external consultants who had monthly contact with the Department of Behavioral Services. These consultants provided feedback on individual behavior support plans and engaged in onsite assessment and training regarding identified individuals. This arrangement had been terminated and a new process of external peer review had been introduced. On 5/11/12, a telephone conference was held between three psychology staff members from ABSSLC and six psychology staff members from Austin SSLC (AUSSLC). One individual case was reviewed by each Facility. On 6/15/12, a second telephone conference was held with participation by three psychology staff members each from ABSSLC and Corpus Christi SSLC (CCSSLC). Although the Director of Behavioral Services indicated that one individual case was presented by each Facility, documentation was provided only for an individual from CCSSLC. The Facility had clearly made progress in ensuring regular internal and external peer review. In order to achieve compliance with this requirement of the Settlement Agreement, it will be necessary to develop a policy regarding peer review, to ensure membership of internal peer review meetings consists of PBSP authors and those that	

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		supervise implementation of plans, to ensure a procedure for regular review of challenging cases, and to demonstrate monthly activity of the external peer review committee.	
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.	Three consecutive months of psychology progress notes were reviewed for 30 individuals. This resulted in a review of 90 progress notes. The time period ranged from 3/12 to 5/12 for four individuals, 4/12 to 6/12 for 12 individuals, and 5/12 to 7/12 for 14 individuals. The format for these progress notes was consistent across individuals. Graphic display of target behavior was presented, progress was summarized, medications were listed, and psychiatry clinic outcomes were noted where applicable, PBSP monitoring was reviewed, and recommendations were summarized. A summary of the Monitoring Team's findings is provided below: ▪ Graphs of an individual's target behaviors were presented in every progress note (100%). Data was presented in monthly totals with general labels (e.g., frequency, months) applied to the vertical and horizontal axes, respectively. In seven of the 90 progress notes reviewed, daily or weekly totals of identified problem behavior data also were presented. ▪ For all of the individuals (100%), progress criteria were identified. For four of these 30 individuals, the progress criteria were indicated as observed within the "reporting period," therefore the time frame for progress was unclear. ▪ The progress notes for five of the 30 individuals (17%) also included graphs depicting replacement behavior. ▪ All of the progress notes (100%) included information regarding monitoring of the PBSP implementation reported in text, graphic display, or both. Reference was made to measures of observed treatment integrity, inter-observer agreement, Planned Activity Check (PLACheck) of engagement, and staff knowledge of the individual's PBSP reflected through interview. Progress notes for 19 of the 30 individuals (63%) included indications that training had been provided when scores fell below an identified level. Much of this information was confusing. There were several progress notes that included data points depicting very poor treatment integrity scores, yet there was no information regarding action taken to address this problem with plan implementation. Inter-observer agreement scores were provided, yet it was unclear whether staff had observed occurrences of the targeted problem behaviors. PLACheck data was provided, yet this is a term applied to the use of a momentary time sample to measure the engagement levels of a group of individuals. It was unclear how this information was relevant to the individual. A brief explanation was provided only with regard to a staff members' knowledge of the PBSP as determined through interview. ▪ Progress notes were signed for only one of the 30 individuals (3%).	Noncompliance

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		Information related to specific progress notes is provided below: ▪ The psychologist for Individual #318 had consulted with a colleague for suggestions to enhance the behavior support plan. This was most commendable. Suggestions to increase the individual's active treatment and introduce a visual schedule were provided, but it was unclear whether these had been acted upon. ▪ Included in this same individual's progress note from 7/12 was a statement indicating that he "…has shown good, but unexpected progress for the second month in a row." It is unclear why progress should be unexpected. ▪ The progress notes for Individual #252 clearly reflected the progression of a completed behavioral assessment, new behavior support plan, and in-service training. ▪ Other progress notes did not reflect this level of response to new information. o For three consecutive months, the recommendations for Individual #150 indicated that the behavior support plan would be revised based upon information obtained in the behavioral assessment. It was unclear why the revisions had not been completed. o Over three consecutive months, Individual #274 displayed increasing rates of vomiting, yet this was not addressed in the recommendation section. Further, over the three-month reporting period, staff noted repeated occurrences of inappropriate urination/defecation, and pica behavior. Each month the recommendations included the following statement: "Determine the frequency and function of (these behaviors) to determine what prevention and intervention may be needed." This should have been addressed. Finally, the report from 4/12 noted the team agreed to focus on the individual using a picture system to communicate. The next month's progress report indicated the new plan would be implemented with a focus on a picture system, and the report from the last month indicated that training on the new plan would continue. While this was a commendable approach to introducing a consistent communication system for this individual, the graphs depicting replacement behavior suggested that staff were still teaching him to use sign language. ▪ Graphs depicted for at least four individuals (i.e., Individual #540, Individual #218, Individual #48, and Individual #67) were difficult to read, because the information contained in the "call out boxes" blocked titles and/or data paths. An example is the graph depicting rates of aggressive behavior displayed by Individual #67. ▪ For Individual #267, Individual #517, Individual #540, Individual #518, Individual #89, and Individual #231, the information provided in the summary specific to the target behavior did not always correspond to the information displayed in the graph.	

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		▪ Two behaviors were combined as "disruptive" behavior in the new behavior support plan (implemented on 5/30/12) for Individual #89. It was unclear how the data for this newly identified behavior was calculated for the time period from 7/11 through 5/12. The numbers displayed did not reflect the data from the two behaviors identified previously even if these had been combined. The combining of previously collected data to establish a baseline measure for a newly identified behavior is not a recommended practice. ▪ For two individuals (i.e., Individual #120 and Individual #252) information was included that post-dated the report date. ▪ For three consecutive months, the recommendations for Individual #397 indicated that replacement data would be available the following month. There was no explanation for the delay in presenting this data. Two to three months of behavior support plan data sheets for 34 individuals were reviewed. The findings are summarized below. ▪ For 21 of the 34 individuals (62%), staff collected data on the frequency of the targeted behavior(s). These measures were collected within specified time intervals across multiple shifts. For seven individuals (21%), data was collected using a partial interval recording. Again, the data sheet was divided into equal intervals of time and staff were required to record the presence or absence of the target behavior(s) within the designated interval. For the remaining six individuals (18%), information on the target behavior(s) was collected using an Antecedent-Behavior-Consequence (ABC) Form. While this provided additional information regarding the location of the event, the current activity, the immediate antecedent, and the immediate consequence, this form did not allow the daily recording of the absence of problem behavior. As a result, it was more difficult to determine whether staff had not recorded events, or if no behavior problems were exhibited. ▪ The data sheets were reviewed for completeness. For the reason noted above, ABC data sheets were excluded from this analysis. When the documents were reviewed for the 26 individuals for whom frequency or partial interval data were recorded, it was determined that data was missing in every case. In spite of this missing data, total occurrences were calculated for 15 of these 26 individuals (58%). The documents for Individual #216 and Individual #525 provide examples where data were not recorded for multiple shifts in one week, yet total weekly occurrences of the targeted behavior(s) were calculated. One cannot assume that the absence of data accurately reflect an absence of the identified behavior. Further concerns were raised during the onsite review of the Facility. In one home, two	

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		staff members were observed filling in data sheets at 1:45 p.m., 15 minutes before their shift ended. When asked if this was typically when they recorded the events of the day for the 14 individuals who lived in the home, the staff indicated that they usually try to complete data sheets at the middle and end of their shift. A review of several Individual Notebooks located in the homes, revealed incomplete data sheets from earlier in the week and/or missing data from earlier in the day. As noted in the past, during the week of the onsite review, the Monitoring Team occasionally observed problem behaviors. In three of four situations, a check of data sheets revealed no recording of the observed event. Specific information is provided below: ▪ Individual #465 was observed in her home on 8/20/12 between 4:15 and 4:25 on the afternoon of 8/20/12. She was repeatedly screaming as she refused to put on her shoes and socks. Her data sheet noted no occurrences of screaming at that time. ▪ On the afternoon of 8/20/12 between 4:40 and 4:55, Individual #525 was observed repeatedly throwing himself against the back of his wheelchair, banging on his wheelchair, and biting himself. There was no record of this behavior on his data sheet. ▪ Individual #142 was observed in her activity center on 8/23/12 at 10:05 in the morning. She dropped to the floor and refused to participate in the activity. There was no record of this behavior on her data sheet. ▪ Individual #397 was observed outside of the workshop on 8/21/12 at 9:46 in the morning. He displayed behavior that met his definition of disruptive behavior. This was recorded in his record. As has been reported in the past, important clinical decisions are made based upon data that is very likely inaccurate and unreliable. Psychology staff again should work closely with direct support professionals to ensure that data collection systems are manageable and are completed with a degree of integrity. Continued efforts to improve staff training, including assessment of inter-observer agreement, will be necessary. As noted in the Section K Presentation Book, weekly or daily data presentation following a significant environmental change was initiated on 8/3/12. As the staff implement this change, it might become apparent that such graphing requirements provide important information regarding the effects of both planned and unplanned events. The Facility is clearly trying to make gains with ensuring that data is collected accurately and consistently. However, based on observation and a review of documents, the Facility remained out of compliance with the requirements of this section of the Settlement Agreement.	

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K5	Commencing within six months of the Effective Date hereof and with full implementation in 18 months, each Facility shall develop and implement standard psychological assessment procedures that allow for the identification of medical, psychiatric, environmental, or other reasons for target behaviors, and of other psychological needs that may require intervention.	A total of 35 assessments, all of which had been written or updated since the beginning of 2012, were reviewed. Twenty-five of these were titled Behavioral Assessments, nine were identified as Abbreviated Functional Assessments, and one was labeled a Brief Behavioral Assessment. All included information related to a functional assessment of problem behavior. The primary difference was that the Behavioral Assessment consistently included more detailed information regarding the individual's observed adaptive behavior along with information found in the most recent psychological evaluation. A summary of the review is provided below: ▪ All of the assessments (100%) identified both indirect and descriptive methods of determining behavioral function. Repeatedly, indirect instruments were identified as the Questions About Behavioral Functioning, the Functional Analysis Screening Tool, and/or the Functional Assessment Interview. Observations were noted in all of the assessments, but the quality of the observations and resulting information varied across the reports. Many referenced informal observations conducted over a period of time, while others included specific dates when sequences of events were formally recorded. ▪ Seventeen of the 25 Behavioral Assessments (68%) were identified as Updates with the original report dated 2011. This raised concerns, because often the information gathered through indirect assessment was reviewed with staff and presented as still relevant. As these indirect measures, particularly rating scales, take little time to complete, the Facility should re-administer these to current staff when updates are employed. ▪ Twenty-three of the 35 assessments (66%) utilized information gained through observation to form hypotheses regarding behavioral function. The remaining assessments relied more heavily on information gathered through indirect assessment (i.e., rating scales and/or staff interview). ▪ All of the assessments (100%) identified setting events, antecedent stimuli, and consequences to problem behavior. Summaries of variables likely maintaining the problem behavior were also provided. ▪ Where appropriate, 82% of the assessments noted the role of biological variables in maintaining problem behaviors. ▪ Thirteen assessments (37%) included suggestions for replacement behaviors that were functionally equivalent to the problem behavior, but all should have. ▪ Twenty-nine reports (83%) included reference to the completion of a preference assessment. As they were described in the report, it appeared that for nine individuals, preferences were identified through staff interview and brief observation of the individual's interaction with materials readily available in the environment. A structured choice assessment was conducted with eight individuals. Seven individuals were interviewed regarding their preferences, but the outcome was reported for only six of these individuals. Six others were noted to have been assessed regarding their preferences, but the format was	Noncompliance

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		unclear in four cases, one included a listing of preferences included in the 2011 behavior support plan, and one indicated the assessment was completed in 2001. The Facility should conduct frequent formal assessment of an individual's preferences. ▪ The reports for 25 individuals (71%) included information regarding monitoring outcomes. For 17 of these individuals, the information was presented graphically with a legend that indicated scores reflecting treatment integrity, PLACheck, interview, or total inter-observer agreement. In the reports for two of the 25 individuals, a graph was presented with one data path that identified "treatment integrity interview" or "integrity and reliability scores." Given that treatment integrity measured through observation, knowledge of a plan demonstrated through interview, and data reliability are very different measures, the information presented made very little sense. The reports for five of the 25 individuals provided information presented in bar graph format. For three of these five, the label of the graph indicated either integrity and reliability or integrity and interview. Again, one data point reflecting a combination of different measures is impossible to interpret. The staff are commended for their introduction of program monitoring measures. However, there must be a clear understanding of what these measures assess and the manner in which the information can be used to improve programming. ▪ The responsible Associate Psychologist had signed nine reports (26%). In 17 other reports (49%) the responsible author was identified on either the cover sheet or last page. Feedback related to specific reports is provided below. ▪ In the report for Individual #87, the text included a statement that her "…personal support team feel many of her target behaviors over the past three to four months have been increasing due to environmental stimulus." There was no identification of specific environmental stimuli that could be causing this change in her behavior. ▪ The results of the assessment for Individual #23 suggested that pain, hunger, and loud environments were all conditions that would occasion his yelling. His replacement behavior was to learn to turn on a radio, which was not a functionally equivalent response. Similarly, it was determined that Individual #267 engaged in her problem behavior to gain attention. Her replacement behavior was to comply with daily tasks. ▪ Graphs included in the assessment were often difficult to read, because information presented in "call out boxes" to note medication changes, health matters, etc. often covered the title of the graph and/or the data paths (e.g., Individual #540 and Individual #150). ▪ The report for Individual #517 included information regarding an observation	

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		and a preference assessment that post-dated the report. The assessment for Individual #540 indicated an observation was completed over one month after the date of the report. Finally, the assessment for Individual #355 suggested that an indirect measure was completed over two months after the report date. ▪ The assessment for Individual #145 indicated that a rating scale (i.e., FAST) was used to help determine the function of his identified problem behavior, pica. However, the report noted that the "FAST results were not specific to pica in that staff responded to the FAST questions based on [Individual #145's] behavior in general." It is unclear how this information is useful in determining the function of the identified problem behavior. ▪ The assessment for Individual #127 included two different dates of birth and admission to the Facility. Further concerns were raised as this man, identified as 56 years of age, was noted to enjoy tickles. The appropriateness of staff tickling this adult is highly questionable. ▪ The report for Individual #231 indicated that her behavior was typically worse following family visits. Although the data presented for one of five targeted problem behaviors suggested worsening, the other four graphs suggested steady decreases in problem behavior in spite of scheduled visits with her family. This discrepancy was particularly concerning, because the solution was to limit her family contact. ▪ The assessment for Individual #142 suggested an increase in her aggressive responding since her admission, but the graphs did not support this statement. In fact, the data reflected a decrease in this behavior. ▪ The assessment for Individual #39 noted: "additional observation was done by interview of DSP who know (individual) best." Staff interview is an indirect assessment method that should not be equated with observation, a descriptive assessment method. ▪ Finally, some reports contained information regarding events that had occurred several years before the assessment date. For example, information from 2004 was included in the assessment for Individual #517. While this might be interesting and provide some insight into the individual's current behavioral profile, this should be summarized briefly to keep the focus on the variables that serve to set the occasion for and maintain the problem behavior. 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 for 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.	

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>The Facility remained out of compliance with this provision due to issues related to the quality of the behavioral assessments, as well as the timely completion of updated psychological evaluations, reviewed with regard to Section K.6.</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 30 of the 35 assessments reviewed in the previous section. This information 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 #87</td><td>1/6/06</td><td>Individual #49</td><td>11/11/98</td></tr>
<tr><td>Individual #23*</td><td>7/24/90</td><td>Individual #89</td><td>2/1/90</td></tr>
<tr><td>Individual #267</td><td>1/23/02</td><td>Individual #127*</td><td>4/11/88</td></tr>
<tr><td>Individual #164</td><td>10/7/87</td><td>Individual #318</td><td>4/6/00</td></tr>
<tr><td>Individual #517*</td><td>7/21/98</td><td>Individual #355*</td><td>9/11/08</td></tr>
<tr><td>Individual #540*</td><td>11/10/88</td><td>Individual #268</td><td>10/11/97</td></tr>
<tr><td>Individual #61</td><td>9/16/85</td><td>Individual #231</td><td>11/4/02</td></tr>
<tr><td>Individual #95</td><td>3/22/11</td><td>Individual #56</td><td>8/31/98</td></tr>
<tr><td>Individual #216</td><td>12/18/89</td><td>Individual #461*</td><td>9/28/94</td></tr>
<tr><td>Individual #518*</td><td>6/25/02</td><td>Individual #252</td><td>4/30/92</td></tr>
<tr><td>Individual #218</td><td>2/26/91</td><td>Individual #67*</td><td>11/17/89</td></tr>
<tr><td>Individual #156</td><td>12/23/07</td><td>Individual #397</td><td>6/22/95</td></tr>
<tr><td>Individual #145</td><td>6/30/88</td><td>Individual #525</td><td>4/3/93</td></tr>
<tr><td>Individual #120*</td><td>2/20/92</td><td>Individual #103*</td><td>9/6/90</td></tr>
<tr><td>Individual #315</td><td>2/15/90</td><td>Individual #39</td><td>6/22/96</td></tr>
</table>

As noted in the past, a statement was included in the reports for 10 individuals (noted by asterisk), or 33% of the sample, suggesting that there "…did not appear to be any clinically significant change in these functional levels since his/her last evaluation." The assessment report for Individual #61 suggested that her evaluation completed over 26 years prior "…appears to be somewhat accurate." It was discouraging to consider the perspective that the training and habilitation that had been provided had resulted in little change for these individuals. Only the assessments for Individual #95, Individual #156, and Individual #355 had been completed within the last five years. As a result only three individuals from the sample (10%) had evaluations that could be considered current.

Based on the inadequate clinical and behavioral data described in Section K.4, and the reliance on outdated psychological evaluations, 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.	One individual had been admitted to the Facility less than two weeks prior to the Monitoring Team's onsite review. Therefore, her psychological evaluation was not yet due. For this individual, the Facility had developed a Behavior Protocol to begin collecting information on reported problem behavior. This protocol also outlined strategies to employ to help prevent problem behavior and identified steps to take when problem behaviors did occur. An Admission ISP had also been developed which outlined some of the individual's preferences and abilities. Due dates for needed assessments were identified. The Facility continued to track the completion of Inventory of Client and Agency Planning. According to documentation provided, a total of 72 individuals had the ICAP administered and updated since 2/12. Based upon the information reviewed and discussed in relation to Sections K.4 and K. 6, the Facility remained out of compliance with this provision of the Settlement Agreement.	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.	The Facility provided a list of individuals receiving counseling services from the ABSSLC Associate Psychologist. This list, generated in June of 2012, identified 25 individuals, 13 of whom were receiving individual counseling, 10 of whom were enrolled in group counseling, and two of whom were receiving both individual and group counseling. Review of attendance revealed that individuals participated in their scheduled sessions between 0% and 100% of the time, with the average rate of attendance at 49%. Three individuals (12%) attended all of their scheduled sessions, but most of the individuals (seven, or 28% of the sample) attended one third or less of their scheduled sessions. The Psychotherapy Progress Note from June 2012 was provided for 10 individuals. A review of these documents is summarized below: ▪ The therapist providing services was identified in every report (100%). However, none of the reports (0%) were signed. ▪ The report was dated in nine of the 10 documents (90%). It should be noted that the date included in the report for Individual #81 was from 2011. This was likely a typographical error. ▪ All of the plans (100%) provided stated goals and objectives. While these clearly were an improvement in identifying observable and measurable objectives, the criterion for determining progress remained unclear. For example, Individual #156 and Individual #268 were learning to identify acceptable and unacceptable behavior when angry. The criterion indicated that he/she would point to pictures for 10 consecutive sessions. It was unclear whether the person was to respond correctly to one picture or 10 pictures, and it was unclear whether correct responding was required across 100% of the opportunities provided. Greater clarity with regard to expected performance would enhance these	Noncompliance

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		behavioral objectives. ▪ Progress in meeting one's objectives was identified as a plus or minus in all of the reports (100%) as long as the person attended his/her scheduled counseling sessions. However, the reports included subjective descriptions of the individual's behavior during therapy sessions. While these notes were informative, they did not provide a measurable assessment of progress. A system to measure behavior change numerically would allow the therapist to objectively determine even small progress made by the individual in meeting his/her identified goals. This would allow the therapist to indicate progress, stability, or regression as outlined in the progress note template. ▪ Two of the 10 individuals attended all of their scheduled appointments, with a third individual missing only one appointment due to a family visit. For the seven other individuals, at least one session was missed in the month of June. The progress note reported a refusal or simply non-attendance. In this latter case, the note included a statement that "… the therapist was not notified of the reason for the non-attendance." It would appear that the therapist should take a more active role in identifying and addressing an individual's poor participation in counseling. ▪ The interventions used to meet the individual's goals were clearly identified in five of the 10 reports (50%). Three individuals were learning appropriate social behavior using the *Circles Curriculum* and two others were learning to manage their anger by learning to *Stop, Think, and Relax,* and *Be Cool*. The other reports did not clearly identify a published approach to intervention. The Settlement Agreement clearly indicates that evidence-based approaches should be used when meeting the psychological needs of the individuals served, it will be important for the Facility to provide documentation regarding all approaches used in individual and group counseling. ▪ As the current service plan was not provided for any of those receiving counseling, it was not possible to determine whether there was a timely response to referral, whether a failure criterion had been established, what steps were in place to promote generalization of learned skills, and how staff had been trained to assist in any generalization. The Facility should take the following steps to improve its compliance with Section K.8 of the Settlement Agreement. Data should be collected to assess the timely initiation of therapy following referral for counseling. As reported in the Section K Presentation Book, this tracking had just recently begun. Each service plan should identify the problem, choice of intervention employing evidence-based practices, goals and objectives that are written in observable and measurable terms, criteria for revision or termination from therapy including repeated refusal to participate, a process for facilitating generalization of learned skills, and staff training and supervision, where	

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		appropriate. Guidelines also should be developed and implemented for addressing repeated refusal to participate or unexplained absence from therapy sessions.	
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.	As reported by the Director of Behavioral Services, a total of 236 individuals residing at the Facility were provided the services of a Positive Behavior Support Plan. A total of 35 Behavior Support Plans were reviewed, representing 15% of this group. These are identified in the documents reviewed section above. All of the plans had identified ISP dates and/or BSP implementation dates from the beginning of 2012. A summary of the review is provided below: ▪ The ISP date was identified in 31 of 35 plans (89%). ▪ Five of the 35 plans reviewed were identified as drafts. In the remaining 30 plans, 20 (67%) included the date of plan implementation. ▪ All of the plans (100%) included operational definitions of targeted problem behavior. ▪ Twenty of the plans (57%) included comparison or baseline data with the dates of data collection indicated. In some cases, the comparison data was from a period of time several months earlier than the implementation date. It was unclear why more current data was not provided for comparison purposes. ▪ Twenty-nine of the plans (83%) included expected treatment outcome presented in observable and measurable terms. Treatment outcomes identified to occur within "the reporting period" were less clear. Thirty of the 35 plans (86%) also included a statement regarding review and/or revision of the plan following three consecutive months without observed progress. ▪ Replacement behaviors were identified in all of the plans (100%). However, adequate operational definitions were provided in only 14 of the plans (40%). Replacement behaviors that were functionally equivalent, based upon the information presented from the behavioral assessment, were evident in 22 of the plans (63%). ▪ Adequate instructions and schedules for teaching replacement behavior were identified in 11 of the 35 plans (31%). ▪ Preventative strategies that corresponded to information gathered through behavioral assessment were clearly identified in 21 of the 35 plans (60%). ▪ Clearly described and sufficient scheduling of reinforcement was found in 11 of the 35 plans (31%). Four plans included descriptions of differential reinforcement of other behavior (DRO). As noted in the past, differential reinforcement strategies are strongly recommended. ▪ Although the psychologist who authored the plan was identified in 32 of the 35 plans (91%), none of the plans were signed. ▪ Plans were divided into two major sections, the "Cover Sheet" and "Staff Instructions." Much of the information presented in the first section was repeated in the second section, resulting in redundancy and unnecessarily long	Noncompliance

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		plans. Of the 35 BSPs reviewed, the plan for Individual #156 was of the best quality. The organization of the plan allowed for clear review, the prevention section addressed variables identified in the behavioral assessment, and the consequence-based strategies were clearly written. While this plan included differential reinforcement of other behavior, it would have been enhanced had a specific time-based schedule of reinforcement been identified. Feedback regarding individual plans is provided below: ▪ The plan for Individual #87 suggested she be offered private time if she engaged in inappropriate sexual behavior. She was also to be encouraged to go to a quiet area of the home, including her bedroom, if she exhibited aggression. As private time in her room was an identified reinforcer, these consequences might in fact strengthen her identified problem behavior. ▪ The plan for Individual #267 included mandatory check and change once per shift, and two showers every seven days. As there were concerns noted in her assessment regarding prolonged periods of her sitting in urine with resultant skin breakdown, these limited opportunities for meeting her hygiene needs were very concerning. ▪ The plan for Individual #120 noted that he would engage in pica behavior when hungry or thirsty, yet the recommendations for treatment included applying a weighted vest and teaching him to use a button to request time in a swing. Further concerns were raised when the consequences for agitation included the provision of food or drink (potentially reinforcing) and the application of a weighted vest (potentially aversive). ▪ Included in the prevention section of the plan for Individual #355 were comments indicating that he "…should be closely monitored when engaged in leisure activities in confined places (e.g., in closets and behind bushes)." The appropriateness of leisure activities in either of these areas for a 19-year old is highly questionable. This same plan identified participation in group activities with his peers as an appropriate replacement behavior. This adolescent lived in a home with 13 others between the ages of 24 and 59. His housemates did not constitute a peer group. ▪ The plan for Individual #150 referenced the Picture Exchange Communication System, but then also suggested that she should use sign language. Unless for this individual, specific reasons existed for teaching two different systems of communication, it is suggested that one communication system be identified and taught to enhance the likelihood that she would learn it efficiently and use it consistently. ▪ The plans for Individual #216 and Individual #49 suggested that problem	

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		behaviors might be indicative of pain and/or discomfort. It is suggested that the prevention section should include a schedule for staff to regularly and frequently check on these individuals, both of whom had limited communication skills. Other concerns identified during this review are detailed below. ▪ The Community Living Discharge Plan, updated 4/20/12, for Individual #272 was reviewed for a meeting with Facility staff held on 8/22/12. Contained in the report was a note from his Associate Psychologist, dated 3/27/12. Within this note, the psychologist indicated that he had revised the Behavior Support Plan, but was unable to train the provider staff prior to the individual's transition because there had not been time to guide the revised plan through the required approval process. When the Monitoring Team questioned the delay in approving the presumed improved plan, the Director of Behavioral Services indicated that the plan had not been revised until a few days before the individual's planned transition date. This is concerning, because it suggested that the information the Associate Psychologist included in the Community Living Discharge Plan was inaccurate and possibly falsified. ▪ Individual #87 had inappropriate sexual behavior as one of her target behaviors included in her Behavior Support Plan. In addition to opportunities for private time in her room was mention of a personal sexual device and access to magazines. Neither of these were described in detail and it was unclear how these had been identified or approved. One ISP addendum, dated 6/28/12, indicated that the individual was displaying increased hypersexuality, including use of an object when outside. A second ISP addendum, dated 6/28/12, addressed an allegation against staff for providing assistance when the individual chose to use this device. The determination was to retrain staff on the individual's ISP with specific instructions not to provide assistance or be present in the room when the individual chose to use the device. If not already in place, the Facility should develop a policy regarding sexuality training and needs. This policy should identify professionals who are qualified to address this behavior and provide training to individuals. Guidelines for involvement of the guardian (if applicable) and the Human Rights Committee should be included. ▪ On 8/23/12, Individual #148 was observed hitting himself, throwing his helmet, and then dropping to the floor. The shift supervisor explained that earlier in the day a similar incident had occurred that resulted in one staff member leaving early due to injury. When a request was made for this individual's Behavior Support Plan, the Monitoring Team was informed that his plan had been discontinued in 2/12. Based on observation and staff report, it was clear that this individual continued to display behaviors that were in need of intervention. ▪ Individual #397 was observed vomiting in the workshop area. The staff member openly commented that this behavior already had occurred multiple times that	

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		day. This behavior also was discussed at the morning unit meeting. As the assessment for this individual suggested that at least some of his problem behavior was maintained by attention, it is critical that psychology staff respond quickly to this emerging behavior to ensure that staff response does not provide reinforcement in the form of attention. ▪ During one psychiatry clinic, the psychologist noted that Individual #540 was leaving her home without proper escort and dropping to the floor less often. The psychologist stated, with some confidence, that this was a result of the woman's move back to her former home. Noteworthy was this woman's confinement to a wheelchair due to her increasingly unsteady gait. This event happened near the time that she returned to her former home. When multiple events occur in close temporal proximity, it is important for staff to maintain a degree of objectivity when drawing conclusions regarding causes for observed changes in behavior. Staff should carefully review behavior support plans to ensure the following: a) functionally equivalent replacement behaviors are identified; b) teaching strategies to support the development and/or strengthening of replacement behaviors are clearly outlined and offer frequent opportunities for practice and reinforcement; c) preventative strategies address all variables identified in the behavioral assessment; d) dense schedules of differential reinforcement are described in detail and implemented accordingly; and e) consequence-based interventions are clear and effective in weakening the targeted problem behaviors. When individuals continue to display unwanted behavior or when new unwanted behaviors are observed, psychology staff should take action to ensure that plans are revised or developed in a timely manner. With only two exceptions, due to either the absence of an external member or a holiday, the Human Rights Committee met weekly from 2/7/12 through 7/10/12. Minutes from 21 meetings were reviewed. The following provides a breakdown of the members in attendance during this period: committee chair (100%), parent member (52%), non-affiliated member (86%), resident member (57%), nurse (90%), associate psychologist (81%), and chief psychiatrist (43%). The addition of the Chief Psychiatrist in HRC meetings was a very positive change. Additionally, in an effort to better address members' concerns or questions regarding medication, the committee chair had begun referencing an individual's psychiatry folder. As of 2/14/12, the minutes had been expanded to provide a brief summary of the topic reviewed and related discussion. The psychologist responsible for an individual's behavior support plan continued to present the plan, often via conference call. There was evidence that review of plans was delayed if the psychologist was unavailable. The HRC meeting that was held during the week of the Monitoring Team's visit reflected active participation by members with thoughtful discussion of topics presented.	

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		The Facility had developed a revised description of Consent/Approval Procedures. As outlined in this document, all behavior support plans required the approval of the Behavior Support Committee, chaired by the Director of Behavioral Services. Only those plans with restrictive procedures and protocols that included restrictions or risk required the approval of the Human Rights Committee. The individual's guardian or Facility Director must also approve plans with restrictive procedures and/or potential risks. The monitoring and tracking record provided to the Monitoring Team provided information from 11/3/09 through 6/26/12. This information proved to be incomplete, with identification of restrictive practices absent from 10/27/10 forward, and the date consent was received absent from 1/5/10 forward. As such, it was difficult to determine whether consents were obtained in a timely manner. A second database was provided that included ISP dates, PBSP dates, BSC approval, HRC approval, and "Consent." This document provided a wealth of information, but was difficult to read due to the small font and missing information. The Facility should develop one database to track consents and HRC approvals. The Facility remained out of compliance with this provision due to ongoing concerns related to behavior support plans and tracking of required consents.	
K10	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, documentation regarding the PBSP's implementation shall be gathered and maintained in such a way that progress can be measured to determine the efficacy of treatment. Documentation shall be maintained to permit clinical review of medical conditions, psychiatric treatment, and use and impact of psychotropic medications.	The Facility had made a concerted effort to implement their PBSP I/R Monitoring tool. As specified in the instructions, the psychologist/psychology assistant was to complete the following: a) an observation of the group while completing a PLACheck or measure of engagement; b) a second observation for five minutes during which data on targeted problem behaviors is collected and later compared to the staff member's data; c) collection of information regarding the observed staff response to targeted problem and replacement behaviors during these observations; d) interview of staff regarding an individual's PBSP and knowledge of core competencies; e) record of staff suggestions or concerns regarding the individual's PBSP; and f) documentation of the training provided. Two concerns were noted in reviewing this information. First, the interview was referenced as "Behavior Support Integrity Probes." It is suggested that a staff member's verbal responses to questions posed by the psychologist or assistant are not necessarily an accurate measure of how he/she interacts with the individual or responds to his/her identified problem behaviors. Therefore this is not a true measure of treatment integrity. Second, while agreement between two observers that the target behavior(s) did not occur during a designated observation period does compute to an inter-observer agreement score of 100%, concerns are raised if only non-occurrences are observed. As noted by Cooper, Heron, and Heward (2007), scored-interval inter-observer agreement is recommended when behaviors occur at low rates to avoid "overinflated and possibly misleading IOA measures (p.119)."	Noncompliance

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		With the exception of a few monthly progress reports that provided one week of daily data or one month of weekly data, the majority of graphs continued to display total monthly occurrence of targeted behaviors. There were several examples where monthly totals of problem behavior(s) were displayed following planned and unplanned changes. These included changes to medication (e.g., Individual #48, Individual #315, Individual #268, Individual #274, and Individual #397), changes to mobility (e.g., Individual #540), changes to programming (e.g., Individual #49, Individual #89, and Individual #274), and changes to health status (e.g., Individual #49). Daily or weekly display of data would allow for better analysis of the individual's response to these changes. Axes were labeled (broadly), and data points and paths were displayed. "Call out boxes" were used to depict changes in medication, change of residential placement, illness, introduction of a new BSP (occasionally), and other events. As noted with regard to Section K.4, these "call out boxes" occasionally blocked the labels and data paths depicted in 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 changes related to health issues. Staff should provide graphic display or targeted behaviors in a manner that will allow analysis of the effects of planned (e.g., changes to the BSP, changes in medication, changes in living environment, etc.), and unplanned changes (e.g., new housemate, illness, death of a family member, etc.). Although monthly review of progress was evident, there were several problems that resulted in the noncompliance rating given to this provision of the Settlement Agreement. These included the following: data collection systems remained inaccurate and lacked regular assessment of inter-observer agreement, assessment of treatment integrity remained elusive, and graphing conventions did not allow for adequate review of progress.	
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.	The Facility had begun conducting regular monitoring of staff members' understanding of individual behavior support plans and identified core competencies. Criteria for mastery were established and when not met, re-training was provided. This initial step in ensuring staff understanding and in recruiting staff input is most commendable. The Facility provided a computer-generated report of the PBSP I/R Monitoring that had been completed between 1/31/12 and 7/11/12. The format consisted of the residence number, the name of the individual, the training date, the interview score, the PLACheck score, the inter-observer agreement score, and the observed treatment integrity score. A review of this report is summarized below: ▪ Monitoring was conducted in 20 homes. The total number of monitoring checks ranged from 23 in home 6480 to 116 in home 6350. ▪ Across the 20 homes, interview scores ranged between 0% and 100%.	Noncompliance

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		▪ Similarly, PLACheck scores ranged between 0% and 100% across the 20 homes. ▪ Inter-observer agreement and observed treatment integrity scores were not summarized for this report, given that the majority of reported percentages were at either end of the range (i.e., zero to 100). This raised concerns regarding the method for calculating and reporting these scores. There was no indication that inter-rater reliability measures had been collected on any of the data contained in the report. As noted in Section K.10, this was a good first step in ensuring that staff understand the plans as written. In addition to improving the processes described above, observing appropriate implementation of the plans will also be necessary.	
K12	Commencing within six months of the Effective Date hereof and with full implementation in two years, each Facility shall ensure that all direct contact staff and their supervisors successfully complete competency-based training on the overall purpose and objectives of the specific PBSPs for which they are responsible and on the implementation of those plans.	The Facility provided the Monitoring Team with a description of the pilot staff training project that had been implemented from 5/13/12 to 8/3/12. Two homes were the focus of the training and analysis. Training times were identified when staff could be relieved of their regular work responsibilities so that the focus could be on training. Additionally, staff were assigned as the primary or secondary person responsible for specific individuals. Discussion with those who participated suggested that training outside of regularly scheduled duties was a helpful practice. The identification of primary and secondary staff was not shown to be effective. Plans were underway to extend this training to other homes at the Facility. This was a good step in developing an enhanced staff training program. The Department of Behavioral Services had employed staff members who served as a Behavior Support Team. These staff had received training to serve as trainers and coaches to the direct support professionals in implementing behavior support plans. At the time of the Monitoring Team's visit, coaching teams had been identified and assigned to groups of homes. The plan was to develop Skills Checklists that would be used by these coaching teams to train the direct support professionals to competency. If this training occurs as the direct support professional works directly with the individual, the Facility will be better able to assess the staff member's competency in implementing all aspects of the behavior support plan. The Facility is commended for these steps taken to meet the requirements of this provision of the Settlement Agreement. It will be important to assess the efficacy of these efforts over the next six months. Although progress clearly was being made, the Facility recognized that these additional steps needed to be taken in order to ensure the provision of adequate competency-based training to staff responsible for the implementation of specific PBSPs. At the time of the Monitoring Team's visit, the Facility remained out of compliance with this provision.	Noncompliance

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K13	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall maintain an average 1:30 ratio of professionals described in Section K.1 and maintain one psychology assistant for every two such professionals.	At the time of the Monitoring Team's visit, the census at ABSSLC was 411. With 18 Associate Psychologists, the Facility met the criterion of one professional for every 30 individuals. With 11 Psychology Assistants, the requirement for one support person for every two psychologists is also met. Although not all 411 individuals had PBSPs, this level of support was essential for several reasons. Individuals might develop problem behaviors that require support and intervention, while others might already be displaying problem behaviors that indicate a need for a behavior support plan. Further, repeated documentation was found of individuals refusing to participate in planned activities, be these required self-care or medication routines, counseling services, or day habilitation or work programs. The involvement of the psychologist in addressing these problems is essential. Lastly, behavioral psychologists are critical members of the interdisciplinary team when designing programs of habilitation and training programs. It is a misconception to consider the field Applied Behavior Analysis only in relationship to problem behaviors as the field focuses equally, if not more so, on the development and expansion of new and enhanced skills. The Facility remained out of compliance with this provision, because the professionals in the Psychology Department were not yet demonstrably competent in applied behavior analysis as required by the Settlement Agreement. This was evidenced by the absence of professional certification, as well as by issues related to the quality of the programming observed at the Facility.	Noncompliance

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

1. As vacancies arise, to the extent possible, 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, direct support professionals, and staff from other disciplines in the Behavior Support Committee. (Section K.3).
4. When completing psychology monthly progress reports, staff should address the following: a) ensure criteria for progress is clearly identified; b) for applicable individuals, include a report regarding their progress in counseling; c) clearly explain and report behavior support plan monitoring activities; d) when revisions are recommended, implement these in a timely manner; e) avoid delays in addressing emerging behaviors, particularly those that are potentially harmful to the individual and/or others; f) ensure correspondence between the information provided in the text and that presented graphically; g) design graphs so that information is not blocked; and h) ensure that all reports are signed. (Section K.4).

5. Data collection systems should be developed to ensure that accurate data is collected on identified target behaviors. 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).
6. Inter-observer agreement measures, between the direct support professional and the monitor, should be collected on a regular basis. (Section K.4).
7. When data is not recorded, staff should not calculate daily and/or weekly totals. (Section K.4).
8. Staff should provide graphic display of targeted behaviors in a manner that will allow analysis of the effects of planned (e.g., changes to the PBSP, changes in medication, etc.) and unplanned changes (e.g., sudden move in home, health problems, etc.). (Section K.4)
9. As recommended previously, revisions to the functional behavior assessment process and report format should be made. Greater emphasis should be placed on information gathered through direct observation, and when conducted, functional analysis. (Section K.5)
10. 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, preventative strategies, and consequence-based interventions that effectively weaken the problem behaviors. (Section K.5).
11. Updated Behavioral Assessments should be used with caution. When an improvement in problem behaviors has not been observed, when worsening is apparent, or when new behaviors are identified, it will be critical to conduct a functional behavioral assessment to ensure that current maintaining variables are identified. (Section K.5).
12. 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).
13. The Facility should implement a system to track referral and initiation of counseling services. (Section K.8).
14. Initial counseling plans should include identification of the problem, observable and measurable goals, identification of evidence-based intervention, and criteria to identify failure or lack of progress. (Section K.8).
15. 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).
16. 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)
17. 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) that 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).

18. If not already in place, the State and Facility should develop a policy regarding sexuality training. This policy should identify professionals who are qualified to address this behavior and provide training to individuals. Guidelines for involvement of the guardian (if applicable) and the Human Rights Committee should be included. (Section K.9)
19. Psychology staff should take an active role in addressing emerging unwanted behaviors in a timely manner. Data collection systems and behavior protocols should be developed to minimize potential reinforcement of the new response. (Section K.9).
20. As necessary and appropriate, transitions of individuals, both on campus and into the community, should be conducted in a gradual and well-planned manner. On an individualized basis, 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 should occur. Once the transition occurs, teams should meet regularly to ensure that any obstacles or problems are addressed in a timely manner. (Section K.9)
21. As the Facility moves forward with its efforts to monitor behavior support plan implementation and efficacy, it will be important to ensure that staff clearly understand the measures identified on the monitoring tool. Interview, observation, PLACheck, and inter-observer agreement data should be viewed as important measures of different events. (Sections K.10, K.11, and K.12).
22. It will be important for Associate Psychology staff to conduct frequent training and supervision with Behavior Support Team members to ensure that coaching provided to direct support professionals and the assessment of their competency is accurate, comprehensive, and effective. (Section K.12).

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

1. Staff are encouraged to proof all documents (e.g., assessments, support plans, progress notes, etc.) to ensure the following: a) reference is made to the individual only, b) gender-specific pronouns are used appropriately, c) information provided in text corresponds to that presented graphically, and d) the individual's name is spelled correctly.

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; o Name and degrees of all primary care providers that are new to Facility since the Monitoring Team's last review; o Number of individuals on each PCP'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 International Statistical Classification of Diseases (ICD) and DSM diagnostic criteria in last six months; o Since the last onsite review, copy of Continuing Medical Education (CME) for each primary care provider, list of CME credits according to topics reviewed, and list per PCP of total CME credits during the time period since the last review; 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, including date of audit from which information retrieved; 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 the Monitoring Team's last visit; o List of individuals who died since the Monitoring Team's last visit, including date of death, death certificate, whether autopsy was done (and if so, copy of autopsy report), medical problem list current at time of death, and for seven days prior to death or hospitalization, all clinical documentation including nursing and physician notes, and all diagnostic studies including radiologic and laboratory for: Individual #20, Individual #202, Individual #350, Individual #376, and Individual #512; o Mortality Reviews (i.e., 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 Twenty most recent annual medical assessments and physical examinations and prior

	annual assessment and examination for: Individual #7, Individual #499, Individual #262, Individual #232, Individual #503, Individual #194, Individual #434, Individual #502, Individual #247, Individual #99, Individual #523, Individual #462, Individual #486, Individual #529, Individual #344, Individual #522, Individual #51, Individual #177, Individual #392, and Individual #39; 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 residential home, copies of all consultant reports (i.e., medicine and surgery inclusive of subspecialties) since Monitoring Team's last visit, and all integrated progress notes commenting on consultant reports (i.e., agreeing or reason not agreeing) and any ISP addendum related to the consultant report; o List of individuals: ▪ With tracheostomies; ▪ With fractures, date of fracture, type of fracture (compound, simple, stress, etc.), 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 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 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; o List of all women age 40 or greater with date of birth; o List of all individuals age 50 or greater, with date of birth; o Current list of all those with diagnosis of osteopenia/osteoporosis with medications and dosage per person, including calcium, Vitamin D, intravenous (IV) bisphosphonate, etc.; date of last DEXA scan or indication if not completed, and copy of most recent DEXA scan reports for each individual with diagnosis of osteopenia or osteoporosis; o For men with diagnosis of osteopenia/osteoporosis, copy of any lab work testing for secondary causes (from current active record), other information indicating cause (specific medications, etc.) of osteopenia/osteoporosis; o For women with diagnosis of osteopenia/osteoporosis and premenopausal, copy of any lab work testing secondary causes (from current active record), other information indicating cause (specific medications, etc.) of osteopenia/osteoporosis; o For each individual with osteopenia/osteoporosis, any active record document for calculation of daily calcium intake; o For individuals with Down syndrome, date of last thyroid test; o For those going to the Emergency Room (ER) and not hospitalized, copy of integrated progress notes from start of signs/symptoms to transfer to ER, ER report, 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: Individual #378, Individual #530, Individual #158, Individual #366, Individual #71, Individual #94, Individual #469, Individual #409, Individual #261, and Individual #146; o For those admitted to hospital, copy of integrated progress notes from start of signs/symptoms to transfer to ER, ER note, hospital 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: Individual #452, Individual #145, Individual #368, Individual #444, Individual #215, Individual #54, Individual #468, Individual #150, Individual #409, and Individual #297; o For these same 10 most recent hospitalizations that have been completed, copy of hospital liaison nurse documentation of hospitalization; 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 for the 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 (e.g., type of cancer, type of sepsis) for past year for individuals who have been newly diagnosed with: ▪ Malignancy; ▪ Cardiovascular disease; ▪ Diabetes mellitus; ▪ Sepsis; ▪ Bowel obstruction or bowel perforation; and ▪ Pneumonia; o List of individuals who have diagnosis of constipation or who are receiving anti-constipation medication at least weekly; o All policies and procedures related to seizure management; o A list of individuals being treated for seizure disorders, including: name of individual, Residence/home, diagnosis (type of seizure), and medication regimen; o For past six months, for the following five individuals, documentation of seizure management (e.g., neurologist's notes): Individual #19, Individual #15, Individual #281,

	Individual #537, and Individual #519; o List of individuals seen by neurologist with dates on which appointments were completed and reason, since Monitoring Team's last visit; o List of 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 vagus nerve stimulator (VNS) placement and the stage of evaluation; o Numbers and percentage of individuals on one, two, three, four and five antiepileptic drugs (AEDs); o Numbers and percentages of persons on older AEDs (e.g., Phenobarbital, Dilantin, Mysoline, Felbamate); o Tracking of data for individuals who have transitioned to community since Monitoring Team's last visit, including hospitalizations, ER visits, and 911 calls. Any Facility review of adverse outcomes, communication with provider agency, and description of technical assistance provided. Any documentation of the final transfer between Post-Move Monitor and community service coordinator at 90-day transfer; o For the three individuals most recently transitioned to the community for at least 90 days, copy of seven, 45, and 90-day reports. For these three individuals, copy of the Community Living Discharge Plan (CLDP), most recent ISP, PBSP, and subsequent addendums, most recent annual medical exam and most recent nursing assessment, copies of any training documents for before and after move, and copies of any sentinel events since transition date, for: Individual #43, Individual #272, and Individual #539; o Since the Monitoring Team's last visit, any ethics committee meeting minutes, with attendance rosters, concerning DNR decisions/changes; o Dates of last two completed annual medical assessments and annual physical examinations for all individuals; o Dates of last two completed quarterly medical reviews/IPNs completed for all individuals; o For specialty clinic appointments (on campus and off site), list of appointments that were completed and ones not completed (with reasons); o For hospitalizations in prior six months, copies of follow-up ISPAs; o Numbers of individuals with a diagnosis of seizure disorder on no anti-epileptic medications; o Number of individuals with VNS in place, date of placement, date of replacement, if applicable; o For concerns identified needing closure at morning provider/medical meetings for period of time 30 to 60 days prior to the Monitoring Team's visit, copy of any documents providing evidence of closure (e.g., minutes of medical staff meeting, copy of ISPA addressing concern, etc.); o For the last five individuals to whom pre-treatment sedation was administered for a

	medical procedure, all information related to medical 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 10 most recent PNMT recommendations with physician orders; o ISPAs addressing missed appointments or refusals in the past three months (for mammograms and colonoscopies); o List of missed medical appointments with reasons for past six months; o Presentation Book Section L; o For each of the following individuals, copies from the active record: DG-1, most current annual medical assessment and physical exam, preventive care flow sheet, most current nursing assessment, past one-year of IPNs, past one-year of lab results, x-rays, 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 ISP and subsequent addendums, most recent PBSP, and past three medical quarterly reviews: Individual #30, Individual #26, Individual #55, Individual #76, Individual #545, Individual #53, Individual #301, Individual #109, Individual #385, Individual #40, Individual #535, Individual #409, and Individual #179; o For each PCP, four active records, including selection of four diagnoses from the active problem list, and for each diagnosis selected, the criteria/test results justifying diagnosis from active record; o A list or lists currently available at the Facility identifying each individual identified to be "at risk" utilizing the State's risk categories, including, but not limited to the categories below, 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: aspiration, aspiration pneumonia/pneumonia, chronic respiratory infections, contractures, gastro-esophageal 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, and acute and chronic pain; o For the last year, lists of individuals 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 individual who have been: seen in the Emergency Room, including the date seen at the ER, and the reason for visit; admitted to the hospital, including date of admission, reason for admission and discharge diagnosis(es), 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 home unit; been diagnosed with pneumonia, including date of diagnosis and type of pneumonia (e.g., aspiration, bacterial, etc.); 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 Morning medical report minutes, from 8/20/12 through 8/24/12, including signed attendance rosters; o External Medical Provider Review, dated 4/4/12; o List of individuals with a diagnosis of Barrett's esophagus, including date of last esophagogastroduodenoscopy, copy of EGD report, biopsy reports, and gastroenterology consults concerning Barrett's esophagus diagnosis, since diagnosis date; o Most recent annual medical assessment and physical exam, most recent nursing assessment, past one-year of IPNs, past one-year of lab results/x-rays/scans/MRIs/ ultrasound reports, hospital discharge summaries for past one year, consults and procedure reports for past one year, physician orders for past one year, bowel movement record for past six months, and weights for past one year, for Individual#351; and o For last six months, copy of physician orders, IPNs, lab, x-ray reports, scans, (ultrasound, CT, MRI, etc.), hospitalization discharge summaries, ER reports, consultant reports, procedure reports, most recent annual medical assessment and physical exam, and one year of weights for following: Individual #122, Individual #19, Individual #466, Individual #226, and Individual #297. ▪ **Interviews with**: o Richard Chengson, MD, Medical Director; o Edward Craig, MD; and o Elizabeth Greer, RN, Medical Program Compliance Monitor. ▪ **Observations of**: o Individual #119, Individual #429, Individual #7, Individual #361, Individual #289, Individual #75, Individual #91, Individual #212, Individual #53, Individual #293, Individual #467, Individual #359, Individual #497, Individual #535, Individual #353, Individual #186, Individual #245, Individual #468, Individual #409, and Individual #193; o Morning Medical Meetings, on 8/21/12, 8/22/12, and 8/23/12; and o Participation in Monitoring Team's review of Community Living Discharge Plan for Individual #272, on 8/22/12.
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section L, dated 8/8/12. In its Self-Assessment, for each sub-section, 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. For Section L, in conducting its self-assessment, the Facility used auditing tools. The Monitoring Team completed a review of the Facility Self-Assessment, the audit templates, a sample of completed auditing tools, inter-rater reliability data, as well as interviews with staff. Based on this review: ▪ The audit tool the Facility used to conduct its self-assessment was the external medical peer review audit of 30 questions. This audit tool did not include adequate indicators to allow the Facility to determine compliance with all areas of the Settlement Agreement. The Facility is encouraged to review the Monitoring Team's report to identify indicators that are relevant to

	making compliance determinations. ▪ The monitoring tools identified methodologies, but appeared limited to record reviews. ▪ The Self-Assessment identified the sample size, including the target population size and the number of records actually reviewed. The goal was of 5% of each PCP's caseload per audit. The sample size for the external audit was not adequate to consider them representative of the campus, because the annual goal was for two external general medical audits, which would total 10% of the campus. ▪ Staff noted the audit tool did not have adequate detailed instructions/guidelines to ensure consistency in scoring. As a result, results varied between the January and April external audits and the external and internal audits, indicating a need to improve inter-rater reliability to provide valid results For the self-assessment process, the Facility had begun to measure the impact of the morning medical meeting by tracking closure of concerns raised in discussion. The Facility indicated the process was new, and there had not been time to accumulate data for analysis. Other than tracking of quarterly medical reviews, the Facility did not use other databases as part of its self-assessment processes. Although several databases had been submitted for review concerning preventive measures, such as colonoscopies, mammograms, osteoporosis treatment, etc., the Facility did not utilize any of this information in analyzing progress or determining areas needing improvement. The Facility also had recently begun to develop data for tracking PCP clinic activities. There appeared to be heavy reliance on the external general medical audit without the realization that most areas of medical care (i.e., preventive, routine/maintenance, emergency, acute, chronic, etc.) remained without monitoring. For all of these areas, the Facility needed a rigorous self-assessment process to identify areas needing improvement. The Facility rated itself as being in noncompliance with all sub-sections of Section L. This was consistent with the Monitoring Team's findings.
	Summary of Monitor's Assessment: Particularly with regard to individuals' chronic health concerns that placed them at risk on an ongoing basis, little improvement was seen in the Facility's critical analysis of treatment provided, and the need for additional or different assertive treatment of such conditions. The morning medical meeting was an important daily forum to review changes in status of individuals. The morning medical meeting also was occasionally used to discuss potential Adverse Drug Reactions (ADRs), provide updates in drug interactions, and to discuss system concerns. However, overall, the process needed more PCP leadership, in providing succinct presentations, asking other departments represented or other PCPs for directed input on specific concerns, and providing a discussion/rationale for the diagnostic and treatment plan. Perceived delays in care or lack of aggressive treatment should be questioned. There was little to no discussion documented concerning how to prevent a recurrent pneumonia, or other significant health concerns. There was considerable progress in completing preventive testing. Database reports provided appeared to

	be helpful. However, it did not appear the Medical Department used these databases to provide guidance to the PCPs, because they were not mentioned in the Facility's Self-Assessment. There did not appear to be limitations to access to specialists. However, there was concern regarding the prolonged time before consultations occurred, including the time between when the PCP ordered the consultation to the time the appointment was set, to the time the appointment was completed, and the report was returned back to the PCP. The Facility should review potential causes for these delays, especially in cases where the individual's health status was deteriorating. There did not appear to be a system to provide a fast track for consultation, or if there was, it did not appear it was used in cases when it would have been helpful. Acute care appeared appropriate. PCP assessment and treatment was timely and thorough once an acute care concern was communicated. However, the Facility needed to consider completing record reviews for most hospitalizations to determine the quality and completeness of the documentation, nursing assessments, respiratory therapy assessments, and potential missed opportunities that could have led to earlier interventions, and earlier communication to the PCPs. Diagnostic testing and treatment early in the course of illness as a result of earlier communication potentially would have led to less emergent situations. Completing a quality review of this critical time period would assist in ensuring the Facility is providing all essential supports in a timely manner, and/or determine areas needing improvement. The Skin Integrity Committee remained focused on data collection, with no current systems approach to begin to reduce the incidence of decubiti. The Facility was not yet using the mortality review process as an opportunity to learn from the deaths that occurred, and identify systemic actions necessary to improve the quality of care. In addition, a system for tracking of mortality review recommendations was not in place. The Facility needed to review the quality of the recommendations that were made, and needed to ensure closure on those recommendations. The external peer review process appeared to have had a positive impact on quality care, but questions had been raised about the inter-rater reliability between the auditors. The Medical Department relied heavily on the general medical audit. The Facility should focus on monitoring the many other areas of medical care. The Facility remained in noncompliance with all subsections of Section L.

#	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	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.	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	<u>Staffing and Administration</u> For the census of 418 as of July 2012 (the census at the time of the Monitoring Team visit was 411), there were five PCPs responsible for this population. The Medical Director had a caseload of 22. Other PCPs had caseloads ranging from 39 to 107. At the time of the submitted information concerning caseload, there was an additional locum tenens PCP, bringing the total of PCPs to six during July 2012. That locum tenens position became vacant as of 7/31/12, but had recently been filled at the time of the Monitoring Team's visit. Since the Monitoring Team's last visit, there was one new staff PCP, a Physician Assistant. There was one vacancy in the department. A list was submitted indicating those members of the Medical Department that remained current in CPR certification. The list was dated July 2012. Of the primary care providers in the department five out of five (100%) were current in CPR. Of the five PCPs in the Medical Department, a list of CME credits was submitted for all five of these PCPs. Over the prior six months, this varied from 4.75 hours to 24.75 hours. All PCPs had current licensure, indicating the number of CME hours for licensure had been maintained for renewal purposes. The purpose of reviewing CME was to determine if the CME focused on diagnoses and topics that would enhance the practice patterns of the PCPs at ABSSLC. The topics that were covered included a wide spectrum of topics applicable to the medical needs of the individuals at ABSSLC, and included the following: diabetes mellitus, blood thinning, infectious disease update with focus on pathogens with complex drug resistance, deep tissue injury, antiplatelet therapy, hyponatremia in chronic heart failure, urodynamic studies/treatment for neurogenic bladder, anemia management in end stage renal disease, refractory angina, community acquired pneumonia, screening for colorectal cancer, Methicillin-resistant Staphylococcus aureus (MRSA) recognition and treatment in at-risk populations, treatment of asymptomatic bacteriuria in chronic UTI, medications for urinary incontinence, proton pump inhibitors and diarrhea, erosive esophagitis and risk of Barrett's esophagus, GERD, cognitive decline in middle age adults, advanced cardiac life support update, near fatal asthma and chronic obstructive pulmonary disease, altered mental status, acute coronary syndrome, the non-trauma surgical abdomen, upper respiratory nightmares, evidence-based resuscitation, palliative care, cryptogenic stroke, managing stable ischemic heart disease, and biomarker guided therapy for heart failure, among several others. <u>Physician Participation In Team Process</u> For the three morning medical meetings the Monitoring Team observed, there was a signed attendance roster in three of three meetings. The following departments/staff members were represented at the morning medical meeting over the week of the Monitoring Team's visit (five days). Four of five PCPs attended 100% of meetings. One	

#	Provision	Assessment of Status	Compliance
		PCP attended 60% of morning meetings. Psychiatry was represented at four of five of the meetings (80%). The Dental Department was represented at five of five of the meetings (100%). The Medical Program Compliance Monitor was represented at five of five meetings (100%). Nursing administration was represented at one of five meetings (20%). The Infirmary charge nurse was represented at five of five meetings (100%). The Habilitation Services Department was represented at five of five meetings (100%). Pharmacy was represented at four of five meetings (80%). Psychology was represented at one of five meetings (20%). QDDP representation was present at five of five meetings (100%). A Unit Director was present at five of five meetings (100%). Direct support professional representation was present at five of five meetings (100%). The Hospital Liaison Nurse was represented at four of five meetings (80%). Dietary and infection control (both attend once weekly) were represented at one of five meetings. For the three morning medical meetings observed, there appeared to be adequate updates of the current status of the acute illness. For the three morning medical meetings observed, including two on adjacent days, there were four hospitalizations and 15 admissions to the Infirmary. One hospitalized individual was subsequently transferred to the Infirmary. This totaled 18 individuals with acute illness concerns with severity sufficient to require hospitalization or Infirmary care. With regard to the morning medical meeting committee's critical review of steps to prevent recurrent Infirmary admission or hospitalization, based on observation and a review of the minutes: ▪ For none of the 18 cases were critical clinical questions raised, followed by a request for the IDT to meet to review the individual's case to identify preventive measures, with subsequent development of an ISPA. ▪ For none of 18 cases, did the committee raise/identify critical clinical questions needing closure concerning steps to be taken to prevent a recurrence. ▪ For none of 18 cases did the committee discuss additional steps to be taken to treat the individual early in the illness to prevent an ER visit, hospitalization, or Infirmary admission. ▪ For none of 18 cases did the committee request that the record be reviewed to determine preceding events, monitoring intensity, etc. before the onset of acute illness. ▪ For those with aspiration pneumonia, reactive airway disease, or recurrent pneumonia with undetermined etiology, there was no scheduling of a record review for the prior seven to 14 days of the illness to review monitoring of care, positioning documentation, feeding concerns, early warning signs that could have been assessed and reported to the PCP, discussion of involvement of the	

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		PNMT, listing of preventive areas to be considered based on the diagnosis causing the acute illness, adequacy of medical evaluation, need for consultation, review of medications and medication side effects, etc. The hospital nurse liaison reported a thorough update of four of four hospitalizations during the meetings the Monitoring Team observed. For the three morning medical meetings the Monitoring Team observed, the on-call PCP (from the prior evening) participated in presenting the cases in two meetings. Coverage was arranged for discussing information for the on-call cases at one meeting when the on-call PCP was unable to attend. Infirmary admissions were discussed at three of three morning medical meetings. There appeared to be adequate acute care testing and treatment in six of six admissions, based on the Infirmary Nurse's presentation. However, following the individual's review by the Infirmary Nurse, it was not routinely expected that the PCP would provide a brief summary of medical progress to date and next steps that were to occur, including rationale. The format of the meeting appeared to be a daily nursing report/update rather than an interdisciplinary health care meeting. PCPs were noted to provide some comments, but there appeared to be no uniform requirement that the PCP share clinical decision-making, rationale, and anticipated next steps/work-up for each individual admitted to the Infirmary. There was in-depth discussion concerning the appearance of initial signs and symptoms prior to the hospitalization, potential precipitating events, past pattern of similar illness, predisposing comorbid conditions, prior tests and results, and the cause and prevention of recurrence in a succinct brief format for none of the four hospital admissions at the observed meetings. Although one might not expect detailed background information on the first day of admission to the hospital or Infirmary, the PCP should be expected within a few days and prior to an individual's return to ABSSLC or to the residence to articulate the important historical events, what tests had been completed with results, differential diagnosis for recurrent problems (e.g., refusal to eat, fevers, anorexia, repeated emesis, repeated pneumonia), and plan. Morning medical meeting minutes did not reflect interdisciplinary discussion when it occurred. For the three morning medical meetings observed, updated information was presented for closure for three individuals. One closure item related to administrative issues in the month of August 2012. As of 8/24/12, there were nine other concerns closed in August. The request dates ranged from 7/27/12 to 8/17/12. There remained nine outstanding	

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		open concerns, dating from 7/5/12 to 8/24/12. An assigned due date should be established at the date of assignment to guide the staff responsible for completion of the task. Morning meeting minutes were submitted from June 26, 2012 to July 10, 2012, as well as the week of the Monitoring Team's visit. Several individuals were identified with repeated or continuing concerns, but, from the minutes, the morning medical meeting committee asked no critical questions to which the IDTs provided follow-up and/or PCPs provided responses. Concerns included: ▪ An individual had an over 45-pound weight loss in five months, with an incomplete medical evaluation during this time. ▪ Another individual had over 30 episodes of vomiting over the prior six months, but the evaluation remained incomplete. Some tests had been done to rule out concerns, but there was no open review of the record to determine time lines/periodicity of vomiting, the role of vertigo in positioning-induced vomiting, the role of the VNS in emesis, the function of the esophageal sphincter in preventing reflux, etc. There appeared to be no methodical approach to the assessment over six months of vomiting. The morning medical team did not ask critical questions to challenge the PCP and the IDT to consider a more timely evaluation. ▪ For another individual, the IPNs recorded 105 meal refusals from January to August 2012. It was not until 7/9/12 that a gastroenterology consult was ordered, but the individual was subsequently admitted to the hospital for septic shock and aspiration pneumonia. Considering the prolonged course and multitude of potential issues from food preferences to reflux to the need for an updated MBS, as well as the history of a potential unwrapping of an earlier fundoplication, there appeared to be a non-aggressive approach in completing the evaluation. Potential areas that were not ruled in or out included depression, dementia, gastroparesis, gastritis, peptic ulcer disease, and medication side effects, among other considerations. It did not appear the morning medical team asked critical questions to challenge the PCP and the IDT to review this individual's case. ▪ Another individual was hospitalized for respiratory arrest in February 2012, with frequent readmission to the Infirmary on 2/24/12 and 4/14/12, hospitalization for respiratory distress on 5/1/12, Infirmary admission from the home on 5/9/12, and hospitalization on 8/20/12 for pneumonia. From the submitted documentation, over the many months, there appeared to be a lack of aggressiveness in the work-up. The Medical Department should review the time lag between an order being written, the consult scheduled, and the date of the consult, to reduce the time delays in obtaining needed evaluations in medically complex individuals.	

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		▪ Other recently hospitalized individuals appeared to have had conditions that if treated early and aggressively, might have reduced the risk of prolonged illness and complications. One individual developed anasarca, due to a severely low albumin. An early aggressive comprehensive evaluation was lacking in the submitted documentation. Despite many episodes of vomiting, and the development of decubiti, it was not until 8/2/12 that a consideration for consultation and testing for this concern was addressed. On 8/13/12, an upper gastrointestinal series identified significant reflux, and an appointment to the surgeon for a repeat fundoplication (which had become unwrapped). The individual then required hospitalization for respiratory distress before any intervention could be completed. There appeared to be lack of an aggressive response from the PCP and the lack of questioning at the morning medical meeting. As an interdisciplinary forum, other business was conducted during the morning medical meetings observed or reviewed in submitted documents, including: ▪ At the 6/29/12 morning meeting, there were several proposals presented. One was a pro-active approach to obtaining a quality family history. A form was created and proposed for use with the ISP. Additionally, listing a pulse oximetry reading as part of the monthly vital signs was proposed at the morning medical meeting. Also, there was discussion about creation of a Wellness Center for promoting exercise and a healthy life style. There was no further information submitted to determine progress in any of these areas. ▪ At the 7/25/12 meeting, the Medical Director requested that pet therapy not occur in the 24-hour nursing residences due to the respiratory conditions of the individuals in these homes. ▪ There was a discussion at the 8/23/12 morning medical meeting concerning an employee with chickenpox, and the role of the infection control nurse in identifying individuals and employees at risk for infection. These examples demonstrated the morning medical meeting played an important role for discussing potential system improvements and concerns at ABSSLC. <u>Routine Care</u> A list of dates of the last two annual medical assessments and physical exams were submitted. The list totaled 421 individuals. Individual names were removed when the prior date of the annual was not provided (which would have occurred with new admissions or missing data), as well as individuals for whom the data entry date for the prior year was likely a typographical error. Eight individual names were removed due to no prior date of completion of an assessment. This left a total of 413 individuals. Of these, 233 out of 413 (56%) of the recent annual medical assessments were completed within 365 days of the prior assessment.	

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		A list of dates of the last two quarterly medical reviews was submitted as part of a data chart, which included annual assessment data. Of the 421 individuals listed, it was noted that in the prior two calendar quarters, 91 quarterly medical reviews had been completed. However, only three quarterly medical reviews are required for each individual. The fourth quarterly review was to be replaced by the annual assessment. The assumption was made that the annual assessments were equally distributed throughout the year. For each quarter, of the 421 individuals, 75% would be expected to have a quarterly medical review completed. Of the 421 individuals, 316 quarterly medical assessments would be expected. For two quarters submitted, this would total 632 quarterly medical assessments. As 91 quarterly medical reviews were listed, this was a compliance rate of 91 out of 632 (14%). For 20 individuals, a copy of the 20 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. 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 two individuals, the prior annual medical summary and physical examination evaluation was not submitted. For the remaining 18 individuals, compliance was 17 out of 18 (94%). For the 20 most recent annual medical assessments, there was an interval history included as part of the document in 20 of 20 reviews (100%). For the 20 most recent annual medical assessments, the major active problems listed had plans of care addressing each of these problems in 19 of 20 assessments (95%). For the 20 most recent annual medical assessments, 20 (100%) addressed smoking history. Family history was adequate/helpful in 11 of 20 (55%). A discussion of requirements for transition to the community was included in 18 of 20 (90%). As part of the review process, the Monitoring Team selected the medical records of 13 individuals to determine compliance with several requirements of Section L.1. These individuals are listed in the documents reviewed section. The reviews selected were based on different sampling methods. First, every 68th name listed on a census was selected, after the first name was chosen by random selection, resulting in the selection of six individual. A second sample of seven was selected by identifying individuals with	

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		various diagnoses/health care issues, and selecting a sample of individuals from each category (e.g., aspiration, GERD, skin breakdown, cardiac issues, etc.). This additional sample was selected to allow the Monitoring Team to comment on the appropriateness of the healthcare provided to individuals with various medical needs. A total number of 13 active records were reviewed for this monitoring process. Documents reviewed included preventive care flow sheet, physician orders for the past one year, integrated progress notes for the past one year, most recent PBSP, last annual ISP and subsequent addendums, labs, x-rays, consult forms from the past one 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. Each aspect is discussed as the relevant preventive or routine care topic is discussed. From 13 medical records reviewed: ▪ 13 of 13 (100%) annual medical assessments had been completed in the past 365 days. ▪ Active problem lists appeared to be thorough (complete and up-to-date) in 11 of 13 (85%). ▪ 13 of 13 (100%) had information about smoking history. ▪ A family history was documented in eight of 13 records (62%). ▪ 13 of 13 (100%) had information discussing requirements for transition. ▪ The DG-1 forms were reviewed. Of the 13 DG-1s reviewed, one of 13 (8%) listed the most significant current diagnoses. These 13 medical records also were reviewed to determine whether the physician IPN note used the SOAP format. In 13 of 13 (100%), the SOAP format was used, and included date and time on the IPN. Eight of 13 medical records (62%) had a PCP quarterly review of medical progress during any quarter in the prior year. Six records only had completed one quarterly review. One record had two quarterly reviews, and one record had three quarterly reviews. For the time period from July through December 2011, there were two quarterly reviews completed. From January through March 2012, there were four quarterly reviews completed. From April through June 2012, there were two quarterly reviews, and from July to August 2012, there were three quarterly medical reviews. Contents of the quarterly medical review were assessed in a sample of eight completed in 2012. Findings included: ▪ Major diagnoses were listed in eight of eight (100%) medical quarterly reviews.	

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		▪ The last three monthly weights or equivalent information was recorded in eight of eight (100%) medical quarterly reviews. ▪ There were brief comments/entries listing numbers of seizures (if applicable) in seven of seven (100%) medical quarterly reviews. ▪ There was documentation of changes in medication in two of two (100%) medical quarterly reviews. ▪ There was documentation of important/abnormal labs and drug levels in none of the medical quarterly reviews. ▪ There was documentation of ER visits, Infirmary admissions, and hospitalizations with dates and discharge diagnoses/treatments in five of five medical quarterly reviews. ▪ There were comments on important consultation results (brief) in six medical quarterly reviews. The quarterly medical reviews were generally two to five pages in length. It is recommended that a format be developed that is one-page in length, into which specific information can be entered (either through transcription or directly), including the important components of a medical quarterly review. It appeared the entire active list was pasted into the document, but this added length without focusing on important information and changes in the prior quarter. <u>Access to Specialists</u> The following numbers of completed off–site visits for consultation or procedures were documented: Allergy – two; Cardiology – 46; Cardiovascular surgery – two; Colorectal surgery – one; Dermatology – one; Gastroenterology – 45; Genetics – one; Hand surgery – one; Hematology/oncology – 27; Infectious disease – two; Internal medicine – two; Nephrology – five; Neurology – four; Neurosurgery – seven; Ophthalmology – 147; Optometry – 25; Orthopedic surgery – 29; Otolaryngology – nine; Pacemaker clinic – one; Pain management – five; Pediatrics – one; Pediatric cardiology – one; Pulmonology – six; Retinal specialist – two; Rheumatology – five; Sleep study – six; General surgery - 12; Urology – six; and Wound care – 10. Information was submitted concerning missed off-site appointments: ▪ For the cardiology visits, six of 52 appointments (12%) were missed. ▪ For cardiovascular surgery two of four appointments (50%) were missed. ▪ For gastroenterology, seven of 52 appointments (13%) were missed. ▪ For hematology/oncology, five of 32 appointments (16%) were missed. ▪ For infectious disease, two of four appointments (50%) were missed. ▪ For ophthalmology, 36 of 183 appointments (20%) were missed. ▪ For optometry, four of 29 appointments (14%) were missed. ▪ For orthopedics, one of 30 appointments (3%) was missed.	

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		▪ For otolaryngology, one of 10 appointments (10%) was missed. ▪ For pulmonology, two of eight appointments (25%) were missed. ▪ For general surgery, four of 16 appointments (25%) were missed. ▪ For urology, two of eight appointments (25%) were missed. ▪ For wound care, one of 11 appointments (9%) was missed. The other specialties listed either did not have missed appointments or they were not submitted. The total of scheduled appointments for all off-site specialty visits was 484. Of these, 411 appointments were kept and 73 were missed. The percentage completed totaled 411 out of 484 (85%). Of the appointments missed, six of 73 (8%) were due to refusals. Other reasons for missed appointments included: no show, MD cancelled, rescheduled, no labs, needs sedation, sick, guardian refused, rescheduled aggressive, rescheduled fracture, MD emergency, and uncooperative. Some of these may have been more appropriately categorized as refusals. On site, several specialty clinics were held to meet the needs of the individuals. These included the following specialty clinics: ▪ Dermatology: on 2/15/12, 3/9/12, 3/14/12, 5/2/12, and 6/13/12; ▪ Ear irrigations: on 2/16/12; ▪ Endocrinology: on 1/26/12, 2/16/12, and 3/15/12; ▪ ENT and allergy: on 1/10/12, 2/16/12, 3/13/12, and 6/14/12; ▪ Gynecology: on 1/26/12, and 5/23/12; ▪ Neurology and VNS: on 1/9/12, 1/23/12, 2/13/12, 2/27/12, 3/12/12, 3/26/12, 4/9/12, 4/23/12, 5/14/12, and 6/11/12; ▪ PAP clinic: on 1/31/12, 2/23/12, 4/4/12, 5/10/12, and 6/20/12; ▪ Podiatry: on 2/21/12, 4/17/12, and 5/29/12; ▪ Radiology: on 1/4/12, 1/10/12, 1/17/12, 1/24/12, 1/31/12, 2/8/12, 2/14/12, 2/22/12, 3/6/12, 3/13/12, 3/21/12, 3/27/12, 4/3/12, 4/10/12, 4/20/12, 4/24/12, 5/1/12, 5/7/12, 5/14/12, 5/23/12, 5/29/12, 6/5/12, 6/12/12, 6/18/12, and 6/26/12; ▪ Urology: on 1/6/12, 2/3/12, 4/6/12, 5/4/12, and 6/1/12; and ▪ Visual screening: on 2/7/12, 3/16/12, 3/21/12, 4/26/12, 5/16/12, 5/24/12, and 6/28/12. The number of specialty clinics per month at ABSSLC was the following: January 2012 – 12; February 2012 – 13; March 2012 – 13; April 2012 – 10; May 2012 – 13; and June 2012 – 10. For onsite clinics, the number of missed appointments for all reasons (i.e., refusals and non-refusals) was submitted, along with the number of visits completed for that clinic/specialty. They included: ▪ For Allergy, one out of eight appointments (13%) was missed.	

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		▪ For Dermatology seven out of 51 appointments (14%) were missed. ▪ For Endocrinology, one out of 22 appointments (5%) was missed. ▪ For ENT, two out of 34 appointments (6%) were missed. ▪ For pap and pelvic clinic, 13 out of 34 appointments (38%) were missed. ▪ For Podiatry, 11 of 91 appointments (12%) were missed. ▪ For Urology, one of 26 appointments (4%) was missed. ▪ For the VNS clinic, 37 of 314 appointments (12%) were missed. The total number of these specialty clinics held at ABSSLC totaled 556. Of these, 483 appointments were kept, and 73 appointments were missed for a completion rate of 483 of 556 (87%). Of the appointments missed, 38 were due to refusals (38 of 73, or 52% of missed appointments). Other reasons for missed appointments included: no show, rescheduled, at school, sick/in the Infirmary, restrictions, furlough, moved, off campus appointment, and had ISP. The following were departments/specialties for which percentages of missed appointments could not be determined, because the number of completed visits was not submitted. However, the number of missed appointments was valuable information. ▪ Missed appointments were also provided for the ear irrigation clinics, including 47 individuals missing appointments. The denominator of attendance was not submitted. It was also noted that ear irrigation was scheduled each month of the prior six months, which was different from the on-site clinic list that only mentioned one ear irrigation clinic for February 2012. It was not determined if the missed appointments for ear irrigation were individualized appointments or appointments scheduled within a formal clinic. ▪ Laboratory also submitted missed appointments. The information for missed appointments was provided for the following months: January 2012 – 17, February – 12, March 2012 - 21, April 2012 – 19, May 2012 – 14, and June 2012 – 22. The reasons for the missed appointment were varied, and provided an opportunity for further review by the IDT and by the morning medical meeting. There was no information submitted to indicate this information was shared with the IDT or morning medical meeting, or if so, any response from these teams. ▪ The x-ray office/department also submitted missed appointments. The information for missed appointments was provided for the following months: January 2012 - 12, February 2012 – six, March 2012 – one, April 2012 – two, May 2012 – five, and June 2012 – none. ▪ A list of missed appointments for annual physical exams and physical exams for surgical clearance was also provided. The following was a list of missed appointments per month: January 2012 – 28, February 2012 – 20, March 2012 – 21, April 2012 – 24, May 2012 – 20, and June 2012 – 25.	

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		▪ For the visual acuity clinics, seven individuals had missed appointments for the prior six months. ▪ For the psychiatry clinics, a list was submitted for missed appointments. In the prior six months, there were 10 missed appointments. The quality of completion of the consultation referral forms by the PCPs is reviewed as part of the peer review process. This is discussed in further detail in Section L.2 and L.3. 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> Preventive care flow sheets were in place to facilitate tracking of standard testing and evaluations in 13 out of 13 records reviewed (100%). Preventive care flow sheets were up-to-date in seven out of 13 records reviewed (54%). Current vision screening was documented since July 1, 2011, in eight out of 13 records reviewed (62%). Current vision screening was documented since July 1, 2010, in 12 out of 13 records (92%). Audiological screening was documented since July 1, 2011, in eight out of 13 records (62%). Audiological screening was documented since July 1, 2009, in 13 of 13 records (100%). The influenza vaccination had been given to 13 individuals (100%) in a timely manner during 2011. 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 12 of the 13 active records reviewed (92%). Whether the individual needed to receive a hepatitis B vaccine (depending on immunity status, carrier state, etc.), and whether the series was completed, if indicated (or being tracked for completion), was recorded in 13 of the 13 active records reviewed (100%). A list was submitted identifying women residing at ABSSLC who were over the age of 40, along with the date of last mammogram, and the reason, if it was not done or outdated. A total of 134 women were identified as being over the age of 40 and under the age of 70. The American Cancer Society recommendations were to be followed, according to a DADS SSLC policy #009.1, dated 2/16/11. Of these 134 women, 13 had reasons not to have a mammogram (e.g., guardian refusal, inability to physically provide proper	

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		positioning for the test, etc.). Of the remaining 121 women, 116 had mammograms within the prior year. This was a compliance rate of 116 out of 121 (96%). It was noted that there were 23 women aged 70 or greater. The State Office recommendation/ guideline used was for those women age 70 or greater, that the decision to order a mammogram was at the discretion of the PCP and individual. Of the 23 women, five had reasons for not completing a mammogram. Of the 18 remaining women, 17 (94%) had a mammogram completed during either 2011 or 2012. Separately, a list of all women age 40 or greater was submitted. This listed 167 individuals, of which 26 were ages 70 or greater. Subtracting 26 (age 70 or greater) from 167, there were 141 women who would be included in the guideline for mammograms. Seven women appeared to be not on the prior list for whom routine mammograms would have been indicated. The reason for the discrepancy was not clear. From the sample of 13 medical record reviews, there were four females between the ages of 40 and 70. Of these, one had a reason documented for not completing a mammogram. Of the three eligible females, three (100%) were up-to-date on mammogram testing. From the sample of 13 active records reviewed, there were five females between the ages of 21 and 65. Of these, one had a reason documented for not completing a pap smear. For the four remaining individuals for whom a pap smear was recommended, four were current in having completed this exam (100%). 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 173 names were submitted for individuals between the ages of 50 and 75. Of these, 14 of these had reasons not to complete a colonoscopy. Therefore, the eligible population was 159 individuals. Of these, 132 completed a colonoscopy within the prior 10 years or had alternate testing considered acceptable as clinical equivalents. Of the 159 individuals for whom a colonoscopy or clinical alternative was indicated between the ages of 50 and 75, the compliance rate was 83%. The Facility indicated that there were "no ISPAs reported regarding missed mammogram or colonoscopy appointments or refusals for the past three months." From the 13 medical record reviews, there were five individuals between the ages of 50 and 75, for whom a screening colonoscopy would be recommended. One had a reason documented for not undergoing a colonoscopy. Of the remaining four individuals, three (75%) had a colonoscopy completed in the prior 10 years.	

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		Osteopenia/Osteoporosis A list of individuals with a diagnosis of osteopenia or osteoporosis was submitted. Identification of the medications and dosages of the medications treating these diagnoses also was requested. Additionally, for all those over 50, a list of the last DEXA scan date and copies of the most recent DEXA scan report, when completed, were requested. A total of 230 individuals with a diagnosis of osteopenia or osteoporosis were reviewed. Of these, 229 were provided on a list for this document request (untitled), and one additional DEXA scan of an individual not on the list was included in the DEXA scan reports. Of these, 218 had a DEXA scan submitted. Of the 230 individuals, 141 were diagnosed with osteoporosis (based on T score radiological interpretation, or if not submitted, according to the diagnosis provided on the submitted list). Another 79 had osteopenia. An additional 10 had normal findings on the DEXA scan report. Notably, 27 had a diagnosis inconsistent with the T score radiological interpretation. With regard to treatment: ▪ For the 79 with osteopenia, 48 had been prescribed calcium (61%), and 42 had been prescribed vitamin D (53%). Additionally, 44 out of 79 (56%) were prescribed additional medication such as a bisphosphonate. ▪ For the 141 with osteoporosis, 87 (62%) were prescribed calcium, 78 (55%) were prescribed Vitamin D, and 112 (79%) were prescribed additional medication, such as a bisphosphonate, Prolia, or Miacalcin, or were on a drug holiday. ▪ The dietary department submitted a review of 226 of these 230 individuals, including calcium requirements. As several were maintained with tube feedings and nutritional supplements, this was valuable information. The Medical Department should ensure the dietary recommendations are incorporated into the medication regimen. The completeness of the information provided was not clear. For those with osteoporosis, that only 79% had been prescribed additional medication for this diagnosis was concerning. It is recommended that the data be reviewed to determine accuracy/completeness of the information. If accurate, then it is recommended that the Medical Department monitor the diagnosis and treatment of individuals with osteopenia/osteoporosis. From the sample of 13 medical records reviewed, eight had a diagnosis of osteoporosis or osteopenia. ▪ Of these, eight (100%) had a DEXA scan/T score recorded. ▪ Of these, eight (100%) had a T score consistent with the diagnosis of osteoporosis or osteopenia. Six had a diagnosis of osteoporosis, and two had a diagnosis of osteopenia.	

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		▪ Of these, eight (100%) had been prescribed supplemental calcium and vitamin D. ▪ Of the six diagnosed with osteoporosis, six (100%) were prescribed a bisphosphonate, Miacalcin, or Prolia. ▪ Of these, four of six (67%) had a bisphosphonate prescribed (i.e., active order or current drug holiday). ▪ Of these, one of six (17%) had Miacalcin prescribed, ▪ Of these, one (17%) had other alternative medications prescribed for treatment of osteoporosis or osteopenia. *Thyroid testing in Individuals with Down Syndrome* A list of those with Down syndrome was submitted, along with the date of the last thyroid test. A total of 17 individuals were identified with a diagnosis of Down syndrome. Of these, 15 (88%) had a current thyroid test. It was noted that the Preventive HealthCare Guidelines for the SSLCs, dated 8/30/11, provided guidance for thyroid testing every three years, and also referenced the HealthCare Guidelines, which recommended an annual level "as indicated." Providing the most recent test results for the listed individuals (and the reference laboratory's normal range values) would have been helpful to determine the need for annual testing, or whether a three-year interval for testing was appropriate. Nine of the 17 had test results included. The reason for lack of test results for the remainder was not provided. <u>Acute and Emergency Care</u> The active record was reviewed for 10 individuals who had most recently gone to the Emergency Room and returned. These individuals are listed in the documents reviewed section. These 10 individuals visited the Emergency Room 11 times. Six of the individuals had gone to the ER from their residence. Four had gone from the Infirmary to the ER. For one visit, the individual was transported while in the community to the ER. The following summarizes the results of this review: ▪ Information was submitted documenting that the ER was notified verbally of the arrival of the individual with appropriate medical background information provided for four of 11 (36%) ER visits. ▪ Prior to the transfer to the ER, a PCP was on site for four of these transfers. In four of four (100%) records, the PCP had written an IPN that included the date and time. ▪ For one of four (25%), a set of vital signs was recorded. For an additional one, a pulse rate was recorded. ▪ For four of four (100%), reason for the transfer was documented. ▪ In three of the four (75%), the SOAP format was utilized. ▪ A copy of the ER report that was filed in the record was submitted in 11 of 11 (100%).	

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		▪ Of the 11 ER visits, diagnostic categories included: hypoxia, respiratory distress, and potential aspiration – three; hypothermia – one; falls - two; pain associated with pulling out a chest tube early – one; failed neuro-check – one; chest pain – one; post-operative vomiting – one; and pneumonia – one. ▪ Transfer to the ER was considered timely in 10 of 11 (91%). For one individual, it appeared the positioning by staff aggravated the illness. An individual was held upright while vomiting with potential subsequent aspiration. ▪ When the individual returned to the Facility after evaluation at the ER, 11 of the 11 active records (100%) had an IPN. Of these 11, 11 (100%) utilized a SOAP format. ▪ These notes included the date and time in 11 of 11. ▪ Vital signs were recorded in five of the 11 IPNs (45%). ▪ A summary of ER information and findings was included in 11 IPN notes (100%). ▪ When returning to the Facility, none returned to the individual's residence, and 11 returned to the Infirmary. ▪ Seven of the 11 records (64%) had additional PCP notes as follow up to the original concern. Additionally, 10 active records were reviewed for those individuals admitted to the hospital. The following provides the results of this review: ▪ For these 10 records, the PCP wrote a pre-hospital evaluation/transfer note or telephone call note in 10 of the 10 hospitalizations (100%). ▪ Ten individuals returned to the Facility. None died while in the hospital. Of the 10 individuals that returned to the Facility, nine (90%) had IPNs post hospitalization. For one post hospitalization, there was a note that there had been a dictation, but it was not available in the submitted documents. ▪ Of the nine post-hospital IPNs submitted, six (67%) included vital signs. ▪ Seven of nine (78%) included date and time. ▪ Nine of nine (100%) had an adequate summary of hospital events and findings. ▪ Nine of nine (100%) active records used the SOAP format. ▪ Nine of 10 records of the hospitalized individuals (90%) included a copy of the hospital admission history and physical. ▪ Nine of the 10 (90%) included a copy of the hospital discharge summary. ▪ Nine of the 10 (90%) included a copy of either the hospital admission history or physical, or a copy of the hospital discharge summary. One included neither of these documents. ▪ Three of the 10 (30%) included hospital liaison nurse notes for the individuals with the submitted IPN entries. Separately, 10 of 10 hospital admissions had hospital liaison nurse notes (100%). It appeared they were not in the active record, or filed separately in the active record.	

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		▪ For seven of the 10 individuals that returned to the Facility (70%), additional PCP notes were included as part of the follow-up. For one individual, there was a note indicating additional dictation, but there was no evidence of this in the submitted documents. ▪ Reasons for hospitalization included: planned surgery - one, respiratory illness - five, both urosepsis and pneumonia - one, and abdominal illness – three. Of the 13 medical records reviewed, four had been hospitalized in the prior year July 1, 2011 through July 1, 2012. Three were admitted to the hospital with respiratory distress and one had a fecal impaction. *Infirmary* ABSSLC had an Infirmary. According to the submitted data, the admissions of individuals to the Infirmary over the prior six months (from 1/1/12 to 6/28/12) was as follows: ▪ The length of stay varied from less than one day to 92 days. The average length of stay was 6.5 days. ▪ The number staying one day or less was 57. ▪ The number staying two days was 19. ▪ The number staying three days was 12. ▪ The number staying four days was 13. ▪ The number staying five to nine days was 29. ▪ The number staying 10 to 19 days was 18. ▪ The number staying 20 to 29 days was three. ▪ The number staying 30 to 59 days was one. ▪ The number staying 60 or more days was two. ▪ There were four individuals admitted in June 2012 for which the date of discharge had not occurred at the time of the submitted data. The number of individuals admitted to the Infirmary per month was as follows: ▪ January 2012 - 36 individuals; ▪ February 2012 – 21 individuals; ▪ March 2012 – 40 individuals; ▪ April 2012 – 21 individuals; ▪ May 2012 – 28 individuals; and ▪ June 2012 – 14 individuals (to 6/28/12). From the 13 medical records reviewed, during the prior year of July 1, 2011 through June 30, 2012, seven of the 13 (54%) were placed in the Infirmary once or more than once. *Pneumonia* There were four datasets that compiled incidents of pneumonia.	

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		▪ From a dataset entitled: "Summary Report (overall)," from 1/1/2012 through 3/31/2012 (three months), there were six pneumonias and one aspiration pneumonia. For the time period from 4/1/2012 to 5/31/12 (two months), there were six pneumonias and two aspiration pneumonias, for a total of 15 pneumonias. A report entitled "Communicable Disease Report" for the first two calendar quarters of the year provided details. Of the 15 cases of pneumonia listed, nine of the 15 individuals (60%) had feeding tubes. Of these nine, two had feeding formulas with a bolus method of feeding, and six had an intermittent feeding schedule. For one, there was insufficient information provided. Six of the 15 (40%) took nutrition orally. Of these, there were two on a regular diet. The other four had therapeutic textures (i.e., chopped, pureed, etc.) and thickened liquids as part of the dietary plans. ▪ The Avatar pneumonia tracking data documented 16 pneumonias during the time period of 1/3/12 through 6/4/12. There were three aspiration pneumonias, and the remainder was categorized as pneumonia. One was considered a community-acquired pneumonia. Seven occurred in the first quarter of 2012 (similar to the above data), and nine occurred in the second quarter of 2012. Eight of the 16 individuals had feeding tubes. Of these, the rate of feeding was bolus – two, intermittent – four, continuous – one, and not submitted – 1. For those taking nutrition orally, two were on a regular diet and six were on a specific therapeutic diet (textured, etc.) and/or thickened liquids. ▪ A third set of data for pneumonia listed 16 individuals. However, there was one name listed not on the Avatar pneumonia-tracking list. It also listed seven individuals of the 16 taking nutrition orally. ▪ A fourth set of data derived from the "Communicable Disease Report" for the period from 1/1/2012 through 3/31/12, listed two aspiration pneumonias and six other pneumonias, which was slightly different than the other data sets. The four sets of data of pneumonia had similar data, but there were inconsistencies when comparing one to the others. It is recommended that these be reviewed to determine steps needed to ensure consistency across the databases. The Dental Department provided information concerning the last dental visit prior to any diagnosis of pneumonia for the past one year (i.e., 6/11 to 6/12). For the first calendar quarter of 2012, eight pneumonias were listed (the prior dataset indicated there were seven pneumonias during this time). For the second calendar quarter of 2012, there were nine pneumonias listed (the prior dataset indicated there were eight pneumonias). Of the 17 pneumonias listed, one had a dental appointment the day the diagnosis of pneumonia was made, but it was an annual exam with no anesthesia. The individual was edentulous. For all other cases, there were seven or more days from the dental visit to the diagnosis of pneumonia. None had anesthesia, and the only procedure completed	

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		was an annual exam, or a recall prophylaxis. The information did not suggest dental procedures were associated with increased risk of pneumonia. For the time period of 6/11 through 6/12, there were 43 pneumonias listed. There was no use of anesthesia for any of these in the prior dental visit. Except for the one dental visit already mentioned, there were no dental visits temporally associated with a diagnosis of pneumonia. *Trauma* During the time period from 1/14/12 through 6/9/12, there was one fracture. During the time period from 1/14/12 through 6/9/12, three individuals went to the ER or were hospitalized for injuries. <u>Chronic Conditions and Specific Diagnostic Categories</u> As part of the review of 13 medical records, GERD was reviewed. Of the 13, five were diagnosed with GERD or recommended to have GERD treatment by a gastroenterology consult. Of these five, four were noted to have adequate treatment (80%). Four were prescribed medications, none underwent surgery in the past one year, and none had a related procedure performed in the past one year. Information was submitted concerning new diagnoses of chronic conditions that occurred over the past year. From July 2011 through June 2012, one individual was newly diagnosed with diabetes mellitus type II. Six individuals were newly diagnosed with cardiovascular disease. Two cases of a newly diagnosed cancer were reported in the past year. Six cases of sepsis were identified. An updated list of pica or ingestion of inedible objects was submitted for the time period of 2/1/12 through 7/9/12. The total included 70 events involving 19 individuals. Of these, seven incidents were listed without dates of occurrence. One individual had 18 pica events, and one individual had 19 pica events. At ABSSLC, 374 individuals had a diagnosis of constipation or were treated with anti-constipation medication at least weekly. This was 374 out of 411, or 91% of the census. According to data submitted, from January through June 2012, four individuals were diagnosed with fecal impaction, ileus, or partial ileus. The Facility submitted names of 11 individuals that had tracheostomies. A Skin Integrity Committee met on 6/1/12, 6/22/12, and 7/13/12. Minutes were submitted for these three meetings. The 6/1/12 meeting minutes reviewed the use of a tool to document and track wound healing progress. This was to be researched for the next meeting. On 6/22/12, the group continued the discussion of a wound assessment tracking tool. At the 7/13/12 meeting, the group reviewed the data for the prior year.	

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		However, this information was not submitted. Nursing Administration noted that the excel database and the paper report did not match. There were differences in terminology, which was an additional challenge. A recommendation was made to consolidate the reporting of decubiti, to standardize the language used, and to develop curriculum for training on database entry. The wound assessment tool continued to be discussed. In these meeting minutes, there was no information provided concerning the number of active pressure sores that were documented. No information was provided concerning whether these ulcers started at ABSSLC, or how many of these ulcers were noted to begin in the hospital or other setting. No information was provided concerning the number of Stage 2 ulcers, Stage 3 ulcers, Stage 4 ulcers, and unstagable ulcers. It is recommended that database discrepancies be resolved, and trend analysis be performed, with a quality improvement plan to reduce decubiti. Given the number of decubiti that occurred in the year prior to the Monitoring Team's last visit, this is an area that needs uninterrupted focus and continued emphasis on preventive care. A list was submitted indicating for the time period of January 2012 through June 2012, 19 decubiti were reported. This was an improvement over the prior six months of June through December 2011, during which 38 decubiti were reported. However, these numbers still showed the need for focused attention on this issue. The Facility submitted information concerning antiepileptic medication usage. The most recent data submitted indicated that 216 individuals were prescribed antiepileptic medication. Of these, 105 (49%) were prescribed one antiepileptic medication, 71 individuals (33%) were prescribed two antiepileptic medications, 35 individuals (16%) were prescribed three antiepileptic medications, five individuals (2%) were prescribed four antiepileptic medications, and none (0%) was prescribed five antiepileptic medications. At ABSSLC, 28 individuals were considered to have a refractory seizure disorder. The definition of intractable (refractory) seizure disorder used for the listing was: "36 or more seizures in the last three months or presence of a vagal nerve stimulator." This definition for refractory seizure disorder was not listed in the definitions section of the SSLC policy: SSLC Nursing Protocol: Seizure Management Guidelines, dated February 2011. In this policy, the definition for intractable epilepsy was: "seizures that do not come under control are called intractable or refractory. There is no standardized definition of medically intractable epilepsy. However, the definition used as an indication for other therapeutic options characterizes intractability as: two antiepileptic drug failures, at least one seizure per month for 18 months, and no seizure-free periods longer than 3 months during that time." It is recommended that the Facility review the various definitions for intractable (refractory) seizures and determine a common definition that is used across all policies and documents.	

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		For the 28 individuals considered to have a refractory seizure disorder, 27 of these had a VNS implant. No individual with a refractory seizure disorder was currently being evaluated for a VNS implant. For these 28 individuals, four were documented to have had more than 36 seizures in the prior three months. The Facility submitted a document indicating that no individual was transferred to the community ER for uncontrolled/prolonged/new onset seizure from January 2012 through June 2012. This was inconsistent with another document listing individuals with prolonged seizures from January 2012 through June 2012. There were 10 individuals listed on this latter document, with notation that four individuals had gone to the ER/hospital. Three of these individuals had visited the ER twice. Additionally, 36 individuals with a diagnosis of seizures were on no antiepileptic medications. A list was submitted indicating the percentage of individuals that were prescribed older antiepileptic medications. A total of 34 individuals (16%) of individuals with seizures were prescribed Dilantin, seven individuals (3%) were prescribed Primidone, 72 individuals (33%) were prescribed Phenobarbital, and five individuals (2%) were prescribed Felbamate. From January 2012 through June 2012, 10 neurology clinics were held on site. For each clinic, there were 21 to 30 individuals seen by the neurologist. 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: ▪ For two of the five individuals (40%) submitted documentation indicated that they had been seen more than once over the past six months. For the other three individuals, this information was not determined. ▪ For five of five individuals (100%), the notes indicated a description of the seizures. ▪ For five of five individuals (100%), the notes included a review of current medications for seizures and dosages. ▪ For four of four individuals (100%), notes included recent blood levels of antiepileptic medications. For one individual, blood levels were not indicated for the antiepileptic medication prescribed. ▪ For five of five individuals (100%), the notes included recommendations. ▪ For five of five individuals (100%), MOSES/DISCUS results were used to determine side effects. ▪ For five of five individuals (100%), reference was made to wellness or exam findings.	

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		▪ For five of five individuals (100%), there was notation of adequacy of seizure control. A medication history was submitted for those with Jejunostomy feeding tube (J-tubes). Four individuals were identified with J-tubes. The list of medications was submitted for each, and the medications prescribed via J-tube appeared clinically appropriate for that route in four of four (100%). <u>Do Not Resuscitate Orders</u> As of 7/10/12, a total of 23 individuals at the Facility had DNR orders in place. For 19 (83%), adequate clinical justification was provided for the DNR. Listed medical diagnoses for which DNR was justified included osteoporosis (11), severe thoracic deformity (two), severe cardiac disease (three), severe pulmonary disease (one), morbid obesity precluding effective CPR (one), and cancer with metastases (one). It is recommended that the State Office develop criteria to guide the SSLCs in determining options for resuscitative efforts in those with severe osteoporosis or morbid obesity, such as intubation/ventilation with oxygen and medication without chest compression. There were four individuals with DNR orders for which no medical justification was given. In these cases, the next of kin made the request. The date of implementation of the DNR indicated the length of time the DNRs were in place. This varied from weeks to years. Implementation dates ranged from 12/13/2000 to 6/21/12. For five of the individuals with DNRs, an ethics committee had met and a note was written in the IPN section focusing on the ethics committee agreement with the DNR. However, the note did not provide any details regarding the details of the discussion. As a result, it could not be determined if adequate medical justification had been identified as the DADS State Office required. It is recommended that a meeting of the ethics committee be held to discuss each of the DNRs and that there be documentation of the committee discussion and conclusion in the IPN section. The documentation should show that the committee considered the State Office guidance on this issue. In addition, there were 18 individuals with DNR status for which no document was submitted to indicate the ethics committee had met to review the order to determine agreement. A list, dated 7/11/12, was provided for individuals for whom a DNR order was rescinded in the past. One DNR was rescinded in 2002, one in 2008, seven in 2010, 22 in 2011, and two in 2012. For the two orders that were rescinded in 2012, there was an order placed for "no chest compressions" due to severe osteoporosis. The Facility submitted copies of ethics committee's hand written entries in the IPN section of the active record, along with the attendance roster. There were two meetings for which information was provided. For the meeting held on 1/12/12, the DNR status	

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		for three individuals was discussed: ▪ For Individual #350, the request for a committee review was due to his recurrent aspiration pneumonia and deterioration of his condition due to the aging process. The committee attempted to contact the guardian by phone, without success, and the Medical Director of ABSSLC was to pursue further discussion with the family. ▪ For Individual #499, major diagnoses were provided, and the request for review was due to "DNR order even though there is no qualifying medical condition as per state supported living center guideline." The guardian was contacted by telephone, and desired continuation of the DNR status, which had been in place since 2002. The ethics committee agreed with the guardian decision. ▪ For Individual #129, major diagnoses were provided, and the request for review was due to "has DNR order as per guardian wish even though there is no qualifying medical condition as per current state supported living center guidelines." The guardian could not be reached for discussion, and further discussion was postponed. For the 3/1/12 ethics committee meeting, one individual was discussed. For Individual #91, major diagnoses were listed, there was no LAR, and the brother was contacted for discussion to consider DNR/Hospice. It was decided the individual would be placed on a Hospice service with DNR status. A few observations and recommendations follow: ▪ Attendance at the meetings was broad and multidisciplinary. There was representation from ABSSLC as well as the community. ▪ The results of the meeting were placed in the respective individual's record the same day as the meeting. ▪ A community physician chaired it. ▪ It would be helpful to have a signature identification sheet with the sign-in sheet, along with titles. ▪ Given the complexity of these decisions, it was helpful to have an attorney on the committee to ensure the decision was consistent with applicable laws and regulations. However, there was no information as to the role or affiliation of the attorney (i.e., community representative, State Office representative, SSLC representative, family/guardian representative, etc.). ▪ There was no background information submitted or referenced. If not done ahead of time, it would be helpful if the Facility prepared a folder of important documents for the committee to have when meeting, including, for example, an active problem list, current guardianship papers, copy of any prior DNR order from the hospital or the Facility, copy of prior correspondence from family/guardian if applicable, and a copy of the State Office or SSLC regulation concerning DNR criteria. ▪ Formal typed meeting minutes would be beneficial. (It appeared this was one of	

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		the only committees in which the minutes were handwritten.) ▪ It was not clear if the guardians who could not be contacted were aware of the meeting and/or if attempts had been made to assist them in accessing the meeting. ▪ It was not clear what the process was for follow-up when the committee assigned a staff member to follow up with the family (i.e., deadline, report back to the committee, etc.). There was no information indicating the committee assignment was completed. <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> From January 11 to 13, 2012, an external peer review was completed. A total of 20 records were reviewed. The State Office had determined a threshold for compliance for both internal and external audits as 80%. Only two questions from the general audit fell below that score, including: "The active problem list was updated with each new problem or when problems are resolved" scored 78%, and "Are the appropriate preventive screening services provided" scored 72%. A total of 17% of the 30 indicators scored 100%. The external audit resulted in 21 corrective action plans. Of these, as of 3/6/12, according to the QA Department, all were resolved. The auditor made a recommendation to document the reason not to complete a preventive screening test, such as a pap smear or mammogram. It was recommended that information be placed on the Preventive Care Flow Sheet that would not subsequently be purged from the record. There was no internal peer review audit conducted at the same time. The Facility completed a second non-facility physician case review in 2012. The following represents a synopsis of the information: ▪ For the external peer review dated April 3 to April 4, 2012, a 5% random sample of each provider's caseload was reviewed, for a total of 25 records for the medical provider quality assurance audit. ▪ PCP compliance in essential areas ranged from 67% to 78%. For areas considered non-essential, compliance ranged from 70% to 94%. Removing the locum tenens PCPs, PCP compliance in essential areas ranged from 73% to 78%. Removing the locum tenens PCPs, PCP compliance in non-essential areas ranged from 79% to 94%. ▪ A total of 117 corrective action plans from the general medical audit were identified requiring QA follow-up. Of the 30 probes/indicators, 13 fell below the threshold compliance level of 80%. Areas that appeared to need improvement	Noncompliance

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		are listed by question number, including: Question #2 "Is the active problem list dated and signed when it was last reviewed?" Question #5 "Is the annual physical summary complete including past medical history, family history, and a plan of care?" Question #10 " Are the appropriate preventive screening services provided?" Question #11 "Is there documentation present for not providing preventive services?" Question #18 "Are responses to lab values that needed interventions documented in the integrated progress note by the provider?" Question #23 "Is the provider's clinical assessment documentation organized in appropriate SOAP format (including assessment and plan)?" Question #27 "Are medical and/or surgical consultant recommendations addressed in the integrated progress notes within five business days after the consultation recommendations are received?" ▪ The new audit process of the external peer review for all SSLCs started in February 2012. This was the first audit for ABSSLC with this "new" process. The questions of the general medical audit were identical/similar to the prior external audits. The audit section for medical management was a new process. ▪ For the general external audit of 30 questions, the wide difference in score results from the January to the April results indicated the need to establish inter-rater reliability among the external auditors. ▪ During the same audit visit, an additional nine records were reviewed for medical management of which three records included each of the following diagnoses: osteoporosis, aspiration pneumonia in the prior six months, and diabetes mellitus. Compliance for diabetes mellitus was 43%, for osteoporosis compliance was 79%, and for aspiration pneumonia, compliance was 50%. A total of 27 corrective action plans were generated from the medical management external peer review audit. Areas needing improvement/areas with low scores are listed by the number of the question in the audit. For diabetes mellitus: Question #1 "Is diabetes listed on the active problem list?" Question #2 "Did the provider prescribe the appropriate follow-up lab?" Question #3 "Did the provider order appropriate diagnostics and consults if warranted?" For osteoporosis: Question #3 "Is there a diagnosis of a pathological fracture? For aspiration pneumonia: Question #2 "Did the provider prescribe a head of bed elevation (HOBE)?" Question #3 "Is there evidence that the individual has had a modified barium swallow completed since a dx of aspiration pneumonia?" Question #6 "Did the provider recommend a suction toothbrush for the individual or refer to dental clinic?" Question #7 "Did the provider refer the individual to the QDDP or the PNMT nurse after the last dx of aspiration pneumonia?" Question #10 "Did the provider order respiratory therapy?" Question #12 "Did the provider review the medications to see if any changes or additions were needed to reduce the risk of	

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		aspiration pneumonia?" Since the audit, some of the questions were being reviewed for changes. For instance, if the individual has an order for nothing by mouth (NPO) and uses a feeding tube as the route for nutrition, ordering a modified barium swallow after a diagnosis of aspiration pneumonia would not be indicated. Overall, it was noted that five of the six indicators for diabetes mellitus scored at or below 80%. For osteoporosis, one of the five indicators scored below 80%. For aspiration pneumonia, seven of 12 indicators scored at or below 80%. ▪ The auditors provided a written document dated 4/4/12 entitled: "External Medical Provider Review." This was the written document summarizing the external auditors' findings. It was distributed to the Medical Director and the State Office. Seven ABSSLC staff attended the exit conference. Findings were somewhat different than the summary of information provided by the QA Department. The auditors summarized their findings, as noted by the differences in the numbers of the question/clinical indicator that were highlighted: (2) "The active problem list needed to be dated when signed." (3) "Ensure the active problem list was updated." (4) "Ensure the annual summary was current." (18) "Document abnormal labs in the IPN." (20) "Ensure documentation in the IPN regarding abnormal diagnostic test." This was considered a difficult area to verify, because it was pointed out that record information had been thinned. (24) Referring to this clinical indicator, the auditors suggested more pertinent positive and negative findings/historical facts/documentation of rationale be provided in the SOAP notes. (27) "Sign and document consultant notes within five days in the IPN." (29) "Ensure there was an IPN entry on readmissions or other procedures." An overall area needing improvement was the dating of dictated notes, summaries, active problem lists, etc., when signing them. Strengths identified included that the record tabs used were helpful in finding required information. The annual medical summaries were considered to be of high quality with treatment plans and therapeutic goals. Overall, the auditors considered most of the items that they reviewed to be in compliance with the current set of auditing tools. ▪ In January 2012, the external audit included a sample of 4.6% of the total number of records. In April 2012, the external general audit review process for Round #5 included a review of 5.9% of the records. An additional nine records were reviewed for the medical management audit, totaling 34 records for the April audit (8%). This was a total of 12.6%, with a goal of a 20% sample annually. ▪ A follow-up system for the January 2012 external medical peer review audit was implemented to ensure compliance/completion of corrective action plans for each PCP's areas of noncompliance.	

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		▪ The QA nurse/QI Department compiled compliance data with corrective action plans. The QA Department tracked corrective action plan resolution every 30 days until resolution ▪ 100% of corrective action plans were completed. 100% of deficiencies were corrected in the action plans. ▪ A follow-up system for the April 2012 external medical peer review audit was not implemented to ensure compliance/completion of corrective action plans for each PCP's areas of noncompliance. ▪ The corrective action plans were distributed to the PCPs for review and completion for the April 2012 external audit. ▪ The QA Department did not track corrective action plans to resolution every 30 days for the April 2012 external audit. ▪ There was no information submitted to indicate whether any of the 144 corrective action plans were completed. It is recommended that the QA Department implement a system to track corrective action plans to completion. Implementing a back-up support system to assist in covering the monitoring tasks while core assigned staff are unavailable to complete the monitoring would allow the QA Department to meet its expectations without interruption. <u>Mortality Reviews</u> At the time of the review, the Facility had no outstanding clinical death reviews for deaths occurring through June 2012. Since the start of the Monitoring Team's last visit, five deaths had occurred: ▪ The average age was 63.6 years (varied from 52 to 82). ▪ Three died under the age of 65, and three died at age 65 or greater. ▪ Of the deaths, one was female, and four were males. ▪ The causes of death were: multiple systems failure (renal failure, dementia) - one, respiratory failure - one, pneumonia with sepsis - one, cardiac arrest - one, and cancer – one. ▪ An autopsy was performed in two of the five. ▪ DNR status was ordered while residing at ABSSLC for one of the five, two had orders for no chest compressions, and DNR status could not be determined from the submitted documentation for one. DNR was ordered for three while in the hospital. ▪ Thee died in a hospital setting. One of these had coded at the Facility and was transported to the ER where the resuscitation was unsuccessful. ▪ Two died at the Facility. ▪ Two had a G-tube. ▪ One record included documentation indicating the individual was aggressively	

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		treated. ▪ Three were enrolled in hospice. ▪ One individual was considered ambulatory. ▪ Four individuals were considered nonambulatory. ▪ Three individuals used maintenance oxygen supplementation. ▪ A copy of the death certificate was available for four of five (80%). For deaths that occurred from January 1, 2012 through June 2012, the minutes of the clinical death review and the administrative death review were submitted. For these five deaths, five of five (100%) clinical death review investigations had been completed. Five of five (100%) administrative death reviews were completed. Of these, four had follow-up recommendations. The clinical and administrative death reviews included from zero to five recommendations, for a total of 11 recommendations. Systemic issues related to potential improvements in medical care were the focus of nine of the 11 recommendations. Systemic issues related to potential improvements in non-medical care were the focus of two of the 11 recommendations. It is noted that one of the reviews included an individual with Barrett's esophagus. The individual subsequently died from esophageal cancer. The medical literature offers several considerations for monitoring of Barrett's esophagus, one or more of which might be applicable to the ABSSLC setting. The Facility could have included a recommendation(s) to review all those with Barrett's esophagus to determine the number of individuals with this condition, review the current medical literature for this condition, develop a draft protocol, discuss with local gastroenterologists the protocols and guidelines they would recommend (e.g., choice of medical treatment, frequency of lab testing if indicated, frequency of EGD evaluation with biopsy, etc.) in following/monitoring individuals (especially those that are non-verbal) with Barrett's esophagus, and finalize internal guidelines for monitoring at ABSSLC. However, the Facility did not take the opportunity to learn from the mortality review and apply the information to other at-risk individuals at ABSSLC. In response to the Monitoring Team's request, the Facility submitted a list of 14 individuals with Barrett's esophagus. Nine of those had an EGD done in the prior two years and one had an EGD scheduled in the near future. There was one for which the last EGD was in 2004. For three, no information was submitted. This wide variation in approach to monitoring and potential treatment of Barrett's esophagus suggested the need for a Facility guideline. It was noted that one of the individuals had a feeding tube changed less than 48 hours before rapid deterioration and transfer to the hospital. The nursing and QA Departments	

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		should consider reviewing protocols, techniques, and monitoring while changing feeding tubes, with attention to positioning during the change to prevent reflux, and post-feeding tube replacement monitoring, as well as other aspects of tube feeding replacement. These two examples showed that clinical systems issues could be identified and recommendations made based on a critical review of the information available at the time of the death reviews. However, using these reviews as an educational opportunity and as an approach to systems improvements remained a challenge at ABSSLC. *Follow-up to Mortality Review Recommendations* The Facility submitted follow-up documentation for one recommendation of the 11 recommendations generated by the death review process. There was no follow-up documentation submitted for 10 recommendations. For the one recommendation for which follow-up was provided, the quality of the follow-up could not be determined. This might in part have been due to the wording of the recommendation. It was not clear from the recommendation which specific departments needed to be trained or in-serviced. As a result, the follow-up discussion to the recommendation was a brief statement signed by the PCPs. It appeared that training for the recommendation would have been applicable to several other departments, and would have benefited from a brief formalized presentation. As it involved spread of air borne infections, it was not clear the reason not to include infection control in the follow-up action plan.	
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>Internal Medical Department Review System</u> For internal medical peer review, the following process was implemented: ▪ There were two internal peer review medical audits completed in the prior six months. One occurred at the time of the external peer review (April 3 to 4, 2012). The same sample of 34 records was pulled and the same indicators/questions were utilized. A review was conducted of 23 of the records within 24 hours of the external peer review. Seven reviews were completed within seven days, and four were completed after one week. The purpose of this internal medical audit was to measure inter-rater reliability, because the internal peer review audit was to be conducted every three months. ▪ A summary of the internal audit was submitted. This document indicated that the same areas of concern were found, but compliance was higher. It was determined that the instructions for the two audits were different, as discussed below. The number of corrective action plans totaled 66, 39 of which were derived from the general medical audit (versus 117 from the external audit), and 27 were derived from the medical management audit (27 were also noted in the external audit). An undated corrective action plan chart for the general audit listed 42 corrective action plans, rather than the 39, which might be due to the addition of the four records that were outstanding when the summary was	Noncompliance

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		submitted to the Medical Department. Questions from the audit needing improvement included the following: Question #3 "Is there evidence that the Active Problem List was updated with each new problem or as problems were resolved?" Question #19 "Are all diagnostic test results and consults initialed and dated?" Question #21 "Has the provider ordered appropriate consultations for identified need and diagnosis?" For each of the PCPs, compliance with essential areas ranged from 91% to 100%. For each of the PCPs, compliance with non-essential areas ranged from 82% to 97%. When the locum tenens PCPs were removed, compliance with essential areas ranged from 91% to 100%. When the locum tenens PCPs were removed, compliance with non-essential areas ranged from 89% to 97%. ▪ A second internal medical peer review was completed from July 16 to 18, 2012. A 5% random sample of each provider's caseload was selected, for a total of 19 records for the general medical audit. An additional eight records were reviewed for medical management of osteoporosis, aspiration pneumonia, and diabetes mellitus. These records were obtained from a list compiled in the Nursing Department for each of those diagnoses. The records were also randomly assigned from this list. ▪ The Facility determined there was significant improvement from the April 2012 audit. Of the 30 indicators/questions, six had a score below 80% compliance. (This was compared to the April 2012 audit in which 13 indicators were below compliance). A graph was submitted for compliance per PCP for essential areas (the label/title of the bar graph was "essential and nonessential compliance," but only essential areas of compliance were graphed). The range of compliance per PCP was 88% to 100%. Four PCPs were included. Areas needing improvement included: Question #5 "Is the annual physical summary complete including past medical history, family history, and a plan of care?" Question #16 "Do the medication orders for acute conditions include indication and duration for all medications prescribed?" This was discussed with the Medical Director and appeared to be problematic in reaching compliance for telephone on–call orders. The Medical Department is encouraged to work with the Nursing Department to provide a systems approach/protocol to resolve this area of concern. Questions #19 "Are all diagnostic test results and consults initialed and dated?" Question #26 "When a referral for consultation is requested, is pertinent current and past medical history included in communication with the consultant?" This was discussed with the Medical Director. For some of the onsite consults, the consult sheet was generated automatically and the PCP might not complete it. It is recommended that a systems approach be developed to resolve this. Whether onsite or off-site consults are ordered, PCP input of selected clinical information is essential in order for the consultant to respond with helpful information to provide guidance related to clinical care of the individual. Accurate and detailed	

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		completion of the document often is the only communication between physicians and is a valuable tool that needs continued improvement. Question #27 "Are medical and/or surgical consultant recommendations addressed in the integrated progress notes within five business days after the consultation recommendations are received?" Question #28 "Is there a clear explanation on the integrated progress notes as to why the provider has chosen to not implement the recommendations?" For this last question, no information was provided to determine the number of recommendations to which this question applied. As a result, the compliance score was difficult to interpret. ▪ For the medical management audit for July 2012, for both diabetes mellitus and osteoporosis, compliance scores were both 100%. For aspiration pneumonia, two of 12 indicators were below compliance of 80%. ▪ For both general and medical management internal audits combined, there was a total of 34 corrective action plans (i.e., 31 from the general medical audit, and three from the medical management audit). ▪ For analysis, discussion, and distribution of the above information, the QA Department provided a quarterly summary report to the Medical Department and Facility Administration summarizing findings of the January 2012 external audit in a document entitled: "QA/QI Data, Section L: Medical Services, Quarter 2 of FY 12," and the April 2012 external audit and April and July 2012 internal audits in a document entitled: "QA/QI Data, Section L: Medical Services. Quarter 3 of FY 12." *Inter rater reliability* The QA Department analyzed inter-rater reliability. Preliminary agreement (minus the four records outstanding for the internal review) ranged from 50 to 80%. Discrepancies were found in the instructions and processes for the external and internal audits. Some examples were provided of this. The external audit requirement was that the active problem list included both the signature and date of the signature. This had not been implemented at ABSSLC, although State Office considered it a requirement. The external audit also scored as a deficiency the lack of dosage and indication for medications in the annual medical summary. This had not been implemented at ABSSLC, although State Office considered it a requirement. Additionally, the external auditors used a timeframe for the span of records reviewed of one or more years, but the internal auditor was instructed to review three to six months worth of documentation. The more extended time period did not provide a measure of progress in the records, because the more recent documentation in the records potentially would reflect improvements in the documentation system at ABSSLC. For the medical management audit of the three diagnoses reviewed, there was close agreement in the results for aspiration pneumonia. The internal audit scored 47% and	

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		the external audit scored 50%. For osteoporosis, the internal audit score was 87% and the external audit score was 79%. One of the questions for osteoporosis (i.e., Question #3, concerning the occurrence of a pathologic fracture) was pointed out as needing review for improved inter-rater reliability. For diabetes mellitus, the internal score was 20% and the external score was 50%. This might have been due to the audit process, as one of the records was scored as "not applicable" by the internal audit, because the individual did not have diabetes mellitus, although required medication used in those with diabetes mellitus. It is recommended that for purposes of the audits, the diagnosis lists used be screened for completeness and accuracy to ensure the sample population meets the criteria before the sample is selected. Some of the differences in the aspiration pneumonia data derived from the lack of documentation of interventions. The audit specifically asked about orders for "Head of Bed Elevation," but the PNMT nurse usually completed this. Orders for some of the positioning were on the record, but did not involve the PCP directly, and were scored differently by the auditors, based on their knowledge or lack of knowledge of the process at ABSSLC. QA made an additional note that the inter-rater reliability might have been affected by the auditors' judgment and preferences. In other words, it was not clear how closely guidelines for the audit were followed. A copy of the guidelines was not submitted for review. Inter-rater reliability also was analyzed per PCP. Overall agreement (for both essential and non-essential components) varied from 59% to 77%. When removing the locum tenens PCPs, the overall agreement was 65% to 77%. As background information, compliance was submitted for essential areas for each PCP for both audits for an inter-rater comparison. A similar graph was submitted for non-essential areas. This data will be more valuable with serial results, as the absolute numbers of medical management cases per PCP were low for this initial review. <u>Medical Department Initiatives and Improvement Projects</u> The Medical Department relied heavily on the various clinical indicators of the general external audit in providing information for quality care. The Medical Department needs to continue the internal audit process, but with a Medical Program Compliance Monitor available to the department, should be able to develop and implement quality assurance measures for other areas of medical care and health care services. For example, using the clinical guidelines/pathways, one diagnosis per quarter could be a focus for a record review to determine compliance with the guideline. Monitoring closure with regard to the concerns identified during morning medical meetings is needed. As individuals are hospitalized, or go to the ER, or are admitted to the Infirmary, measuring preventive steps taken to reduce a recurrence would assist in guiding the Medical Department and IDTs in further interventions that should be considered. For hospitalized individuals,	

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		record reviews of selected conditions could be completed to determine whether there were signs and symptoms that were not noticed by residential staff or nursing staff prior to the sudden health status decline, and/or not reported to PCPs. Analyzing the types of diagnoses leading to hospitalizations or ER visits would be another potential area of review. These activities would allow for the development of systems approaches to improve care. As noted in the last report, 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, using the State Office clinical guidelines, clinical indicators should be used for data collection to determine quality of care for a number of clinical issues.	
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.	Since the Monitoring Team's last visit, the following policies/procedures/protocols were implemented: The Medical Department submitted the Medical Management questions for aspiration (12 questions), constipation (5 questions). Diabetes mellitus (6 questions), osteoporosis (7 questions), seizures (6 questions), and UTIs (4 questions) as evidence of clinical guidelines developed and implemented since the Monitoring Team's last visit. There did not appear to be formal implementation of the clinical protocols/flow charts developed by the State Office and distributed to the SSLCs. There were no initiatives beyond the medical audits created by the State Office. Additionally, there was no information submitted to determine whether the various clinical guidelines/pathways were reviewed at a medical staff meeting with dates, attendance rosters, minutes, to ensure the PCPs were aware of each guideline, the reason for the guideline, and the expectation of how they were to be used. Depending on the depth of review and discussion, a series of meeting would be needed to focus discussion on each clinical guideline separately. There was no information to determine if each PCP had read each guideline and understood the content, whether questions were raised by the PCPs, or whether there was discussion concerning how these clinical guidelines would be utilized and incorporated into the practice patterns of the PCPs. There was no information	Noncompliance

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		submitted to determine if the PCPs understood these guidelines would also be used as a reference for monitoring quality care.	

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

1. For individuals that are hospitalized, the Facility should conduct a record review for the prior seven to 14 days of the illness to review monitoring of care, positioning documentation, feeding concerns, early warning signs that could have been assessed and reported to the PCP, discussion of involvement of the PNMT, listing of preventive areas to be considered based on the diagnosis causing the acute illness, adequacy of medical evaluation, need for consultation, review of medications and medication side effects, etc. (Section L.1)
2. For individuals hospitalized or admitted to the Infirmary, at the morning medical meeting, the PCP should be expected within a few days and prior to an individual's return to ABSSLC or to the residence to articulate the important historical events, what tests had been completed with results, differential diagnosis for recurrent problems (e.g., refusal to eat, fevers, anorexia, repeated emesis, repeated pneumonia), and plan. (Section L.1)
3. Discussion reflected in morning medical team minutes should include potential steps to prevent recurrence of an Infirmary admission or hospitalization. This should include in-depth discussion concerning the appearance of initial signs and symptoms, potential precipitating events, past pattern of similar illness, predisposing comorbid conditions, prior tests and results, and the cause and prevention of recurrence in a succinct brief format. (Section L.1)
4. For task identified during the morning medical meetings, due date should be identified at the date of assignment to guide the staff responsible for completion of the task. (Section L.1)
5. The Medical Department should review the time lag between an order being written, the consult scheduled, and the date of the consult, to reduce the time delays in obtaining needed evaluations, particularly for individuals with medical complexities. (Section L.1)
6. A format or template should be developed for the quarterly medical review that identifies the essential element of such a review. (Section L.1)
7. An ISPA should be requested when there is a refused appointment for a procedure or consultant visit. Information for missed medical appointments should be tracked, identifying reasons such as refusals, reasons that do not need IDT intervention (e.g., inclement weather, individual illness) and reasons for which the IDT or Facility might have an influence on improving the appointment completion rate (e.g., double booking, furlough without notifying the clinic, staff shortage, etc.) (Section L.1)
8. The Medical Department should review the database for osteoporosis treatment for accuracy and completeness, and take action as needed to ensure that individuals are prescribed appropriate treatment. (Section L.1)
9. The various sets of data for pneumonia should be reviewed to improve their accuracy and completeness with the goal of consistency and agreement of information across databases. (Section L.1)
10. The database discrepancies should be resolved for decubiti, and trend analysis performed, with implementation of a quality improvement plan. (Section L.1)
11. The Facility should review the various definitions for intractable (refractory) seizures and determine a common definition that is used across all policies and documents. (Section L.1).
12. The State Office should develop criteria to guide the SSLCs in determining options for resuscitative efforts in those with severe osteoporosis or morbid obesity, such as intubation/ventilation with oxygen and medication without chest compression. (Section L.1)
13. With regard to the ethics committee's review of individuals' DNR Orders:
    a. For individuals the ethics committee reviewed, but for whom no medical justification was provided for the DNR, a meeting of the ethics committee should be held, each DNR discussed, and documentation of the committee discussion and conclusion included in the IPN section of each individual's record. The documentation should show that the committee considered the State Office guidance on this

issue. (Section L.1)

b. For the additional 18 individuals with DNR status for which no document was submitted to indicate the ethics committee had met to review the DNR, meetings should be held and documentation maintained in the individuals' records. (Section L.1)
c. It would be helpful to have a signature identification sheet with the sign-in sheet, along with titles.
d. Prior to the meeting, important documents should be collected for committee member review, such as an active problem list, current guardianship papers, any prior DNR order from the hospital or the Facility, prior correspondence from family/guardian if applicable, a copy of the State Office or SSLC regulation concerning DNR criteria, etc.
e. Formal typed meeting minutes should be maintained.
f. Documentation should be maintained regarding whether the family/guardian is contacted prior to the meeting to be informed of the need for their participation, and any other communication prior to the meeting such as assistance in calling in to the meeting, etc.
g. When the committee assigns responsibility for follow-up, the assignments should be documented to closure. (Section L.1)

14. For transitions, a system should be in place for PCPs and other relevant team members to rapidly respond to questions and concerns of the provider agency in requesting a change in the transition plan. (Section L.1)
15. Inter-rater reliability should be established among the external medical peer review auditors. Written guidelines would both assist the auditors in uniformly interpreting the questions, and would provide guidance in interpretation of results by the Facility. (Section L.2)
16. The QA Department should consistently implement a system to track corrective action plans to completion. Implementing a back-up support system to assist in covering the monitoring tasks while core assigned staff are unavailable to complete the monitoring would allow the QA Department to meet its expectations without interruption. (Section L.2)
17. The Nursing and QA Departments should consider reviewing protocols, techniques, and monitoring while changing feeding tubes, with attention to positioning during the change to prevent reflux, as well as other aspects of tube feeding replacement. (Section L.2)
18. The death review process should be monitored for quality to ensure educational opportunities are identified, systems issues are identified and improvements occur, and follow-through of committee recommendations is completed thoroughly, with evidence of completion. (Section L.2)
19. For purposes of the audits, the diagnosis lists utilized should be screened for completeness and accuracy to ensure the sample population meets the criteria before the sample is selected. (Section L.3)
20. The Medical Department is encouraged to work with the Nursing Department to ensure after hours/on-call medication orders for acute conditions include indication and duration when ordered. (Section L.3)
21. A systems approach should be developed to ensure pertinent current and past medical history is available for the consultant at the time of the visit. (Section L.3)
22. The Medical Department should continue to utilize the internal audit process and the results of the audits to improve care, but should also develop and implement quality assurance measures for other areas of medical care and health care services. Some examples include: using the clinical guidelines/pathways, selecting one diagnosis per quarter as a focus for a record review to determine compliance with the guideline; monitoring closure with regard to the concerns identified during morning medical meetings; measuring preventive steps taken to reduce repeat hospitalizations or ER visits; reviewing documentation in records to determine whether there were early signs and symptoms or lack of documentation prior to an emergency hospitalization; and analyzing the types of diagnoses leading to hospitalizations or ER visits. (Section L.3)
23. 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's Nursing Department Presentation Book; o ABSSLC's Infection Control Presentation Book; o ABSSLC's Nursing Monitoring Tool raw data; o ABSSLC's Infection Control Monitoring Tool raw data; o ABSSLC's Corrective Action Plans for Nursing; o ABSSLC's lists of individuals who were seen in the emergency room, Infirmary, and hospital; o Infection Control Summary Reports; o Medication Variances Monthly Summary data; o Medical records for the following individuals: Individual #74, Individual #452, Individual #38, Individual #293, Individual #346, Individual #447, Individual #409, Individual #16, Individual #152, Individual #257, Individual #199, Individual #504, Individual #272, Individual #43, Individual #539, Individual #398, Individual #149, Individual #532, Individual #371, Individual #170, Individual #503, Individual #403, Individual #518, Individual #377, Individual #75, Individual #270, Individual #497, Individual #296, Individual #488, Individual #151, Individual #101, Individual #257, Individual #229, Individual #42, Individual #191, Individual #142, Individual #150, Individual #16, Individual #152, Individual #14, Individual #267, Individual #378, Individual #478, Individual #185, Individual #110, Individual #257, Individual #232, Individual #337, Individual #538, Individual #293, Individual #97, Individual #524, Individual #458, Individual #214, Individual #9, Individual #150, Individual #146, Individual #446, Individual #49, Individual #307, Individual #35, Individual #399, Individual #180, Individual #390, Individual #493, Individual #414, Individual #495, Individual #359, Individual #409, Individual #451, Individual #162, Individual #541, Individual #215, Individual #407, Individual #348, Individual #527, Individual #59, Individual #396, Individual #146, Individual #327, Individual #324, Individual #542, Individual #381, Individual #376, Individual #64, Individual #519, Individual #418, Individual #517, Individual #43; 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 "Real Time" Audit tool and raw data for Infection Control; o ABSSLC's Outbreak timelines; o Emergency Drill Checklist;

	○ Infection Control Committee meeting minutes, dated 4/5/12; ○ Infection Control Rounds audit data; ○ Medication Variance Committee meetings minutes, dated 2/1/12, 2/17/12, 6/27/12, and 6/31/12; ○ ABSSLC Medication Variance Graphs; ○ Medication Variance Committee Meeting notes for 7/31/12; ○ ABSSLC's Infection Control overall summary report list; ○ ABSSLC's Immunization Database; ○ Drug Utilization Discrepancy Reports; ○ 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; ○ Emergency Response Drill monitoring data; ○ Emergency Response Drills forms; ○ Emergency Drills 3rd Quarter March to May 2012 graph data; ○ ABSSLC Leadership Council/QA/QI Notes, dated 6/4/12; ○ Emergency Drills Incident Management Review Team Meeting Drill Summary report; ○ ABSSLC Mock Code Drill Summary (February to August 2012); ○ Pharmacy and Therapeutics Committee meeting minutes, dated 2/15/12, and 4/25/12; ○ Medication Administration Observation raw audit data; and ○ Medication Administration Record Spot Checks. ▪ **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; ○ Marjorie Hutchinson, BSN, RN, Case Manager Supervisor; ○ Krista Hamilton, RN, Infection Control Manager; ○ Mary Willingham, RN, Program Compliance Nurse; ○ Carole Ivy, RN, Nurse Operations Officer; ○ Catrina Ramos, RN, BSN, Case Manager; ○ LeRoyce Hart, RN, Case Manager; ○ Amy DeLeon, RN, Case Manager; ○ Becky Pliml, RN, Case Manager; ○ Hae Sean Kim, RN, BSN, Nurse Educator; ○ Jennifer Huffaker, RN, Infection Control Nurse; ○ Charlotte Myers, Respiratory Care Practitioner;

	○ Vicki Williams, LVN, Nurse Educator; ○ Richard C. Martinez, Risk Manager; ○ Jeff Goza, Assistant Director; ○ Debbie Taylor, Facility Competency Training and Development Director; ○ Participants of the Live Review: ▪ Cathy Northrup, RN, MSN, CPN, Chief Nurse Executive; ▪ Carole Ivy, RN, Nurse Operations Officer; ▪ Krista Hamilton, RN, Infection Control Manager; ▪ Marjorie Hutchinson, BSN, RN, Case Manager Supervisor; ▪ Debralea Sessions, MS CCC/SLP Physical Nutritional Management Coordinator; ▪ Tammy Bayer, RN, Physical Nutritional Management Team; ▪ Nicole Spalding, Registered Dietitian; ▪ Tricia Reyes, Registered Dietitian; ▪ Charlotte Myers, Respiratory Care Practitioner; ▪ Karen Mayfield, PT, DPT; ▪ Bobbie Holden, OTR, Director Of Habilitation Therapy Services; and ▪ Amy Gleaton, OTR. ▪ **Observations of**: ○ Medication Administration in the Infirmary, and Residence 6521; and ○ Use of emergency equipment at the Infirmary, and Residences 6521, and 6510.
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section M, dated 8/8/12. In its Self-Assessment, for each sub-section, 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. For Section M, in conducting its self-assessment, the Facility: ▪ Used monitoring/auditing tools. At the time of the review, the Facility focused on the monitoring of the following areas: Urgent Care/Emergency Room Visits, and Hospitalizations; Acute Illness and Injury; and Nursing Assessment to determine if nursing care was provided according to policy. However, based on a review of the Facility's Self-Assessment: ○ It was unclear why only certain items from each tool were reflected in the Facility's Self-Assessment, and what the specific criteria for compliance were for a number of the items presented. ○ In many of the sub-sections for Section M, the items presented did not reflect the quality of the documentation as was the Monitoring Team's focus in its findings. As the Facility reviews its monitoring tools, the Facility is encouraged to review the Monitoring Team's report to identify indicators that are relevant to making compliance determinations. ▪ In addition, there was no inter-rater reliability established for each of the monitoring tools. An important component of inter-rater reliability is ensuring that the current monitoring/audit tools have adequate instructions/guidelines to ensure consistency in monitoring and the validity of the results. Without establishing inter-rater reliability, it was likely that different auditors would score compliance differently. ▪ The Self-Assessment identified the sample sizes. However, it did not include the description of the

	overall population from which the sample was selected (N) or present a percent sample size. From the numbers that were provided, it did not appear that these samples sizes were adequate to consider them representative samples. ▪ In addition from the information in the Self-Assessment, it was not clear which staff/positions were responsible for completing the each of the audit tools ▪ It was also not clear from the documentation provided that the staff responsible for conducting the audits/monitoring had been deemed competent in the use of the tools and/or were clinically and/or programmatically competent in the relevant areas. ▪ Although some improvement was seen, the Facility did not yet consistently present data in a meaningful/useful way. Specifically, the Facility's Self-Assessment: o Did not consistently present findings based on specific, measurable indicators. For example, as noted above, at times, it was unclear what criteria had been used to determine if adequate documentation existed, such as a nursing protocol. In addition, at times, indicators combined more than one item, making it difficult to determine which of these requirements had been met and which had not. o Did not consistently measure the quality as well as the completion of documentation. o Did not distinguish data collected by the QA Department, or different nursing positions, such as Nursing Educators. o Although it was evident that the Facility was investing a great deal of energy in collecting monitoring data, it was unfortunate that due to the overall presentation of the data, it was rendered in most cases uninterpretable. The Facility should consider adopting a standardized format for presenting data in a meaningful way that facilitates its interpretation and analysis, and provide training to the disciplines regarding how to analyze their data to identify problematic trends. ▪ The Facility rated itself as being in compliance with none of the sub-sections of Section M. This was consistent with the Monitoring Team's findings. However, of concern, many of the indicators included in the Self-Assessment showed high levels of compliance, which was not consistent with the Monitoring Team's findings. In reviewing the Monitoring Team's report, the Facility should attempt to determine the reason for this discrepancy. ▪ The Facility's data identified areas of need/improvement. However, for these areas of need, the Facility Self-Assessment did not provide an 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.
	Summary of Monitor's Assessment: Since the Monitoring Team's last review, nursing staffing continued to be a challenge for the Facility, especially for Licensed Vocational Nurses (LVNs). In response to this challenge, the Facility converted 4.5 LVN positions to three Registered Nurse (RN) 2 positions. In addition, ABSSLC had some changes regarding the Nursing Department and nursing positions, which included an additional full-time Infection Control Nurse (RN), a full-time Hospital Liaison, a full-time Registered Nurse was hired for the Nurse Case Manager Supervisor position, five new Nurse Case Managers were to be added in order to decrease the number of individuals on each Nurse Case Manager's caseload, and the existing Quality Assurance Nurse had been on leave since June 2012.

	Some of the Facility's positive steps forward included: ▪ The Facility reported that approval was obtained to focus auditing efforts mainly on three problems areas, including: Urgent Care/Emergency Room Visits/Hospitalizations, Acute Illness and Injury, and Annual Nursing Assessments. ▪ The minutes of the Infection Control Committee Meetings had developed into an exceptional document that provided clear and concise information. ▪ In April 2012, infection control had an Integrated Progress Note approved through the Medical Records Committee and had begun to implement its use. ▪ The Facility had a tracking form that clearly identified the audit information regarding the emergency mock drills by item, by month, and the drill status (passed or failed). ▪ The Facility was in the process of developing a Nursing Education database to track the training classes and in-services nurses completed. The expected completion date for the database was noted to be September 2012. ▪ Two pilot residences, 6400 and 6480, had made a transition from using the Health Management Plans (HMPs) to address high and medium health and mental health risks to using an Integrated Health Care Plan that will ultimately replace the current Risk Action Plans and Health Management Plans. ▪ In March 2012, a new database was developed and implemented to more accurately track the medication variances leading to better trending and analysis of the variance data. Although the Facility had made some positive steps forward in the areas noted above, the overall lack of progress, and in some areas, regression, found regarding the nursing care plans, the nursing assessments and documentation in response to changes in status, the quality of the quarterly and annual Comprehensive Nursing Assessments, the lack of emergency equipment drills conducted, and the unreliable systems regarding medication variance data were very concerning at this juncture in the review process.

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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.	In assessing its progress, ABSSLC indicated in the Facility's Self-Assessment that the following steps were initiated since the last review regarding this requirement of the Settlement Agreement: ▪ Staffing continued to be a challenge for the Facility. Recruitment continued, especially for Licensed Vocational Nurses. The RN2 positions were being redirected to focus more on the delivery of services to individuals. In addition, the Facility converted 4.5 LVN positions to three RN2 positions: one RN2 position was assigned to nursing education, and the other two RN2 positions would provide individual care. ▪ The Facility indicated that a review of Nurse Case Manager (NCM) caseloads revealed that each one had 19 to 30 individuals. The Facility indicated that they would be adding five new NCMs, which would lower the caseloads to 16 to 20 individuals each. Also, a Case Manager Supervisor had been hired to focus on training and accountability of the NCMs. ▪ In June 2012, the Facility began an initial review of the use of nursing protocols. Thus, there was little data generated at the time of the review. However, the Facility reported that staffing issues, such as floating nurses to other homes had contributed to problematic issues that were initially identified in documentation regarding nursing assessments. The Facility indicated that additional training on the expectations of the protocol cards would continue with additional focused monitoring. Based on the findings from its self-assessment, the Facility indicated that: "this provision is not in substantial compliance because review of Health Monitoring Tools, Emergency Drill data, and Nursing Protocol documentation forms show we are not in compliance. We will continue to train as concerns are identified and develop corrective action plans." <u>Staffing</u> At the time of the review, ABSSLC had a census of 411 individuals. Since the Monitoring Team's last review, ABSSLC had made some changes regarding the Nursing Department and nursing positions, which included: ▪ In August 2012, an additional full-time Infection Control Nurse (RN) was hired; ▪ A full-time Hospital Liaison was hired; ▪ A full-time Registered Nurse was hired for the Nurse Case Manager Supervisor position; ▪ Five new Nurse Case Managers were to be added in order to decrease the number of individuals on each Nurse Case Manager's caseload; and ▪ Since June 2012, the existing Quality Assurance Nurse had been on leave. These additional positive staffing advancements should assist the Facility in moving forward in achieving positive clinical outcomes for the individuals residing at ABSSLC.	

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		In addition, at the time of the review, the Nursing Department had a total of 175 allotted positions, including 80 for RNs and 95 for Licensed Vocational Nurses. At the time of the review, nursing vacancies included two RN positions and ten LVN positions. From a review of the Facility's nursing staffing data and discussions with the Chief Nurse Executive, since the Monitoring Team's last review, ABSSLC had experienced some turnover in nursing staffing for both RN and LVN positions. Although since February 2012, the nursing staffing fill rates had experienced some variability, overall nursing staffing had remained basically stable at ABSSLC. In addition, the Facility continued to host student nurses from the local university and technical college and since the last review, had hired five RN graduates students. As previously recommended, the Facility should continue its efforts in recruiting, maintaining, and evaluating reallocations of nursing positions to meet the requirements of the Settlement Agreement. Also, as 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> Unfortunately, at the time of the review, the Quality Assurance Nurse, had been on leave since June 2012, and was expected back to the position in the near future. Thus, the Monitoring Team was not able to interview the QA Nurse regarding any updates or analyses of her areas. In order to avoid lapses in staff's designated responsibilities, the Facility should consider implementing a backup system when events such as leaves occur to ensure continuity. <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: ▪ The Facility reported that approval was obtained to focus auditing efforts mainly on three problems areas: Urgent Care/Emergency Room Visits/Hospitalizations, Acute Illness and Injury, and Annual Nursing Assessments. Although the Facility presented some of the data from the Urgent Care/Emergency Room Visits/Hospitalizations monitoring tool (data discussed in the Self-Assessment Section above), the quality of the documentation was not addressed, such as the adherence to the nursing protocols regarding nursing assessments. Thus, it was unclear how the Facility measured compliance and what was meant in the Self-Assessment by the following: "Documentation of nursing assessments and the SOAP format are consistently good while others are inconsistent."	

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		A review of 10 individuals' records (i.e., Individual #74, Individual #452, Individual #38, Individual #293, Individual #346, Individual #447, Individual #409, Individual #16, Individual #152, and Individual #257) who had been transferred to a community hospital, emergency room, or the Infirmary found: ▪ Nurses promptly and consistently performed a physical assessment on an individual displaying signs/symptoms of potential or actual acute illness in none (0%). ▪ Licensed nursing staff timely and consistently informed the PCP of symptoms that required medical evaluation or intervention in none (0%) of the cases. ▪ Appropriate (i.e., as consistent with nursing practice) 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 alignment with nursing protocols 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 10 individuals found essentially the same significant problematic clinical issues regarding nursing assessments and documentation that the Monitoring Team identified during the past five reviews. The overall problematic issues that were found in the 10 records included: ▪ 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 behaviors, 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 (PRN) medications (as needed medications); ▪ There were 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;	

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		▪ 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 individuals with 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; ▪ 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; ▪ Based on review of the Facility's abbreviation list, 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; ▪ Nursing Care Plans addressing health issues were consistently inadequate with regard to individualized 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	

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		equipment individuals required, such as catheters, tracheotomies, and G-tubes. 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. Although there were some Integrated Progress Notes that contained an adequate nursing assessment, and associated findings, the inconsistency of these adequate notes clearly indicated that these were not the result of a structured system. The Facility should continue to implement and expand the use of nursing protocols (as is discussed in further detail with regard to Section M.4) to guide nursing practices. In conjunction with the continuation of the adequate competency-based nursing skills training being provided by the State Office Nurse Practitioner Group, mentoring and supervision of nurses should focus on the expanded use of the protocols. As noted in past reports, due to the number of individuals with complex medical needs 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 these 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 a few of the Comprehensive Nursing Assessments 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 (IC)</u> At the time of the review, the Facility recently had hired an additional full-time RN for Infection Control who had minimal previous experience in Infection Control. From discussions with the IC Nurse, the new Infection Control Nurse had received some initial competency-based training regarding infection control principles. This should be continued and documented in order to ensure competency in this specific clinical area. From the documentation contained in the Presentation Book addressing Infection Control, as well as interviews with the IC Nurse, review of the documentation, and information gathered during the review, some positive steps forward had been made regarding the process of continuing to build an infrastructure to meet the requirements of the Settlement Agreement. Some of the progress noted included: ▪ As noted in the previous report, the Facility's Presentation Book addressing	

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		Infection Control was very organized and contained a significant amount of information regarding the activities of the IC Nurses since the last review. ▪ The Facility continued to utilize the process addressing data reliability to accurately identify the Facility's trends related to infectious and communicable issues. From data generated by the Drug Utilization Discrepancy Reports contained in the Presentation Book for Infection Control, discrepancies for March through July 2012 were seven, 13, 18, and 11, respectively. These data not only reflected a very positive step forward in tracking discrepancies regarding Infection Control information to ensure data reliability, but also a positive increase in compliance regarding the accuracy of the documentation contained on the Infection Control Reports completed by the residential staff. ▪ The Infection Control Immunization Database continued to be updated at the time of the review. ▪ The minutes of the Infection Control Committee Meetings had developed into an exceptional document that provided clear and concise information, especially regarding some problematic issues noted during outbreaks and the associated action steps that included start dates and completion dates. ▪ Since the Monitoring Team's last review, the documentation regarding the Outbreak Investigations also had become very detailed and included specific Plans of Correction from the review and analysis of the data contained in the reports. Problematic issues that were found from these reviews were clearly outlined and easily connected to the Plans of Correction. ▪ In April 2012, infection control had an IPN note approved through the Medical Records Committee and had begun to implement its use. ▪ On 3/21/12, the physicians and Infection Control Nurse attended an Infectious Disease Update: Focus on Sepsis and Antimicrobial Coverage of Multi-Drug-Resistant Pathogens at Hendrick Medical Center. ▪ The Presentation Book for Infection Control contained a number of "Real Time" Infection Control monitoring tools focused on issues regarding the overall clinical care of acute infectious episodes. Specific comments were noted on each of the monitoring tools regarding both positive and negative findings from the audit. A review of the raw data indicated that some significant problematic issues were found, especially regarding the lack of adequate nursing care plans in place addressing the infectious illness. The Facility should consider aggregating and analyzing these data, along with other monitoring data addressing IC issues, and data regarding actual infection rates in order to better identify systematic and/or staff-related problematic trends that might be impacting the rates of infections at the Facility. ▪ The Facility had purchased two Adenosine Triphosphate (ATP) Hygiene Monitors that measures ATP, which is the universal energy molecule found in all plant, animal, bacterial, yeast, and mold cells.	

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		▪ The Infection Control Nurse attended the International Association for Professionals in Infection Control Conference in June 2012. Although the IC Nurses made several positive steps forward, there continued to be a number of significant problematic areas regarding infection control that were in need of further attention, including; ▪ Although the Facility had developed and had been updating the Facility's immunization database, consistent with past reviews, the Facility could not generate a list of all the individuals whose past immunizations had been researched, and were updated, as appropriate. A formalized schedule should be developed clearly indicating which individuals' immunization status and immunizations have been researched and confirmed or updated to ensure all individuals have received all the required immunizations as outlined in the Health Care Guidelines. ▪ The results of the "Real Time" Infection Control audits were not trended or analyzed in conjunction with other IC data to determine if there was a correlation between the problematic issues found during the audits and rates of infections. Such analyses and related discussions about action plans implemented or potential solutions should be included in the minutes of the Infection Control Committee meeting minutes. ▪ Consistent with previous reviews, the same significant problematic issues existed regarding the lack of nursing care plans or adequate nursing care plans regarding infectious diseases (more specific details of findings are discussed with regard to Section M.3). Although the Presentation Book contained a number of nursing care plans about which the Infection Control Nurse had provided good clinical comments and recommendations for modifications, nursing staff did not make the necessary changes in order for the care plans to be considered clinically adequate. Although the Facility had made some solid positive steps forward, there continued to be a significant amount of work yet to be done, especially regarding nursing care plans addressing infectious illness, in order to make substantial gains in meeting the requirements of the Settlement Agreement. As noted in previous reports, 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 and the Settlement Agreement, 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> Since the Monitoring Team's last review, ABSSLC indicated the following steps were	

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		initiated regarding this area: ▪ Emergency drills were conducted routinely with no advanced warning. If prompting was needed, the drill was failed, retraining was conducted, and the drill was repeated. The Facility reported that a total of 370 drills were conducted with an 86.2% initial pass rate. In addition, the Facility reported that various scenarios were used during the drills and were changed monthly. The Facility reported that: "It is theorized scenarios which do not include CPR tend to be more difficult for staff to think through critically. We are working to make sure all aspects of each scenario are covered in initial new employee training and refreshers." ▪ In May 2012, Competency Training and Development (CTD) staff had taken over conducting all the Mock Drills. ▪ The Facility recently had received a new manikin that was equipped with training for a number of medical issues. ▪ The Education Department had been moved to a larger area dedicated to skills acquisition. ▪ The Facility had a tracking form that clearly identified the audit information regarding the emergency mock drills by item, by month, and the drill status (passed or failed). 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: ▪ Since the State Office Emergency Response policy was implemented in December 2011, there had been various interpretations regarding the role of the Risk Manager and checking the emergency equipment to ensure it was present or to see if it was operational. At the time of the review, the Risk Manager reported that he had been checking the emergency equipment to verify it was operational. The Facility in conjunction with the State Office should clarify the role of Risk Management and the role of the clinical staff regarding the requirement addressing checking the emergency equipment. ▪ There was no analysis found regarding actual medical emergencies and the data addressing Emergency Mock Drills. In addition, the CNE reported that the Facility did not have a form in place to record actual responses and actions for actual medical emergencies. Although the CTD staff reported improvement, there continued to be some staff resistant regarding participation in the Mock Drills. ▪ During the review, it was found that the Emergency Competency Checklist that should be conducted at least every quarter for each nurse had not been conducted. Although the Facility implemented these checklists in the Infirmary during the week of the review, it was clearly evident from the Monitoring Team's	

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		observations of the use of the emergency equipment that nurses were unfamiliar with some of the equipment. In addition, in Residence 6510, the suction machine was wrapped tightly with plastic indicating that it was not being regularly checked. Also, it was noted that were no checklists found for two oxygen tanks, and the nurse asked to demonstrate the use of the oxygen tank was clearly unfamiliar with the use of the tank. In addition, some new Automatic External Defibrillators (AEDs) had been placed in some of the buildings without staff being provided training on their use. In fact, the Nurse Educator that accompanied the Monitoring Team during the emergency equipment demonstrations noted he had not seen the new AEDs that were already placed in some of the buildings. It was very concerning that the Facility had not discovered this issue prior to the Monitoring Team's visit due to the number of individuals that have complex medical challenges. The data from the drills conducted since the last review were as follows: ▪ 84 drills conducted in February 2012 – 83 passed (99%); ▪ 98 drills conducted in March 2012 – 88 passed (90%); ▪ 72 drills conducted in April 2012 – 67 passed (93%); ▪ 72 drills conducted in May 2012 – 56 passed (78%); and ▪ 90 drills conducted in June 2012 - 80 passed (89%). The Facility had made some positive steps forward regarding ABSSLC's Emergency Response System. However, there continued to be problematic issues as noted above that needed to be addressed.	
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 had been taken regarding this requirement of the Settlement Agreement: ▪ Although the Facility's Self-Assessment indicated that out of 80 RNs currently employed at ABSSLC, all but 10 had completed the Physical Assessment training provided by the State Nurse Practitioner group, no training rosters were provided to verify this. Such a roster should have been provided either as part of the Presentation Book or in response to the Monitoring Team's comprehensive request for training documentation included in the pre-visit request. However, the Self-Assessment did indicate that by the end of September 2012, 100% of the RNs would have received this training, which will be a positive step forward for the Facility. ▪ The caseloads for the Nurse Case Managers were in the process of being decreased in an effort to increase the accountability for nurses in this position. ▪ Information contained in the Presentation Book for Section M.2 indicated that the Facility was in process of developing a Nursing Education database to track	Noncompliance

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		the training classes and in-services nurses completed. The expected completion date for the database was noted to be September 2012. ▪ The Facility hired a full-time RN Case Manager Supervisor to oversee the RN Case Managers. The introduction of this new statewide position should increase the accountability of the crucial role of the RN Case Managers at the Facility. <u>Self-Rating:</u> The Facility's Self-Assessment indicated that: "based on the findings from this self-assessment, this provision is not in substantial compliance. We will increase focused audits, accountability, and training to identify concerns and develop corrective plans." A major concern for the Monitoring Team was that thus far in the review process, ABSSLC had not generated findings addressing the quality of the documentation contained in the Comprehensive Nursing Assessments, which continued to be inadequate. Although the Facility's finding of noncompliance was consistent with the Monitoring Team's findings, the reasons for the Monitoring Team's finding of noncompliance as noted below, were far more specific regarding the significant problems with the quality and content of the Comprehensive Nursing Assessments than what was reflected in the Facility's Self-Assessment. In addition, the Facility's Action Plan addressing Section M.2 did not include any action steps regarding the poor quality of the Comprehensive Nursing Assessments or how it was to be addressed by the next review. 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 #451 for dental issues; Individual #162, Individual #541, and Individual #215 for constipation; Individual #407, Individual #348, and Individual #527 for cardiac issues; Individual #59, Individual #396, Individual #146, and Individual #327 for weight; Individual #324 for diabetes; Individual #542, Individual #381, Individual #376 for osteoporosis; Individual #64, Individual #519, and Individual #418 for fractures; and Individual #517, and Individual #43 for challenging behaviors. ▪ Of the 20 individuals' nursing quarterly assessments reviewed, 13 (65%) were timely completed. Assessments that were not timely completed included those for: Individual #407, Individual #527, Individual #327, Individual #542, Individual #376, Individual #64, and Individual #418. ▪ 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.	

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		▪ Nursing assessments were updated as indicated by the individual's health status in none (0%) of the Comprehensive Nursing Assessments reviewed. Although there were some positive steps forward, as noted previously, the Monitoring Team found no progress had been made regarding the quality of the quarterly/annual nursing assessments. Consistent with the findings from the previous reviews, none of the Comprehensive Nursing Assessment summaries reviewed included an adequate or appropriate analysis of the individuals' health/mental health issues between quarters indicating if the health issues were improving or getting worse. The consistent lack of progress found by the Monitoring Team regarding the Comprehensive Nursing Assessments, and the Facility's lack of establishing a concrete plan to address this requirement suggested that nursing at ABSSLC continued to lack the ability and understanding regarding how to analyze, summarize, and document health/mental health issues to determine whether the individuals under their care were actually making progress regarding their health status. 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. As noted in previous reports, without providing adequate and appropriate competency-based training and ongoing mentoring regarding the process and documentation of a clinical analysis, it is unlikely improvement will be seen in the quality of the Comprehensive Nursing Assessments as required by the Settlement Agreement. The Monitoring Team reviewed the information that the Facility provided in response to the pre-review request for nursing documentation for individuals who have transitioned to the community. In reviewing the information provided for eight individuals including: Individual #199, Individual #504, Individual #272, Individual #43, Individual #539, Individual #398, Individual #149, and Individual #532 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. As noted in previous reports, a number of problematic issues that were found during past reviews continued to be found in all eight Nursing Discharge Summary Assessments	

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		reviewed by the Monitoring Team that included: ▪ A lack of a comprehensive and specific nursing assessment for individuals being discharged/transitioned to the community; ▪ 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; ▪ A lack of clear information addressing the nursing interventions that were needed to care for individuals; ▪ Discrepancies in recommended treatments and services between the nursing documentation and documentation from other disciplines that was not discovered and reconciled prior to the community transition; and ▪ The use of biased language in the Nursing Assessment rather than statements of fact addressing behaviors, such as Individual #199 "can walk when she wants to and that is the operative word—when she wants to." It is crucial that ABSSLC review and revise its current nursing discharge procedures and documentation requirements to ensure that upon an individual's transition/discharge from the Facility, the nursing documentation is specific and detailed enough to maintain continuity of care. The chronic lack of attention to this area indicated that there was a lack of recognition from nursing as well as the teams that the more information provided to the community staff regarding an individuals' health/mental issues, the greater the potential for consistency in care, and a successful transition. The consistent problematic findings regarding nursing transition/discharge documentation at this stage of the review process was extremely concerning. As clearly noted in past reports and during past reviews, the problematic issues regarding the nursing assessments for discharges/transitions to the community had not been impacted by the implementation of a new state-wide form. It was troubling that from review of the Facility's Action Plans and discussions with the CNE, the Facility had no plan in place to address this area by the next review. In addition, due to the poor quality of the Risk Action Plans/Health Management Plans (as discussed with regard to Section M.3), the Monitoring Team found no nursing documentation that provided specific guidance regarding the type and frequency of nursing interventions the individuals required. The Facility's Self-Assessment indicated that it was not in compliance with the elements of this requirement. This was consistent with the findings of the Monitoring Team.	
M3	Commencing within six months of the Effective Date hereof and with	In assessing its progress, ABSSLC indicated that since the last review, the following steps were initiated regarding this requirement of the Settlement Agreement:	Noncompliance

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	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.	▪ Although the Monitoring Team could not accurately interpret the data contained in the Facility's Self-Assessment, the Facility reported that there were multiple areas of concern found regarding the Health Management Plans (HMPs). The Facility indicated that in response to these findings, Acute Care Plans were being monitored and returned to the Case Managers with comments. However, no information or data were provided to the Monitoring Team addressing this action. Based on the pre-review document request #I.22, any documentation showing the Facility's efforts to comply should have been presented to the Monitoring Team. ▪ The Facility indicated that a Care Plan Committee was to be implemented to review all care plans. However, at the time of the review, the Committee had not yet met. ▪ Information contained in the Presentation Book for Section M.3 indicated that the training curriculum for Acute Care Plans from the Corpus Christi State Supported Living Center Nurse Operations Officer was to be implemented in late September 2012. Although the training had been provided to the Nurse Educators across the State and was to be provided to the Case Manager Supervisors in August 2012, from a previous review of the curriculum, the Monitoring Team was not able to determine how competency regarding the development of care plans was actually being assessed. ▪ From discussions with the CNE, since the Monitoring Team's last review, two pilot residences, 6400 and 6480, had made a transition from using the Health Management Plans to address high and medium health and mental health risks to using an Integrated Health Care Plan that will ultimately replace the current Risk Action Plans and Health Management Plans. The training rosters included in the Presentation Book for Section M verified that on 6/27/12, the State had provided the At Risk (Integrated Health Care Plan) training. Although the use of an Integrated Health Care Plan was a very promising clinical move forward for ABSSLC, it was of major concern to the Monitoring Team that a review of some of the initial Integrated Health Care Plans found them to be inadequate as noted below. In addition, there was no plan in place at the time of the review addressing how nursing interventions for certain chronic conditions that did not rise to the level of a high or medium risk or were not acute issues would be accounted for in a plan of care. The records of 20 individuals who the Facility identified as being at high risk for specific health indicators were reviewed, including: Individual #451 for dental issues; Individual #162, Individual #541, and Individual #215 for constipation; Individual #407, Individual #348, and Individual #527 for cardiac issues; Individual #59, Individual #396, Individual	

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		#146, and Individual #327 for weight; Individual #324 for diabetes; Individual #542, Individual #381, Individual #376 for osteoporosis; Individual #64, Individual #519, and Individual #418 for fractures; and Individual #517, and Individual #43 for challenging behaviors. Of the 20 individuals' Nursing Care Plans/Health Management Plans reviewed: ▪ Sixteen (80%) were found to have a HMP addressing their high-risk health/mental health indicator. Individuals who did not have a related HMP included Individual #451, Individual #407, Individual #527, and Individual #64. ▪ None (0%) of the nursing goals listed in the HMPs were clinically appropriate. ▪ None (0%) of the nursing interventions contained in the HMPs indicated who would implement the intervention, how often they were to be implemented, where they were to be documented, how often they would be reviewed, and/or when they should be considered for modification. In addition, the overall quality of the nursing interventions was poor in that they were generic, and non-specific to the individual health care needs. In addition, the interventions listed were not in alignment with nursing protocols addressing the specific health issue. ▪ None (0%) of the 20 HMPs were found to be clinically adequate. ▪ None (0%) of the 20 HMPs included adequate proactive interventions addressing the health indicator. ▪ None (0%) of the 20 HMPs were adequately individualized. ▪ Due to the nonspecific interventions contained in all of the 20 HMPs validating the implementation of the interventions was not possible, rendering them inadequate guides for the provision of care. As noted above, the Facility reported that they were in the process of transitioning from using the traditional nursing care plans (Health Management Plans) to using an Integrated Health Care Plan (IHCP) in the buildings that were conducting the pilot for the At Risk Individuals, Residences 6400 and 6480. Although the use of an integrated care plan was a promising step forward, a review of six individuals' Integrated Health Care Plans (i.e., for Individual #371, Individual #170, Individual #503, Individual #403, Individual #518, and Individual #377) found essentially the same significant problems as noted above with the HMPs. Specifically, the problems found included the following: ▪ The rationale for several risk levels did not include the needed clinical justification to support the designated level. Consequently, it was difficult for the Monitoring Team to determine the accuracy of the risk levels and the need for action steps addressing the health risk. ▪ Although there was some promising documentation regarding the nursing goals listed in the IHCPs reviewed that indicated the etiology of the health problem was being considered as an objective clinical indicator to focus on, there was no associated action steps found that actually addressed the goals listed.	

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		▪ None of the nursing action steps found were in alignment with the clinical assessments required by the nursing protocols for the specific health issues. ▪ The action steps contained in the IHCPs needed to include more specific information regarding who would implement the intervention, such as the RN, LVN, or Speech Therapist; how often they were to be implemented, such as on which shift if daily; consistently noting where they were to be documented; how often they would be reviewed; and/or when they should be considered for modification. Overall, most of the nursing action steps continued to be meaningless in that they were at times generic, and non-specific to the individual health care needs. ▪ None of the six IHCPs were found to be clinically adequate. ▪ None of the six IHCPs included appropriate proactive action steps addressing the health indicator. ▪ None of the six IHCPs were adequately individualized. Although the use of the IHCP was only recently implemented for the At-Risk pilot, many of the problematic issues noted above that have been found and not addressed and resolved with the existing HMPs have unfortunately been transferred to the new system. Regardless of the system and system changes made to the Facility's overall plans of care, it is essential that the Facility address the lack of clinically adequate care plans for the individuals under their care. The Facility should develop and implement appropriate care plans based on priority, and risk for all the individuals at ABSSLC Regarding nursing care plans addressing infectious illness, the Outbreak Report the Facility provided to the Monitoring Team indicated there were 16 individuals with either upper respiratory symptoms or flu-like symptoms between 3/2/12 and 4/5/12 (i.e., Individual #75, Individual #270, Individual #497, Individual #296, Individual #488, Individual #151, Individual #101, Individual #257, Individual #229, Individual #42, Individual #191, Individual #142, Individual #150, Individual #16, Individual #152, and Individual #14). ▪ Of the 16 individuals, none (0%) were found to have had acute HMPs addressing the infectious issue. Although a document request was submitted to the Facility prior to the review for the Health Management Plans for all individuals who were affected by any outbreaks since the last review, none addressing this issue were found among the documents provided. This indicated that none had been developed and implemented for these Individuals. ▪ Since no acute HMPs were found, none were reviewed addressing these infectious symptoms, thus, none (0%) were found to be adequate. Regarding nursing care plans addressing other infectious illness, the Facility list provided to the Monitoring Team indicated that since the Monitoring Team's last review,	

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		six individuals were diagnosed with MRSA (i.e., Individual #180, Individual #390, Individual #493, Individual #414, Individual #495, and Individual #359), and 22 individuals were diagnosed with Conjunctivitis (i.e., Individual #267, Individual #378, Individual #478, Individual #185, Individual #110, Individual #257, Individual #232, Individual #337, Individual #538, Individual #293, Individual #97, Individual #524, Individual #458, Individual #214, Individual #9, Individual #150, Individual #146, Individual #446, Individual #49, Individual #307, Individual #35, and Individual #399). ▪ Of the six individuals diagnosed with MRSA, four (67%) were found to have had acute HMPs addressing the infectious issue. Individuals who did not have HMPs addressing the infectious issue included: Individual #180, and Individual #493. ▪ Of the four Nursing Care Plans reviewed, none were found to be adequate (0%). ▪ Of the 22 individuals diagnosed with conjunctivitis, 10 (45%) were found to have had acute HMPs addressing the infectious issue. Individuals who did not have HMPs addressing the infectious issue included: Individual #478, Individual #110, Individual #232, Individual #337, Individual #538, Individual #293, Individual #97, Individual #524, Individual #458, Individual #214, Individual #150, and Individual #399. ▪ Of the 10 Nursing Care Plans reviewed, one was found to be adequate (10%). Individuals' care plans that were not found to be adequate included: Individual #267, Individual #378, Individual #185, Individual #257, Individual #9, Individual #146, Individual #466, Individual #307, and Individual #35. A review of the documentation from the Infection Control Nurse, including comments and recommendations she made to increase the clinical quality of some of these care plans was found to thorough and clinically sound. Unfortunately, only one of the care plans was modified in alignment with her recommendations while the others were either left unaltered or only minimally revised resulting in clinically inadequate nursing care plans. At the time of the review, 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. Consistent with findings from previous reviews, it was very concerning to find that individuals with contagious/infectious illnesses did not have care plans or adequate care plans addressing these illnesses. Nursing Administration, in conjunction with the Infection Control Nurse, should develop and implement a system to ensure that the care plans 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 HMPs/Integrated Health Care Plans should:	

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		▪ Be in alignment with interventions from the nursing protocols; ▪ 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 ▪ Accurately reflect the clinical needs of the individuals regardless of the format and system utilized. Since the last review, the Facility had taken a positive step by beginning collaboration with other disciplines regarding the development of Integrated Health Care Plans so that an interdisciplinary team approach would be used consistently, and interventions from other disciplines would be integrated in all Health Care Plans as required by Sections G and F of the Settlement Agreement. In alignment with this collaboration, the Facility should continue to give thoughtful and serious consideration to how to incorporate an individual's health risks into one plan in alignment with the At-Risk system and the clinical needs of the individual. Overall, there had been little to no progress made addressing this provision of the Settlement Agreement. The Facility indicated that it was not in compliance with this requirement of the Settlement Agreement. This was consistent with the findings of the Monitoring Team.	
M4	Within twelve months of the Effective Date hereof, the Facility shall establish and implement nursing assessment and reporting protocols sufficient to address the health status of the individuals served.	In response to this requirement, ABSSLC's Self-Assessment indicated the following actions were implemented: ▪ The Facility's Self-Assessment indicated that an education and training database was being developed at the time of the review. However, the Facility reported that currently there were no data to analyze with no further explanation provided. In addition, the Facility indicated that an additional RN Educator would be incorporated to "assist in planning and proper utilization of the education department." However, it was unclear as to how this action addressed this specific provision of the Settlement Agreement. ▪ In addition, the Facility's Self-Assessment indicated that due to "time and staffing issues, documentation of health status and continuity of care is not provided as needed." Although this was in alignment with the findings of the Monitoring Team's review, the Facility Self-Assessment provided no indication as to how the Facility determined its findings. Although the Self-Assessment indicated that prompts were being developed to record care such as tracheotomy care, there was no information contained in the Self-Assessment for Section M.4 addressing the specifics of this provision regarding nursing assessment and reporting protocols. In addition, there was no data provided addressing the monitoring of protocol cards as noted in the Action Plan for M.4.	Noncompliance

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		Although the Action Plan indicated that this monitoring had begun in July 2012, it was unclear if any data had actually been generated. If such data had been generated, it should have been included as part of the Presentation Book and/or in response to the pre-review document request #I.22. Regarding the Facility's self-rating, the information contained in the Self-Assessment indicated that: "based on the findings from this self-assessment, this provision is not in substantial compliance because review of the data shows the documentation is not in compliance. Uniform education and compliance of nursing will result from a detailed record of each nurse's activities." Although the CNE reported that nursing protocols had been implemented since the last review, the Monitoring Team found the same significant problematic issues regarding nursing assessments, care plans, and the overall nursing care and associated documentation as was found during previous reviews. As noted with regard observations at an ISP meeting discussed with regard to Section I.1, the findings regarding nursing care plans outlined in Section M.3, and the documentation of nursing care for individuals who were admitted to a community hospital detailed in Section M.1, since the Monitoring Team's last review, the lack of understanding regarding the importance of nursing protocols among the nursing staff at ABSSLC has not improved. The already present concern regarding the consistent problematic issues the Monitoring Team found in past reviews regarding individuals with high-risk health indicators, changes in status warranting Infirmary admission, and hospital admissions was heightened during an onsite observation and review of Individual #409's health issues. While on site, a review of Individual #409's medical record was conducted with some members of the nursing staff as well as members of the Facility's Physical and Nutritional Management Team. She had been hospitalized five times for respiratory distress and aspiration pneumonia thus far this year. The documentation indicated that since 4/5/07, Individual #409 was enterally nourished by a G-tube. In addition, since April 2006, she had a tracheotomy and has had a number of episodes of respiratory distress and aspiration pneumonia. She was noted to be at high risk for respiratory compromise and dental issues, and medium risk for aspiration, gastrointestinal problems, and falls. Initially, when members of the Monitoring Team went to observe medication administration for Individual #409, she was found in her room in her wheelchair very diaphoretic (sweating), her mouth opened, and having difficulty breathing through the thick mucous being expelled from her tracheotomy. Her congestion was clearly audible from across the room. Both the medication nurse and the Nurse Educator were present with the Monitoring Team at this time, and were noted not to initiate any type of assessment in response to Individual 409's status. It was only when the Monitoring	

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		Team recommended an assessment be initiated that a nurse was summoned to the room and began to suction the individual, which appeared to ease her ability to breathe. In addition, when the Monitoring Team asked about her excessive diaphoresis during this episode, both nursing staff and direct support professional staff present stated the Individual "always has these episodes of sweating." However, when asked to see data regarding when specifically Individual #409 had experienced these profuse episodes of sweating, staff reported that no data had actually been collected tracking this symptom. In addition, during the onsite review, none of the staff present from the different disciplines that provided services to Individual #409 was able to identify any actions that had been taken to possibly identify the cause of these episodes. A review of Individual #409's Aspiration Trigger sheets found that there were no triggers documented for the month in spite of staff reporting that the individual had frequent episodes similar to the one the Monitoring Team observed, as well as episodes of vomiting. In addition, members of the PNMT indicated that her positioning in her current wheelchair was not adequate, and in fact, was precipitating more problematic posture issues for Individual #409. Although the team indicated that Individual #409's wheelchair was being replaced that day, there had been no safe alternative used during the time she had to wait for her new wheelchair. In reviewing the documentation for Individual #409, a number of significant problematic issues were found regarding the recent care of this individual. Some of these problems included: ▪ The Comprehensive Nursing Assessments, dated 4/27/12 and 7/31/12, were essentially identical, including identical Summary Sections in spite of the fact they were dated three months apart. ▪ The HMPs found in the Active Record were the basic template with little to no individualization. ▪ None of the HMPs reviewed were in alignment with nursing protocols. ▪ The IPNs contained no consistent and regular nursing assessments to establish baselines and promptly identify changes in baselines regarding physical assessments, mental status, daily activities, positioning, treatments provided, pain assessments, vital signs, oxygen saturations, functioning of G-Tube, site inspections for G-Tube, tracheotomy site inspections, bowel and urinary output, and daily fluid input. ▪ There were gaps in the nursing documentation indicating that nursing was not regularly checking and assessing an individual with several health risks and changes in status. ▪ Episodes of decreased oxygen saturations or changes in vital signs were not timely or adequately reassessed. ▪ No nursing assessments were conducted in response to subtle changes in status.	

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		▪ There was no indication that the physician was consistently notified of changes in status. ▪ There was no indication that the PNMT was notified of changes in status. ▪ No IPNs were found indicating that Individual #409 was being followed, assessed, or regularly monitored by the PMNT, when changes in status occurred. ▪ No IPNs were found documenting the frequent episodes of diaphoresis she experienced that was staff reported and the Monitoring Team observed. Also, a review of an additional nine individuals that were admitted to the Infirmary and/or hospital since the last review (i.e., Individual #74, Individual #452, Individual #38, Individual #293, Individual #346, Individual #447, Individual #16, Individual #152, and Individual #257) found similar problematic issues throughout the nursing documentation as those found during Individual #409's onsite review (more detailed findings are provided with regard to Section M.1). These consistent problematic findings did not support the Facility's report indicating that nursing protocols were actually implemented. Although ABSSLC indicated that they had implemented nursing protocols, there was no indication that nursing was actually using these protocols as part of a structured system 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 care plans 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. The consistent problematic findings from this review 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. This 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	In response to this requirement, ABSSLC's Self-Assessment indicated that since the last review, the following activities were implemented: ▪ As noted in more detail with regard to Section I, revisions had been made to the At-Risk Individuals policy (in draft form at the time of the review). Some of the revisions included regrouping the Risk Guidelines so that the risk factors that	Noncompliance

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	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.	were clinically inter-related regarding outcomes or provision of services and supports were listed together, linking each risk factor with specific clinical indicators, and reformatting the Integrated Risk Rating Form to follow the same grouping sequence as the Risk Guidelines. In addition, the Risk Action Plans for the identified high and medium risk indicators were replaced with Integrated Health Care Plans designed to provide a comprehensive plan that will be completed annually, supplemental forms regarding IRRF and the IHCP were developed addressing changes in status, the Aspiration Pneumonia Enteral Nutrition evaluation was revised to be used as a data collection tool rather than a format for assessment, and individual-specific Trigger Data Sheets were developed to include observable and measurable clinical signs and symptoms that alert the staff to possible changes in status. ▪ In July 2012, two teams from ABSSLC implemented the "Enhanced Risk Process" described above at Residences 6400 and 6480. Since the system had only been implemented recently at the time of the review, the Monitoring Team was not able to adequately assess any progress made from the system revisions. However, the Facility Self-Assessment contained no information or Action Plan addressing the problematic issues found from previous reviews regarding the Comprehensive Nursing Assessments and the health risk indicators. The Facility's Self-Assessment indicated that "based on the findings from this self-assessment, this provision is not in substantial compliance because triggers which are designed to identify changes and risks have not been utilized appropriately. State-facilitated training has begun to implement better focus on each individual's risks." Consistent with past reviews, the findings from the Monitoring Team noted below indicated the quarterly and annual Comprehensive Nursing Assessments reviewed did not adequately address the risk issues. A review of records for 20 individuals determined to be at risk (i.e., Individual #451, Individual #162, Individual #541, Individual #215, Individual #407, Individual #348, Individual #527, Individual #59, Individual #396, Individual #146, Individual #327, Individual #324, Individual #542, Individual #381, Individual #376, Individual #64, Individual #519, Individual #418, Individual #517, and Individual #43), found that none (0%) included adequate nursing risk assessments. A review of the most current quarterly or annual Comprehensive Nursing Assessments for the above 20 individuals found that none of them (0%) contained an adequate assessment of the specific high-risk health indicators or provided any type of analysis of the high-risk health indicators in the Summary Section of the Comprehensive Nursing Assessment form. In fact, the Comprehensive Nursing Assessments the Monitoring Team reviewed were noted to have regressed from the previous review in that some of the nursing assessments did not	

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		reflect any clinical information regarding the health risk indicators, while others merely listed the entries from the IPNs or physician orders. As noted from the previous five reviews, nursing had no specific procedure in place to address the nursing assessment process and the analysis of the identified risk indicators. Consistent with the findings from past reviews, the nursing assessments for the At-Risk individuals were not adequate to address the health risks of the individuals reviewed. 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 in the Integrated Risk Rating forms. Although overall more specific clinical information was contained on the forms, for some of the areas that nursing was responsible for assessing and/or providing information, such as constipation, cardiac, osteoporosis, and dates of injuries/fractures, a decrease in this individual-specific information was noted from the previous review. In addition, when reviewing some the Integrated Risk Rating forms that included dates of revisions, the areas that contained deficits in individual-specific information remained unchanged from the original IRRF. In addition, a review of 20 records for individuals determined to be at risk (i.e., Individual #451, Individual #162, Individual #541, Individual #215, Individual #407, Individual #348, Individual #527, Individual #59, Individual #396, Individual #146, Individual #327, Individual #324, Individual #542, Individual #381, Individual #376, Individual #64, Individual #519, Individual #418, Individual #517, and Individual #43), there was documentation that the Facility: ▪ 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 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, could not be verified. ▪ 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%). Although some generic interventions were found in some ISPs addressing, for example, the need for exercise or to encourage fluids, which would have led to a preventative intervention, because these interventions were not written in measurable terms to allow them to be implemented and tracked, they did not result in compliance with this indicator. ▪ When the risk to the individual warranted, took immediate action in none of the cases (0%).	

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		▪ Integrated the plans into the ISPs in 12 of the cases (60%). Individuals who had not had their Risk Action Plans integrated into their ISPs included: Individual #451, Individual #407, Individual #59, Individual #146, Individual #64, Individual #418, Individual #517, and Individual #43. ▪ 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 Facility staff, the revisions to the At-Risk Individuals Policy and the recent pilot project initiated regarding the At-Risk process had promising potential. However, the significant existing deficits in the current At-Risk system, especially the nursing components of the system regarding the Comprehensive Nursing Assessments, the individual-specific information contained in the IRRFs from nursing, and the quality of the all the interventions contained in the Risk Action Plans still needed to be addressed. In addition, the Facility, in conjunction with the State, should specifically define the nursing assessment process regarding at-risk individuals, and provide training and mentoring addressing this area. At the time of the review, ABSSLC indicated that they were not in compliance with this requirement of the Settlement Agreement. This was consistent with the findings of the Monitoring Team.	
M6	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall implement nursing procedures for the administration of medications in accordance with current, generally accepted professional standards of care and provide the necessary supervision and training to minimize medication errors. The Parties shall jointly identify the	In response to this requirement, ABSSLC's Self-Assessment indicated that since the last review, activities addressing this provision included the following: ▪ The Facility reported that a review of the Medication Variance Committee Meeting Minutes for patterns and trends was difficult, since out of 276,994 monthly medications doses administered, the average medication variance was only 0.06 percent. This low percentage was related to Medication Variance forms not being appropriately filed, including those for overages and omissions of medications. The Self-Assessment noted that this issue had deterred the Facility from being able to accurately identify problematic trends. Although not included in the Self-Assessment for Section M.6, the minutes of the Medication Variance Committee, dated 6/27/12, indicated that because of the unreliable data from the lack of Medication Variance reports, which made analysis of the	Noncompliance

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	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.	medication variance data impossible, re-education was the only corrective action initiated. However, no curriculum or training rosters were provided to verify that the training was actually conducted. Based on the pre-review document request #I.22, any documentation showing the Facility's efforts to comply should have been presented to the Monitoring Team. ▪ While the Facility's Self-Assessment indicated that it would review the Medication Administration Observation results on a quarterly basis to assure nurses were competent with Medication Passes, the Facility reported that the required number of medication observations was not conducted. No further information was provided in the Self-Assessment addressing this issue. However, from discussions with the CNE and from the documentation contained in the Medication Variance Committee minutes, dated 6/31/12, the current responsibilities of the Nurse Educators rendered them unable to complete the required observations. The minutes indicated that in September 2012, the Nurse Managers would be trained to complete the Medication Observations. In addition, the data that was included in the Self-Assessment regarding the medication observations that were conducted could not be accurately interpreted, since the sample size was not included and only an overall average compliance score was presented for a multi-item monitoring tool for a six-month period of time. Although the Facility indicated that their findings showed noncompliance with nurses following the Physical Nutritional Management Plans, which was one issue consistent with the findings of the Monitoring Team, and not cleaning pill crushers, no Action Plan was found addressing these issues. Regarding the Facility's compliance rating, they indicated that: "Based on the findings from this self-assessment, this provision is not in substantial compliance because work is needed to consolidate the methods of writing med variance reports and time issues with current educator." Although not included in the Facility's Self-Assessment, there were some indications from the minutes of the meetings reviewed that the Facility was making positive attempts to move forward regarding the medication administration system. Some of these included: ▪ In March 2012, a new database was developed and implemented to more accurately track the medication variances leading to better trending and analysis of the variance data. ▪ The Facility clarified with State Office that both a Medication Variance Report and an Excess/Shortage form would be completed in the event of short or excessive medications found during the auto fill count by nursing or at the end of the week that could not be reconciled.	

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		▪ The Director of Pharmacy began reviewing a 10% to 20% randomly selected sample of Medication Variance Reports. The purpose was to determine if there was agreement with the nurse completing the form regarding issues such as the severity of the variance. The Minutes of the Medication Variance Committee meeting, dated 6/27/12, indicated that these data would be presented at the September 2012 meeting. ▪ The Pharmacy variance data demonstrated a positive decrease due to the addition of a Monday auto fill and newly hired Pharmacy Technician. ▪ The Facility's prompt and thorough review of a Prescriber variance resulted in a significant system change that included a review of all orders for chemical restraints, prohibiting the use of Thorazine as a chemical restraint. It also resulted in modifications to the quarterly report for psychiatry to ensure there were no contraindications to the medication regimens and the medications ordered as chemical restraints. ▪ In June 2012, the Facility developed a form describing the Medication Variance Reporting Process. Although there was more information contained in the minutes of the Medication Variance Committee meeting minutes, it was not always clear from the minutes the specific actions being taken, when they were actually 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 continue to need interventions. Although since the previous review, ABSSLC made some positive steps forward, they continued to have significant problematic issues regarding the overall medication administration system. From review of the Medication Variance Committee meeting minutes, the Pharmacy and Therapeutics Committee meeting minutes, the medication variance data, and discussions with Nursing Department staff and the Clinical Pharmacist, the following were some of the problematic issues identified: ▪ The Facility continued to have significant problematic issues regarding the unexplained medications that were being returned to the Pharmacy each week indicating that these could be reflective of individuals not receiving their prescribed medications. Although at the time of the review, the procedures for documenting and tracking short and excessive medications was being implemented and monitored, the Clinical Pharmacist and CNE candidly reported that the data regarding this issue remained unreliable. ▪ The overall medication variance data reported by the Facility continued to strongly suggest that there was significant under-reporting of medication variances.	

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		▪ The number of medication observations each quarter as required by policy was not being conducted. In addition, problematic issues the Monitoring Team found during a medication observation on 8/21/12 that the Nurse Educator did not identify or address during that observation called into question the reliability of the Medication Administration Observations that had been conducted. ▪ Consistent with the past review, staffing issues, such as vacant nursing positions, leaves of absences, sick calls, and staff fatigue from overtime hours had been identified in the minutes of the Medication Variance Committee Meeting minutes as issues resulting in medication variances. Although the Facility indicated that one LVN was hired to assist with the medication administration and two additional LVNs would be hired to relieve the stress for the 6:00 a.m. medication administration passes within the month of July 2012, the minutes did not indicate if this in fact had occurred and if there had been any initial results noted in the medication variance data. In addition, there was no indication if other interventions had been temporarily initiated while the hiring process was being completed. A review of the medication variances reported by the Facility indicated the following: ▪ February 2012 – 92 variances; ▪ March - 140 variances; ▪ April - 82 variances; ▪ May - 76 variances; and ▪ June - 86 variances. However, as noted previously, the Facility clearly indicated that it recognized the medication variance data available was not reliable. In addition, it was unclear from the Medication Variance Summary report if Medication Administration Record blanks and pharmacy and provider variances were included in these data. The Monitoring Team conducted two observations of medication administration at the Infirmary on 8/21/12 and Residence 6521 on 8/23/12. The following problematic issues were found on 8/21/12: ▪ There was no floor stock Colace on the medication cart. Thus, the medication nurse had to check other areas to find the medication; ▪ The lock on the medication cart was broken; ▪ The nurse did not review the PNMP for Individual #467, who only recently had a G-Tube placed on 8/7/12 before she began administering medications. In addition, the individual was not in the proper position according to the PNMP, which the Monitoring Team pointed out. The individual essentially was lying flat in bed, which potentially increased the risk of aspiration;	

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		▪ The nurse being observed and the direct support professional assisting the individual had not received any training or competency-based training before being assigned to take care of Individual #467; ▪ No lung sounds were obtained before and after administering medications for an individual who only recently received a G-Tube; ▪ The nurse did not provide education to the individual regarding the medications administered; and ▪ The Nurse Educator (LVN) that accompanied the Monitoring Team and also conducted a medication administration observation did not identify any of the above problematic issues during the observation. When asked by the Monitoring Team why she did not intervene during the observation, she reported that she was so shocked by the practices she was seeing that she was "speechless." The following problematic issues were found on 8/23/12 at Residence 6521: ▪ The nurse did not wash hands prior to putting on gloves when administering medications to Individual #409; ▪ The nurse did not review PNMP for Individual #409; ▪ The nurse had to be prompted to ensure Individual #409 was in the correct position, prior to medication administration; ▪ The nurse did not provide water according to the physician's order until prompted by the Nurse Educator (RN); ▪ No lung sounds were obtained before and after administering medications for an individual with a G-Tube; and ▪ The nurse did not provide education to the individual regarding the medications administered. However, the Nurse Educator that accompanied the Monitoring Team during this observation was noted to provide timely and appropriate instructions to the nurse administering the medications to ensure safe medication practices. Based on the significant 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 successfully complete competency-based training regarding the PNMPs, and understand the clinical rationale for the instructions contained in 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.	

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		Although the Facility had initiated some positive steps to review some of the elements of the medication administration system, there continued to be a number of significant problematic issues regarding the medication administration systems at ABSSLC. The Facility should aggressively continue its efforts to critically review all aspects of the medication administration system in order to accurately identify problematic areas, and implement plans of 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, and reconcile discrepancies regarding the actual variances that have occurred. In addition, further collaboration should occur between the Pharmacy, Nursing, and the Medical Departments in constructing a solid process that results in a thoughtful and critical review of the overall medication system. The Facility indicated that it was not in compliance with the elements of this requirement. This was consistent with the Monitoring Team's findings.	

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

1. As previously recommended, the Facility 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. 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. (Section M.1)
3. In order to avoid lapses in staff's designated responsibilities, the Facility should consider implementing a backup system when events such as leaves occur to ensure continuity. (Section M.1)
4. The Facility should continue to implement and expand the use of nursing protocols to guide nursing practices. In conjunction with the continuation of the adequate competency-based nursing skills training being provided by the State Office Nurse Practitioner Group, mentoring and supervision of nurses should focus on the expanded use of the protocols. (Section M.1)
5. As recommended in past reports, due to the number of individuals with complex medical needs at ABSSLC, individuals who have been hospitalized or have experienced a change in status 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. (Section M.1)
6. The Facility should 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. (Section M.1)
7. The Facility should consider aggregating and analyzing the data from the "Real Time" Infection Control audits, along with other monitoring data addressing IC issues, and data regarding actual infection rates in order to better identify systematic and/or staff-related problematic trends that might be impacting the rates of infections at the Facility. (Section M.1)
8. Such analyses of infection data and related discussions about action plans implemented or potential solutions should be included in the minutes of the Infection Control Committee meeting minutes. (Section M.1)
9. A formalized schedule should be developed clearly indicating which individuals' immunization status and immunizations have been researched and confirmed or updated to ensure all individuals have received all the required immunizations as outlined in the Health Care Guidelines. (Section M.1)

10. 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 and the Settlement Agreement, as well as providing professional feedback regarding the quality and completeness of the Infection Control Program. (Section M.1)
11. The Facility in conjunction with the State Office should clarify the role of Risk Management and the role of the clinical staff regarding the requirement addressing checking the emergency equipment. (Section M.1)
12. 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. (Section M.2)
13. It is crucial that ABSSLC review and revise its current nursing transition/discharge procedures and documentation requirements to ensure that upon an individual's transition/discharge from the Facility, the nursing documentation is specific and detailed enough to maintain continuity of care. (Section M.2)
14. The Facility should develop and implement appropriate care plans based on priority, and risk for all the individuals at ABSSLC. (Section M.3)
15. Nursing Administration, in conjunction with the Infection Control Nurse, should develop and implement a system to ensure that the care plans addressing infectious and communicable diseases are clinically adequate, individualized, and are being implemented consistently. (Section M.3)
16. The Facility should continue to give thoughtful and serious consideration to how to incorporate an individual's health risks into one plan in alignment with the At-Risk system and the clinical needs of the individual. (Section M.3)
17. The Facility, in conjunction with the State, should specifically define the nursing assessment process regarding at-risk individuals, and provide training and mentoring addressing this area. (Section M.5)
18. The Facility should develop and implement a system to ensure that prior to nurses providing care to individuals with a Physical Nutritional Management Plan, they successfully complete competency-based training regarding the Physical Nutritional Management Plans, and understand the clinical rationale for the instructions contained on the Physical Nutritional Management Plans. (Section M.6)
19. Nurses designated as auditors for medication administration observations should successfully complete training regarding how to appropriately assess compliance regarding positioning and other medication administration interventions, including following the instructions in the Physical Nutritional Management Plans. (Section M.6)
20. The Facility should aggressively expand its efforts to critically review all aspects of the medication administration system in order to accurately identify problematic areas, and implement plans of actions aimed at long-term resolutions. (Section M.6)
21. The Facility should expand and implement strategies to increase the reliability of the medication variance data, and reconcile discrepancies regarding the actual variances that have occurred. (Section M.6)
22. In addition, further collaboration should occur between the Pharmacy, Nursing, and the Medical Departments in constructing a solid process that results in a thoughtful and critical review of the overall medication system. (Section M.6)
23. As the Facility reviews its monitoring tools, the Facility is encouraged to review the Monitoring Team's report to identify indicators that are relevant to making compliance determinations. (Facility Self-Assessment)
24. The Facility should consider adopting a standardized format for presenting data in a meaningful way that facilitates its interpretation and analysis, and provide training to the disciplines regarding how to analyze their data to identify problematic trends. (Facility Self-Assessment)
25. In reviewing the Monitoring Team's report, the Facility should attempt to determine the reasons for any data/findings discrepancies. (Facility Self-Assessment)

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 Policies, procedures, and/or other documents addressing the provision of pharmacy services; o 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 Monitoring Team's last visit, including background information, data collection forms utilized, results, and 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 Monitoring Team's last visit; o Minutes of the committee addressing seizures with any attachments, since the Monitoring Team's last visit; o DUE calendar for next 12 months; o For Quarterly Drug Regimen Reviews (QDRRs), for all individuals the Facility serves, a listing of the individuals, their review periods, the dates in which reviews must be completed, and the dates on which reviews were actually completed for the last one-year period; o For QDRRs, two most recent per residential home that have been completed with physician signatures and dates, including those for: Individual #250, dated 2/23/12, and 5/18/12; Individual #118, dated 1/5/12, and 4/5/12; Individual #87, dated 1/2/12, and 4/3/12; Individual #213, dated 1/5/12, and 4/6/12; Individual #119, dated 3/5/12, and 6/13/12; Individual #138, dated 1/5/12, and 4/6/12; Individual #30, dated 3/14/12, and 6/19/12; Individual #230, dated 2/2/12, and 5/2/12; Individual #328, dated 3/1/12, and 6/8/12; Individual #534, dated 1/2/12, and 4/3/12; Individual #220, dated 3/14/12, and 6/14/12; Individual #105, dated 2/8/12, and 5/7/12; Individual #300, dated 1/2/12, and 4/3/12; Individual #417, dated 2/7/12, and 5/8/12; Individual #479, dated 2/8/12, and 5/7/12; Individual #228, dated 2/7/12, and 5/8/12; Individual #218, dated 3/8/12, and 6/20/12; Individual #452, dated 3/5/12, and 6/13/12; Individual #227, dated 3/1/12, and 6/8/12; Individual #485, dated 1/18/12, and 4/13/12; Individual #81, dated 3/1/12, and 6/8/12; Individual #84, dated 1/9/12, and 4/10/12; Individual #237, dated 1/2/12, and 4/3/12; Individual #196, dated 3/14/12, and 6/19/12; Individual #345, dated 1/18/12, and 4/13/12; Individual #38, dated 2/22/12, and 5/13/12; Individual #318, dated 3/14/12, and 6/14/12; Individual #293, dated 2/24/12, and 5/22/12; Individual #231, dated 2/20/12, and 5/15/12; Individual #405, dated 3/1/12, and 6/8/12;

	Individual #320, dated 2/23/12, and 5/18/12; Individual #157, dated 2/22/12, and 5/13/12; Individual #215, dated 2/24/12, and 5/22/12; Individual #50, dated 3/7/12, and 6/15/12; Individual #139, dated 2/2/12, and 5/2/12; Individual #447, dated 2/20/12, and 5/15/12; Individual #98, dated 2/2/12, and 5/2/12; Individual #238, dated 1/23/12, and 4/17/12; Individual #388, dated 1/23/12, and 4/17/12; Individual #205, dated 1/9/12, and 4/10/12; Individual #165, dated 3/7/12, and 6/15/12; Individual #146, dated 2/2/12, and 5/2/12; Individual #284, dated 3/8/12, and 6/20/12; and Individual #206, dated 1/5/12, and 4/5/12; o For 10 most recent QDRRs in which recommendations were made and accepted, copies of physician orders, including for: Individual #178, dated 5/21/12; Individual #108, pharmacy consultation on 6/19/12; Individual #81, dated 3/1/12; Individual #315, dated 1/23/12; Individual #472, dated 2/23/12; Individual #346, dated 5/13/12; Individual #363, dated 6/19/12; Individual #349, dated 2/8/12; Individual #397, dated 6/8/12; Individual #324, dated 6/19/12; and Individual #264, dated 6/19/12; o For 10 most recent QDRRs in which recommendations were made and not accepted, copy of IPN or other entry indicating reason for non-agreement: Individual #23, dated 4/6/12; Individual #364, dated 2/23/12; Individual #293, dated 2/24/12; and Individual #99, dated 6/19/12; o All "single patient intervention reports" in WORx system, since Monitoring Team's last visit; o Since the Monitoring Team's last review, 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 All "notes extracts" associated with "single patient intervention reports;" o For the past six months, any adverse drug reaction reports (ADR) completed; o Policies and/or procedures regarding medication error/variance, including prescription, dispensing, administration, documentation and potential errors; o Number 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, per quarter), and analysis reports, including corrective action plans, root cause analysis summaries, etc.; o The last 10 medication error forms completed and any plans of correction arising from review of the medication errors; o Communication between pharmacy and Nursing Department 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 Policies, procedures and/or other documents addressing medication administration; o List of Antibiograms per months for last six months by building; o Medication history for individuals with J-tubes or Gastrostomy/Jejunostomy feeding tubes (G/J tubes) (i.e., not G-tubes); o A schedule of when Quarterly Drug Regimen Reviews are conducted by home/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 poly-pharmacy; o All documentation for each emergency chemical restraint, including restraint checklist, for the following individuals with date/time of chemical restraint: Individual #163 on 6/16/12 2005 hour (hr); Individual #483 on 4/15/12 1235hr; Individual #137 on 5/20/12 1310hr; Individual #120 on 5/25/12 2050hr; Individual #268 on 4/20/12 1550hr; Individual #268 on 4/23/12 1810hr; Individual #268 on 5/10/12 1415hr; Individual #99 on 4/19/12 2310hr; Individual #99 on 4/29/12 1506hr; Individual #313 on 3/29/12 1850hr; Individual #231 on 4/28/12 1815hr; Individual #231 on 6/5/12 1200hr; Individual #384 on 3/23/12 0835hr; Individual #384 on 3/23/12 0955hr; Individual #384 on 3/24/12 1205hr; Individual #384 on 3/24/12 1802hr; Individual #384 on 3/25/12 1030hr; Individual #384 on 3/26/12 0825hr; Individual #384 on 3/26/12 1025hr; Individual #384 on 3/27/12 1030hr; Individual #384 on 3/28/12 1100hr; Individual #384 on 3/28/12 1515hr; Individual #384 on 3/28/12 1635hr; Individual #384 on 3/29/12 1130hr, and Individual #304 on 5/20/12 1030hr; o Trend analysis of chemical restraint use (graphs, etc.); o For each database maintained on use of chemical restraints, summary list(s) of all chemical restraints administered over the last six months; o For 10 orders involving drug-drug interactions, copies of serial computer screen shots for each step, for following individuals: Individual #180, dated 6/12/12; Individual #180, dated 5/22/12; Individual #70, dated 5/18/12; Individual #455, dated 5/17/12; Individual #247, dated 3/27/12; Individual #236, dated 6/8/12; Individual #328, dated 7/2/12; Individual #186, dated 4/19/12; Individual #469, dated 7/13/12, and Individual #156, dated 7/6/12; o For five orders involving potential allergic reactions for new orders, copies of serial computer screen shots for each step, for following individuals: Individual #218, dated 5/10/12; Individual #399, dated 6/28/12 Individual #250, dated 5/25/12; Individual #538, dated 5/3/12, and Individual #342, dated 3/27/12; o For five orders involving drug dosages below or exceeding normally prescribed dosage regimens, copies of computer screen shots for each step, for following individuals: Individual #538, dated 7/10/12; Individual #253, dated 6/8/12; Individual #82, dated 6/1/12; Individual #147, dated 7/3/12, and Individual #164, dated 5/16/12; o For five new orders in which labs are reviewed/monitored, copies of serial computer screen shots for each step, for following individuals: Individual #201, dated 4/5/12; Individual #275, dated 3/7/12; Individual #253, dated 3/37/12; Individual #111, dated 4/2/12, and Individual #63, dated 7/2/12; o For five new orders for which there was potential for significant side effects, copies of serial computer screen shots for each step, including any written documentation/information provided to PCP and response of PCP, for following individuals: Individual #447, dated 6/11/12; Individual #180, dated 6/11/12; Individual #304, dated 6/7/12; Individual #80, dated 7/9/12, and Individual #8, dated 6/13/12; and

	○ Presentation Book for Section N. ▪ **Interviews with**: ○ Leah Robinson, R.Ph., Chief Pharmacist; and ○ Marla Knight, R. Ph. Pharm.D., Clinical Pharmacist. ▪ **Observations of**: ○ Pharmacy and Therapeutics Committee meeting, on 8/22/12; and ○ Medication Variance Meeting, on 8/22/12.
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section N, dated 8/8/12. In its Self-Assessment, for each sub-section, 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. For Section N, in conducting its self-assessment, the Facility used monitoring and auditing tools. Based on a review of the Facility Self-Assessment, the monitoring/auditing templates, a sample of completed monitoring/auditing tools, as well as interviews with staff: ▪ The monitoring/auditing tools the Facility used to conduct its self-assessment included Medical Services Monitoring Tool: Pharmacy Services. This monitoring/auditing tool did not include a comprehensive list of indicators to address all the subsections of the Settlement Agreement. The Facility is encouraged to review the Monitoring Team's report to identify indicators that are relevant to making compliance determinations. ▪ This specific monitoring tool did not include adequate methodologies. For instance, the sample provided demonstrated that the form was completed based on review of a new order. However, the tool appeared to have several independent sections, and not all sections applied to a new order, but it was completed with each new order. The section on QDRRs might apply if a record review was also completed. However, the questions concerning the Pharmacy and Therapeutics (P&T) Committee also needed a review of the minutes, as opposed to a review of a new order or an individual record. Similarly, the section on safe medication practices appeared to require a review of actual and potential medication variances, as well as a review of adverse drug reactions. However, the form was completed based on a new order and/or record review. When the appropriate data was not reviewed in order to answer the questions, the results tabulated appeared to have little validity. ▪ The Facility's Self-Assessment did not appear to identify this monitoring tool in the self-assessment section. However, it was the only formal monitoring tool used, and was separately submitted. For the samples provided, the clinical pharmacist completed 100% of the sample. It was not clear if there was a QA representative simultaneously completing a sample for inter-rater reliability. There was no information about inter-rater reliability for this monitoring tool. The Facility used several other pharmacy data reviews as part of the self-assessment process. These included review of the WORx interventions entries, a computer search for the dates of prior QDRRs completed, an emergency chemical restraint database the Pharmacy Department maintained, MOSES and DISCUS monitoring, training attendance reports and rosters, and DUE results. For the QDRRs, a total number was recorded as part of the self-assessment, along with percent compliance. The calculations were

	not always in agreement with the Monitoring Team findings. However, for Sections N.1 through N.7, there was quality data provided from which analysis was derived. The databases appeared to be accurate. The Facility consistently presented data in a meaningful way. Specifically, except for Section N.8, the Facility's Self-Assessment presented findings consistently based on specific, measurable indicators. The Facility rated itself as being in compliance with the following sub-sections of Section N: Section N.1, Section N.2, Section N.4, and Section N.7. This was not consistent with the Monitoring Team's assessment. The Monitoring Team did not find compliance with Section N.1, or Section N.4, although considerable progress had been made in these two sections.
	Summary of Monitor's Assessment: The Facility demonstrated that new orders in which there were concerns for drug-drug interactions, allergies, dosage concerns, significant side effects, and need for further testing were appropriately followed up and had documentation of each step of the process. The Health Monitoring Tool used for the new order process needed review, because only the first part of the tool appeared to apply. The quality and completeness of the QDRRs continued to improve. Using agreed upon timeframes for completion, 91% had been completed in a timely manner. This was less than the Pharmacy Department concluded, but the rate of timely completion remained high. Laboratory reviews, benzodiazepine reviews, and atypical antipsychotic monitoring for metabolic side effects were thorough. Chemical restraint usage appeared to be reviewed in each case by pharmacy in a timely manner. This had been a challenge in the past, but a system appeared to be in place for the Pharmacy's review of all emergency chemical restraints. Poly-pharmacy identification and anticholinergic risk/benefit analysis needed further review and documentation. PCPs were responding to the QDRRs in a timely manner, but psychiatrists needed to improve their timely review of the QDRRs. The Adverse Drug Reaction (ADR) identification and reporting process had progressed in its development. Direct support professionals had been trained, but only 12% of nursing had undergone training. The DUE process also was in place. The reports were timely and the results were pragmatic and shared with the PCPs. Medication variances in the pharmacy needed tracking, data collection, and proof of progress. Little to no progress had been made in addressing medication variance issues.

#	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	General Information The Pharmacy Department staffing included the following: Chief Pharmacist, two other Staff Pharmacists, one Clinical Pharmacist, and four Pharmacy Technicians.	Noncompliance

#	Provision	Assessment of Status	Compliance
	new medication, a pharmacist shall conduct reviews of each individual's medication regimen and, as clinically indicated, make recommendations to the prescribing health care provider about significant interactions with the individual's current medication regimen; side effects; allergies; and the need for laboratory results, additional laboratory testing regarding risks associated with the use of the medication, and dose adjustments if the prescribed dosage is not consistent with Facility policy or current drug literature.	The Pharmacy Department had no state/federal regulatory surveys since the Monitoring Team's last visit. The Pharmacy Department utilized the "Medical Services Monitoring Tool Pharmacy Services" (revision date 8/2/10). This incorporated aspects of the Health Care Guidelines and the Settlement Agreement for new orders (Section N.1), QDRRs (Sections N.2, N.3, N.4), tardive dyskinesia monitoring if appropriate (Section N.5), review of ADRs (Section N.6), interpretation of DUE data by P&T Committee (Section N.7), and systematic tracking, analysis, and action steps for medication variances (Section N.8). The most recent quarterly data analysis was submitted. A graph of results for each month (March, April, May 2012) was submitted. A 10% sample each month was reviewed. From a handwritten notation, the sample pool each month was the number of different drug interactions identified each month. It appeared this was a subset of the larger patient interventions that occurred each month and included more than drug interactions. For example, the interventions log for February 2012 included 111 interventions. The handwritten note for February 2012 indicated: "74 different interactions; 10% sample =7." For April 2012, the handwritten note stated: "48 different interactions; 10% sample = 5," while the interventions log listed 91 interventions. For May, there was no similar handwritten notation. The "Pharmacy Services Analysis" was provided in graph form for each month. For each component of the "Medical Services Monitoring Tool Pharmacy Services," the results were graphed. For March 2012, seven of 74 drug interaction alerts were reviewed. Areas needing improvement included: (1.c.3) "There is documentation that upon the prescription of a new medication, a pharmacist as clinically indicated, made recommendations to the prescribing physician about allergies." (2) "Tardive dyskinesia monitoring is conducted as appropriate, at least quarterly, using a validated rating instrument such as the MOSES or DISCUS (this includes the medication: Reglan)." The percentage compliance was based on a denominator of those applicable to that specific probe rather than the total sample of seven. For New Medication Orders (1.c.3), compliance was 83%. For Safe Medication Practices (2), compliance was 67%. Additionally, the raw data sheets were provided for each. For one individual, Individual #374, the reference was to page 12 of the interventions log. However, the date of the order on the "Drug Interactions Alerts" was 2/22/12 and the date on the interventions log was 2/14/12, suggesting a different order. However, under the interventions date of 2/22/12, the drug interaction of concern (Lithium and Hydrochlorothiazide) could not be found. It would have been helpful to have further information for verification of the information used in the data interpretation and data analysis. For April 2012, a total of 57 drug interaction alerts were the sample pool, from which a sample of six was derived (10%). A graph provided the summary results. Areas needing	

#	Provision	Assessment of Status	Compliance
		improvement included: New Medication Orders (2)"There is documentation following the pharmacist's review of the order, that if the pharmacist has any concerns, the medication was not dispensed or available to the individual until the issue was discussed between the PCP and the pharmacist;" Safe Medication Practices (2) "Tardive Dyskinesia monitoring is conducted as appropriate, at least quarterly using a validated rating instrument such as the MOSES or DISCUS (this includes the medication: Reglan)." Compliance for New Medication Orders (2) was 67%. Compliance for Safe Medication Practices (2) was 67%. For May 2012, a total of 48 drug interaction alerts composed the sample pool, from which a sample of five was reviewed. One area needing improvement was: Safe Medication Practices (2) "Tardive Dyskinesia monitoring is conducted as appropriate, at least quarterly using a validated rating instrument such as the MOSES or DISCUS (this includes the medication: Reglan). Compliance was 80%. This data was summarized for the entire quarter. For New Medication Orders (1.c.3), for the quarter, compliance was 94%. For New Medication Orders (2), compliance was 89%. For Safe Medication Practices (2), compliance was 71%. A few observations and concerns follow: ▪ It is recommended that for any analysis, a brief description in bullet form be included, describing the precise sample, sample population, sample size, and how the sample was derived (i.e., random, highest risk, etc.). A number of assumptions had to be made to interpret the monitoring process. ▪ Compliance appeared to be set at 70% (a bold line across the graph at that level). This was a low expectation for compliance. ▪ A number of the questions on the monitoring tool did not appear to apply to a new order or any specific order. The sections for Pharmacy and Therapeutics Committee and the process of identification of adverse drug reactions were two examples. In reviewing the new orders for drug interactions in the sample provided, it was not clear the rationale of checking these areas as in compliance. It would seem these areas applied to other aspects of pharmacy and need to be monitored in other ways. The reason to review tardive dyskinesia monitoring during a review of a drug interaction for a new order involving non-psychotropic medications, such as Simvastatin and Amlodipine also was not clear. Although each section of the tool asked valuable probes, usefulness was reduced when the probe was no longer focused on medication orders, but instead included probes concerning P&T Committee reviews. The results of these probes for areas beyond new medication orders appeared to have little value and did not provide guidance to the Pharmacy Department. It is recommended that the implementation of this monitoring tool be reviewed,	

#	Provision	Assessment of Status	Compliance
		with a focus on the appropriate use of its component parts, in order to provide more applicable information for quality improvement. ▪ There was no inter-rater reliability established for this process. Other pharmacists, given clear instructions, could complete additional reviews, and provide inter-rater reliability data to verify the findings of the current analysis. <u>New Orders</u> "Patient intervention" entries for new orders entered into the WORx software program were submitted for review. The following lists the number of patient intervention entries generated per month: February 2012 (starting from 2/20/12) - 48, March 2012 – 93, April 2012 - 94, May 2012 – 139, June 2012 – 93, July 2012 (through July 7, 2012) - 21. There were a total of 488 patient intervention entries. They appeared complete, stating the concern, needed follow-up information documented, and order, including medication, dosage, and frequency. There were no subcategories to separate types of patient interventions. As an internal pharmacy monitoring tool, creating a few subcategories with clear criteria might assist the Pharmacy Department and Quality Assurance Department in sampling focused areas of patient intervention. A sample of 30 new prescriptions was reviewed. The following summarizes the results: ▪ 10 new orders were submitted in which the pharmacy found concerns with **drug-drug interactions** with the current drug regimen. A computer screen shot of the order was submitted for 10 of 10 (100%). For these 10 new orders, 13 drugs–drug interactions were identified, requiring further PCP review for potentially 13 orders. For 12 of 13 (92%), a copy of the patient intervention form was submitted indicating these drug-drug interactions had been communicated. A handout was provided to the PCP in 13 of 13 (100%) drug-drug interactions. A change in the medication order occurred in seven orders, one order was generated for additional testing, and no change was made in five orders. The PCP decided to order additional monitoring for three new orders, but there was evidence this was accomplished in one of three (33%). ▪ Five new orders were submitted in which **allergies** were reviewed and determined by the Pharmacy to be a concern. A computer screen shot of the order was submitted for five of five (100%). A copy of the patient intervention was submitted in five of five (100%). As a result of the pharmacy review, there was a documented change in order for three of five orders. There was confirmatory documentation of no change for two orders. Based on this information, adequate documentation of the new order process for allergies occurred in five of five (100%) of submitted cases. ▪ Five new orders were submitted in which significant **side effects** were reviewed by the Pharmacy and determined to be a concern. A screen shot was submitted in five of five (100%). A patient intervention note was submitted for five of five	

#	Provision	Assessment of Status	Compliance
		(100%). Evidence of an order change was submitted in two of five. For two orders, additional lab monitoring was recommended. For one of these two, there was evidence that additional lab monitoring was ordered (50%). In summary, for these five orders submitted, four (80%) had adequate documentation concerning side effect review/collaboration with the PCP. ▪ Five new orders were submitted in which **current laboratory results and potential need for further testing** were identified by the Pharmacy during initial review. A copy of the screen shot was submitted in five of five (100%). A handout to the PCP occurred in three of five (60%). A copy of the patient intervention was submitted in five of five (100%). New orders were written for none of the medications. Lab data was submitted in five of five (100%). Documentation of steps in this new order process had adequate evidence in five of five (100%) ▪ Five new orders were submitted in which pharmacy had concerns about the potential need for **dosage adjustments**. For five of five orders (100%), there was a copy of the screen shot submitted. For two of five, there was documentation the PCP was contacted. A copy of the patient intervention was submitted for this in two of five orders. For three of the five new orders, it appeared that there was no need to provide communication to the PCP, because the Pharmacy reviewed labs and completed computations based on lab data. A change of order based on the Pharmacy's review and PCP contact occurred in one of five. In summary, there was adequate documentation of the process in five of five. It is recommended that for computations completed by the lab to ensure appropriate dosage, that the labs be current, as defined by Pharmacy Department policy. Two of the lab computations were completed on lab results that were approximately 11 months old. In summary, for the above 33 new medication errors, there were 28 out of 33 (85%) for which the necessary documentation was provided. For five orders, there was need for more evidence (using updated information in computing renal function, and ensuring that a PCP's monitoring orders were in place to reflect the information on the patient intervention form). Additionally, the Clinical Pharmacist used the morning medical meeting as a forum to provide PCPs and other members with medication updates, especially drug side effects. Several examples of this were submitted, including the 7/27/12 morning medical meeting, in which Avelox and Levaquin and the differences in their effect on the QTc interval were discussed. A handout also was provided at the meeting. At the 5/18/12 Infirmary rounds meeting, a new Federal Drug Administration (FDA) warning on the use of azithromycin was discussed, and a handout concerning Reglan was provided during the 5/23/12 Infirmary rounds.	

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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 "Drug Regimen Review Schedule 2012" was submitted, which verified the due dates (end date of the review period) per quarter for each of the individuals according to residence. For each residence, all individuals were assigned four due dates (every three months) to provide the framework of completion of the QDRRs across the campus. All 22 residences were listed. A memo from the State Office provided further guidance that the "the QDRR may be conducted up to seven days prior to the end of the review period and will be considered delinquent if completed 14 calendar days from the end date of the review period. All subsequent review periods will be set in three month increments from the initial review period…" A schedule of completed QDRRs was submitted for 2012. Each of the prior QDRRs was reviewed for date of completion and compared to the current QDRR's date of completion. 376 of 422 current submitted QDRRs (89%) were completed within the period of time from seven days prior to the due date of the QDRR to 13 days after the 90-day due date (day 14 was considered delinquent according to the State Office directive). A total of 24 (from Residence #6510) were completed earlier than seven days prior to the "seven days prior to the end of the review period," and 22 (from Residence #6450) were completed at 14 calendar days (defined by State Office as delinquent). The current submission of data made it difficult to track the QDRRs across campus. It is recommended that a more user-friendly database be developed that would quickly highlight to the Pharmacy Department those QDRRs that might exceed the agreed upon limits for completion of the QDDRs. A sample of 44 QDRRs (two from each residence) was submitted, as well as the prior QDRR for each of these 44 most current QDRRs. These are listed above in the documents reviewed section. Each of the 44 QDRRs was reviewed for date of completion and compared to the prior QDRR date of completion. Timeliness for completion of the most current QDRR was determined by the agreed upon due date of 90 days after the prior QDRR, with additional parameters established as a time period of seven days prior to the due date and extending through 13 days after the due date. A total of 40 of 44 (91%) most current QDRRs submitted were considered timely. Based on the sample of 44 QDRRs, the following summarizes the results of the review: ▪ Laboratory information was submitted as part of 44 QDRRs (100%). ▪ The lab results included exact values or indication of normal range for applicable tests (100%), such as Vitamin D levels, complete blood counts (CBC), electrolytes, glucose, Hemoglobin (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). ▪ 44 QDRRs (100%) included the date the lab was drawn. ▪ Lab results with significant abnormalities were listed in 20 QDRRs. Of these 18	Substantial Compliance

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		out of 20 QDRRs (90%) included comments pertaining to these abnormalities.	
N3	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, prescribing medical practitioners and the pharmacist shall collaborate: in monitoring the use of "Stat" (i.e., emergency) medications and chemical restraints to ensure that medications are used in a clinically justifiable manner, and not as a substitute for long-term treatment; in monitoring the use of benzodiazepines, anticholinergics, and polypharmacy, to ensure clinical justifications and attention to associated risks; and in monitoring metabolic and endocrine risks associated with the use of new generation antipsychotic medications.	This provision of the Settlement Agreement encompasses a number of requirements. Each of 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 25 chemical restraints used from 3/23/12 to 6/16/12. A total of 10 individuals were administered these 25 emergency chemical restraints. For the 25 emergency chemical restraints, the pharmacy sections were reviewed for adequacy of completion and compliance. The following summarizes the review of these documents: ▪ Of the 25 emergency chemical restraint forms, 25 forms (100%) included information/comments concerning the justification of use due to the behavior. The pharmacy analysis determined that two of the chemical restraints were not considered justified based on information provided to the pharmacy. ▪ Effectiveness of the chemical restraint was documented in 24 out of the 25 chemical restraint forms completed (96%). It was documented that 13 of the chemical restraints were determined to be effective, nine were not effective, and for three chemical restraints, effectiveness could not be determined based on information provided to the Pharmacy Department. ▪ Side effects and adverse effects were reviewed in 25 of the completed chemical restraint forms (100%). ▪ A discussion of drug/drug interactions was noted in 25 of 25 completed chemical restraint forms (100%). ▪ There were nine statements that were considered recommendations. ▪ The range of time for completion of the forms was from two to 13 days. Sixteen chemical restraint forms were completed within five days of the chemical restraint use. Nine were completed within six to 10 days, and one was completed greater than 10 days after the chemical restraint was administered. Separately, the Clinical Pharmacist, when noting a concern on the chemical restraint document, provided feedback via email to those monitoring chemical restraint use and documentation. The psychiatrist also had a designated space for completion on the "Face-to-Face	Noncompliance

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		Assessment, Debriefing, and Reviews for Crisis Intervention Restraint." Review of these documented showed: ▪ Of the 25 completed, there were 25 forms (100%) signed and dated by the psychiatrist. ▪ For none of the chemical restraints used (0%) was there a description of the behaviors and prior steps taken by the IDT/psychologist. ▪ For 23 of 25 (92%), clinical justification was documented. ▪ Side effects/drug-drug interactions were mentioned in five of the reviews (20%). ▪ Effectiveness was documented in 21 of the 25 cases (84%). Twelve were considered to have been effective, and nine were considered to have been not effective. ▪ There were 12 recommendations documented for changes in medication. ▪ There were no recommendations for a change in PBSP or change in environment. ▪ The range of time for completion of the chemical restraint forms was two to 13 days. Ten chemical restraint forms were completed in five or less days. Seven chemical restraint forms were completed within six to 10 days. Ten chemical restraint forms were completed greater than 10 days after chemical restraint administration. For one chemical restraint form, the date of completion could not be determined. Separately, there were changes made in monitoring the use of emergency chemical restraints. Psychiatry added a review of emergency chemical restraint recommendations to the psychiatric quarterly reviews. Additionally, as part of the review process, the Clinical Pharmacist had begun to review all emergency chemical restraint recommendations, and a section entitled "Clinical Pharmacist's Quarterly Review" was incorporated into the "Physician Psychotropic Quarterly Assessment and Medication Review" form. <u>Polypharmacy</u> Of the 44 QDRRs reviewed, the Pharmacy recorded polypharmacy in 14 reviews. ▪ Justification by diagnosis of each of the medications listed in the polypharmacy regimen was documented in 14 of 14 (100%). ▪ Clinical justification for the use of polypharmacy was addressed in 14 of 14 (100%). Examples of justification included referencing the document name and date in which it was discussed and approved (for example, neurology clinic notes with date of visit confirming the continued need for the polypharmacy, or reference to the polypharmacy committee minutes with a specific date, with comment by the pharmacy that there was sufficient information to justify polypharmacy).	

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		▪ Potential interactions with other drugs or food/side effect risk were reviewed in 14 of 14 QDRRs (100%). ▪ For 14 of 14 (100%), the QDRRs reviewed whether monitoring/evaluation had occurred for effectiveness and appropriateness of the drug regimen. ▪ Although there were 14 QDRRs in which polypharmacy was identified, an additional five QDRRs appeared to have polypharmacy that was not identified by the Pharmacy Department. Three of these had polypharmacy for medications used to treat hypertension, one had poly-pharmacy for antiepileptic medication, and one appeared to be re-categorized as an antiepileptic medication, when it was categorized in the prior QDRR as a psychiatric medication. When the newly categorized medication was reduced, behaviors were exacerbated and the dosage had to be increased, indicating a role in psychiatric treatment. However, although the former QDRR identified polypharmacy, the current QDRR did not. These five additional QDRRs with poly-pharmacy added to the 14 QDRRs discussed with polypharmacy increased the total to 19 QDRRs with poly-pharmacy. The Pharmacy Department identified 14 of the 19 (74%). Because polypharmacy was not identified for these five records, none of the requirements listed above for the Pharmacy's review of polypharmacy had been completed. ▪ Additionally, one QDRR listed as having polypharmacy did not list the medications that would meet the criteria for the definition. It was not clear if the medication was not listed, or the individual did not have polypharmacy. At the 8/22/12 Pharmacy and Therapeutics Committee meeting, the use of psychotropic medications was summarized in chart form. Five quarters of data was available. In the first quarter of 2010, there were 748 psychotropic medications used/prescribed. In the second quarter of 2012, there were 360 psychotropic medications prescribed. The average number of psychotropic medications per individual also decreased, from 3.12 psychotropic medications prescribed in the second quarter of 2010, to 1.89 psychotropic medications prescribed in the second quarter of 2012. Over the prior 10 calendar quarters, psychotropic medication use was reduced by 52%. Polypharmacy also was reviewed and analyzed through the Psychotropic Polypharmacy Report discussed at the 8/22/12 P&T Committee. The percentage of individuals at ABSSLC with psychotropic polypharmacy had been stable over the prior three months (June to August 2012). Those Facility staff believed had stable polypharmacy increased slightly, and those with active poly-pharmacy decreased. This is discussed in greater detail with regard to Section J.11. <u>Benzodiazepine Use</u> Benzodiazepine use was noted in eight of the 44 QDRRs. For one QDRR, the	

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		benzodiazepine was not listed in the list of primary medications, but it was discussed under the comment section. ▪ Of these eight, eight (100%)documented justification with appropriate diagnoses; and ▪ Eight of eight QDRRs (100%) indicated whether side effects or other adverse risks were present. Additionally, at the 4/25/12 Pharmacy and Therapeutics Committee meeting, each PCP was given a list of individuals on the PCP's caseload taking benzodiazepines on a routine basis. <u>Anticholinergic Monitoring</u> Of the 44 QDRRs, 43 individuals (98%) were screened for significant anticholinergic side effects of prescribed medications. One was listed with no mention of anticholinergic risk, but the prior QDRR documented a high risk of anticholinergic side effects. The Pharmacy identified a total of 31 QDRRs with anticholinergic medications. The Pharmacy had not identified one individual for whom anticholinergic monitoring should have occurred. The results of the review of the QDRRs in which the anticholinergic monitoring did occur were as follows, using the total of 32 QDRRs with anticholinergic load: ▪ Eight of 32 QDRRs (25%) documented clinical justification of the use of each of the medications contributing to anticholinergic load/effect. The clinical burden of the side effects was less than the benefit. 31 of 32 (97%) QDRRs listed/addressed side effects/significant risks. Further information on reduction of anticholinergic medication was discussed at the 8/22/12 Pharmacy and Therapeutics Committee. The number of high anticholinergic drugs prescribed was reduced by 52% from the first quarter of 2010 to the second quarter of 2012. Additionally, at the 4/25/12 Pharmacy and Therapeutics Committee meeting, a list of the individuals on each PCP's caseload prescribed anticholinergics was distributed for review. <u>New Generation Antipsychotic Endocrine and Metabolic Side Effects</u> Out of the 44 QDRRs reviewed, 17 listed atypical antipsychotic medication. Of these, 17 (100%) included lab values that reviewed endocrine and metabolic risks [i.e., Basic Metabolic Panel (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 timely review and complete review by psychiatry of chemical restraints, identification of polypharmacy so that adequate review and justification for polypharmacy can occur, and monitoring and justification for	

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		anticholinergic medications.	
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 44 QDRRs showed the following: ▪ Of the 44, 44 QDRRs (100%) had the PCP signature. ▪ Of the 44 (100%) had the date the PCP reviewed the document. ▪ There were 18 QDRRs with recommendations. ▪ Evidence of PCP review of recommendations with agreement or disagreement with justification and plan was documented in 43 out of 44 (98%). o Agreement was documented in 43 out of 44. For one out of 44, the box indicating agreement was not checked. o There was disagreement by the PCP for none of the QDRRs. o The PCP responded within 14 days of the QDRR being completed by pharmacy in 39 of 44 QDRRs (89%). It was noted that the PCP responded within seven days in 36 QDRRs. o The average length of time between completion of the QDRR by pharmacy and the PCP review was 5.5 days. ▪ Psychiatry reviewed the QDRR when there was polypharmacy due to psychotropic medication. A psychiatrist reviewed and signed eight QDRRs. Of these eight, seven had polypharmacy, and it was not clear the reason for the psychiatrist to sign one QDRR without polypharmacy as an issue. ▪ Of the seven, agreement was documented in seven of seven (100%). ▪ For two QDRRs, there was polypharmacy, but no psychiatry review. Of the nine QDRRs with polypharmacy (these two and the prior seven), psychiatry reviewed seven out of nine (78%). ▪ The psychiatrist responded within 14 days of the QDRR being completed by pharmacy in two of seven QDRRs (29%) that identified polypharmacy. The average time between the pharmacy completing the QDRR and psychiatry review was 20 days. 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 of 10, 10 (100%) demonstrated that the PCP/psychiatrist acted upon the recommendation. Evidence was provided of the order, lab result obtained, etc., verifying the recommendation was completed. Additionally, it was noted that in one case, psychiatry consulted the clinical pharmacist on the drug regimen choice concerning a cardiac concern, which prompted recommendations back to the PCP and psychiatrist. The 10 QDRRs and the pharmacy consultation indicated the value and positive clinical impact of the QDRR process and clinical pharmacy service at ABSSLC. It was also noted in the above QDRR data that there had been 18 recommendations from pharmacy for the 44 QDRRs sampled, and there were no PCP disagreements with these recommendations.	Noncompliance

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		The Facility submitted four active records in which recommendations from the QDRR were not followed or incompletely followed, due to lack of agreement. These are listed in the documents reviewed section. In three of four cases (75%), although there was a response indicating agreement, a rationale for not following the recommendation was written on the QDRR, with plan as appropriate. For one of these three, an additional recommendation was followed. For one of four cases (25%), the psychiatrist did not agree or disagree, as the psychiatrist had not seen the individual. This was written on the QDRR as the response and plan. The Pharmacy could not find any other QDRRs with partial or complete disagreement by the PCP since the Monitoring Team's last visit, indicating that when recommendations were made, they were valuable in providing guidance to the PCP in care of the individual.	
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 discussed with regard to Section J.12, the Settlement Agreement mandated 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 MOSES every six months. The Facility actually performed the MOSES every three months, in conjunction with the DISCUS. This was not due to a specific policy, but rather, represented an internal mechanism that linked the performance of both evaluations to a quarterly schedule. This was, in turn, aligned with the Quarterly Review of the individual in the Psychiatry Clinic. An additional component of this process was also the latency between the time that the nurse completed the exam, and the documentation was reviewed and signed by the prescribing physician. The review of the sample of the records of 28 individuals prescribed psychotropic medication showed the documentation the MOSES evaluation was current (completed within the last three months) and had been performed at least every three months for the prior year, was present for all, with the exception of Individual #355, for whom there was a gap of greater than three months between the 5/2/11 and 10/6/11 evaluation. However, this interval was still within the six-month parameter (by one month) specified in the Settlement Agreement. Thus, timely documentation could be identified for 28 of the 28 individuals (100%). The records of 23 of the 28 individuals (82%) contained documentation that the prescribing physician had reviewed the MOSES evaluation in a timely manner, which had been defined as ten days prior to this review, but was now calculated based on 14 calendar days. Those individuals whose MOSES documentation was not reviewed in a timely manner (latency between dates) were those of: Individual #540 (5/1/12 – 5/23/12); Individual #168 (12/2/11 – 12/20/11); Individual #355 (10/6/11 – 10/24/11); Individual #97 (4/30/12 – 5/23/12); and Individual #151 (5/1/12 – 5/23/12). Thus, the evaluations of 23 individuals had been reviewed in a timely manner, resulting in the overall completion rate of 82 percent.	Noncompliance

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		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 28 individuals indicated that the Facility carried out quarterly evaluations with the DISCUS of all individuals receiving psychotropic medications, regardless of whether or not one of these medications was an antipsychotic agent. This was similar to the findings of the Monitoring Team's previous review, which indicated that the Facility's practice was to perform the DISCUS for all individuals who received psychotropic medication. The January 2012 guidelines from the Executive Formulary Committee, which addressed this issue, only specified that the DISCUS be used to monitor for the side effects of the antipsychotic agents and Reglan. Thus, the rationale was similar to that related to the quarterly evaluations with the MOSES and was not mandated by an internal policy, but rather reflected an internal mechanism to routinely administer these evaluations to ensure completion for all of those requiring them. In regard to the DISCUS, it also provided a baseline of evaluations if an individual should be started on antipsychotic medication in the future. Documentation that the DISCUS was current, and had been performed quarterly for the past year was identified for all but the following individuals: Individual #168 (most recent evaluation 3/23/12), and Individual #518 (interval of greater than 90 days between 12/12/11 and 6/1/12). Thus, the DISCUS had been performed as specified for 26 of the 28 individuals (93%) that the Facility included in their protocol for monitoring with the DISCUS, which set a higher standard than that required by the Settlement Agreement. 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 prescribing physician reviewed it. Those seven individuals whose records indicated that there was a significant delay between the date the Nurse completed the DISCUS evaluation, and the prescribing physician reviewed and signed it (latency before review), were as follows: Individual #51 (5/1/12 – 5/23/12), Individual #97 (4/30/12 - 5/23/12), Individual #465 (2/16/12 – 3/6/12), and Individual #540 (5/1/12 – 5/23/12. Thus, the prescribing physician reviewed the DISCUS in a timely manner for 24 of the 28 individuals (86%). 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 similar to those of antipsychotic agents. A list was obtained from the Pharmacy of all individuals receiving 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	

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		Reglan, but not also prescribed psychotropic medication. There were a total of 19 individuals receiving Reglan, only two of which were also prescribed psychotropic medication. The following sample of five individuals (29% of the 17 individuals who fit the above criteria) was selected: Individual #226, Individual #333, Individual #458, Individual #265, and Individual #53. Review of the records of these individuals related to the MOSES indicated the examination had been performed quarterly for all five individuals (100%). The evaluations also were reviewed with regard to the elapsed time between when the nurse completed the evaluation and the PCP reviewed it. This analysis indicated that the review by the prescriber had been completed in a timely manner for all five individuals (100%). With regard to the completion of the DISCUS for the individuals in the sample, these evaluations were completed as specified for four of the five individuals (80 %): Individual #333, Individual #458, Individual #265, and Individual #53. Once completed, the prescribing practitioner had reviewed the DISCUS evaluations in a timely manner for all five individuals in the sample (100%). During the Monitoring Team's prior reviews, the subject of the latency between the completion of the MOSES and DISCUS and the date the prescribing physician reviewed and signed them had been discussed with the Psychiatry Department, because there had been considerable deficiencies. ABSSLC had responded to this problem with interventions that have considerably improved the results. The coordination of the timing of the quarterly MOSES/DISCUS evaluations with the Quarterly Psychiatry Reviews appeared to have been a key intervention. During the Psychiatry Clinics observed during the onsite review, the Unit Nurse that performed these evaluations brought the newly completed reviews to the prescribing Psychiatrist for their review, and the results were discussed. During the 8/21/12 Psychiatry Clinic, a member of the Monitoring Team discussed this process with the Nurse who had completed the MOSES and DISCUS evaluations. She indicated that linking of the evaluations to the Quarterly Psychiatry Reviews had been helpful, because she had to prepare other documentation for these reviews, and this served as a prompt to also complete these evaluations. The scheduling of these evaluations, in conjunction with these meetings, also facilitated the timely review with the Psychiatrist at the time of the meeting. During this discussion, the nurse also was asked about the training the nurses received related to the administration of the DISCUS. Her response was that the training was thorough and included an instructional video, as well as a post-test related to that video. Following this meeting, a request was made for documents related to this training, and the Psychiatry Department provided an example	

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		of materials used in these trainings, but did not produce attendance logs, or dates of trainings. In the future, ABSSLC should maintain a log of these activities. The timely review of the MOSES and DISCUS evaluations was also the subject of a detailed internal audit the Clinical Pharmacist conducted. Specifically, this audit entailed the review of every MOSES and DISCUS evaluation performed at ABSSLC from December 2011 through mid-August 2012. The spreadsheet that reported this data provided monthly results and quarterly summaries. The results of the quarterly summaries from March through May of 2012 were as follows: 12/11 through 2/12 293/374 (78%) 3/12 through 5/12 381/512 (74%) 6/12 through 8/12 481/529 (91%) This data was consistent with the results of this review in terms of both the significant improvement and the current status. Because the Facility had expressed confusion as to whether the ten-day requirement referred to ten business days or ten calendar days, which would be complicated by weekends and holidays, the Monitoring Team discussed the definition of what constitutes a "timely review" of the MOSES and DISCUS evaluations by the prescribing physician. The consensus decision was to utilize a standard of 14 calendar days, because this would greatly simplify the process and be flexible enough to allow for weekends and holidays. This was communicated to both the Psychiatry Department and the Clinical Pharmacist. ABSSLC had made significant process in both the completion of the MOSES and DISCUS evaluations on schedule, and the timely review by the prescribing practitioner. The Facility remained out of compliance with this provision. Some problems continued to be noted with the timeliness of the prescribing practitioners' timely review. As both the Monitoring Team's review and the Facility's Clinical Pharmacist internal review indicated the full effect of the positive changes that the Facility has implemented had only been fully realized in recent months. Hopefully, the full effects will be firmly in place at the time of the Monitoring Team's next review.	
N6	Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall ensure the timely	The Facility developed two training programs for recognizing and reporting a potential adverse drug reaction. One training program was part of the orientation training for new staff at ABSSLC, and it was also repeated as part of an annual refresher in-service. The in-service was entitled "Observing and Reporting Clinical Indicators of Health Status	Noncompliance

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	identification, reporting, and follow up remedial action regarding all significant or unexpected adverse drug reactions.	Change." A copy of the PowerPoint was submitted. Training documentation was recorded in a database entitled: "Active Employee Course Participation Report" for "Observing and Reporting Clinical Indicators of Health Status." For the time period of 7/1/11 through 7/9/12, 923 staff attended the training. The other training program was specific to the Nursing Department staff. This was entitled: "Adverse Drug Reaction (ADR)." A training roster included all nurses in the Nursing Department (166 names were listed). Of these, 20 had completed the course during the time period between 6/15/12 and 7/3/12. From the data submitted, this represented 20 out of 166 (12%) of the Nursing Department. On an ongoing basis, when ADRs were reported, they were also discussed at the morning medical meeting, once the Clinical Pharmacist had gathered and analyzed the information. The number of ADR reports submitted for review in the prior six months was six. Five were considered not to be ADRs. One was considered to be an ADR (related to Forteo) and was reported to the FDA. These demonstrated a process was in place and various departments were notifying the Pharmacy of adverse reactions and significant side effects. The Pharmacy then researched the event and made decisions as to whether it was an adverse drug reaction or not. For one, the pharmaceutical company was contacted for further information. The Medication Adverse Reaction Report clearly identified the event as an adverse drug reaction, side effect, etc. Medication Adverse Reaction Reports were submitted, and showed the following numbers: for February 2012 – one, March 2012 – two, and April 2012 – three. Separately, ADR reports were completed and presented to the P&T Committee for review. The time span was different for the quarterly P&T Committee than the six-month time span of the submitted documents, and the numbers therefore varied. Four ADR reports were discussed at the 4/25/12 P&T Committee. The conclusion of the P&T Committee was that all four were not adverse drug reactions, but drug side effects. Four ADR reports were discussed at the 8/22/12 P&T Committee, involving the following medications: Forteo, Chlorpromazine and Olanzapine, varicella virus vaccine, and Keppra. The conclusions of the P&T Committee on the ADRs reviewed were the following: three of four ADR reports were determined to be actual ADRs. Three were reported to the FDA. One was determined not to be an ADR, but a known potential side effect. Since the Monitoring Team's last review, progress had been made in that training had been initiated. However, training of nurses was an important component of this process, and this training had just begun. A process continued to be in place to review potential	

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		ADRs when they were identified. The Facility remained out of compliance with this provision.	
N7	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall ensure the performance of regular drug utilization evaluations in accordance with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	A schedule for Drug Utilization Evaluations for the 2012 calendar year was in place, and continued to be followed. The studies that had been completed at the time of the Monitoring Team's visit included; January 2012 - Reclast and kidney function monitoring/creatinine clearance, and follow up study on Zostavax; April 2012 - Zyprexa monitoring of metabolic effects; July 2012 – Risperdal monitoring of metabolic effects; and for October 2012 – chronic Hepatitis B/C and HIV carriers to determine whether they had the Hepatitis A vaccine. During the prior six months, the following DUE studies were completed and presented to the appropriate clinical staff: ▪ At the 4/25/12 Pharmacy and Therapeutics Committee meeting, an analysis of the DUE on "Reclast and Creatinine Clearance" was reviewed, which had been completed during the first quarter of 2012. Compliance for the 29 active records examined was 100% for all three areas of focus reviewed. The three areas of focus for the DUE involved use of Reclast in individuals with renal impairment or risk of dehydration, which might contribute to renal impairment. Probe questions included whether any individuals with an estimated creatinine clearance of less than 35ml/min received Reclast, whether any of the individuals had a diagnosis of kidney disease, and whether any individual was routinely prescribed a diuretic. It was noted that one individual with a borderline renal function had the Reclast order discontinued based on the calculations used in this study. ▪ At the 8/22/12 Pharmacy and Therapeutics Committee meeting, results of a DUE concerning monitoring of Zyprexa use were reviewed, which had been completed during the second quarter of 2012. Twenty of the 33 individuals currently prescribed Zyprexa were monitored for the following: lipid panel annually, fasting plasma glucose or Hemoglobin A1C quarterly, stability of weight (not greater than 5% gain in one year), DISCUS completed quarterly, and DISCUS reviewed timely. Results indicated that there was compliance with all but the last parameter (i.e., DISCUS reviewed timely). The prescriber reviewed 85% of DISCUS assessments within 10 days of assessment. Because of the lack of compliance with the last parameter, a follow-up DUE for this was scheduled for September 2012. For August 2012, a DUE had begun to evaluate the appropriate monitoring of side effects, with special focus on metabolic side effects, for Risperdal. A sample of 20 of 27 individuals prescribed Risperdal was chosen for participation. Background information and the data collection form were distributed at the 8/22/12 Pharmacy and	Substantial Compliance

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		Therapeutics Committee meeting. The DUE for Reclast did not require any follow-up study to be conducted. The DUE for Zyprexa did require a follow-up study, but given it had just been completed and reported, this was to be scheduled in the future. As noted in the last report, 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 psychiatrists, 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 Pharmacy Department submitted a statement that there were no updated policies, procedures/protocols in the prior six months. However, the 6/27/12 Medication Variance Committee Meeting minutes referenced a pharmacy policy the Facility Administration had approved that focused on the use of promoting metric measurements when ordering and dispensing medication dosages, and prohibiting the use of apothecary measurements. The policy provided guidance for current orders of medications, such as phenobarbital and iron supplements, and replaced the need to reorder, re-write, and correct the exact strengths of medication on the physician orders and medication administration records. Separately, there was also clarification from the State Office when to complete a medication variance report or excess/shortage form for omissions. However, neither of these policies or protocols was submitted, and it was not clear the reason for not acknowledging these updated policies in the requested documents. <u>Pharmacy Review of Categorization of Errors</u> The Pharmacy Department was active in verifying that the Nursing Department's categorization of medication errors was consistent with the Pharmacy's interpretation of the medication error categorization. According to information provided in the Presentation Book for Section N, the Pharmacy Director reviewed a sample of medication errors on a monthly basis to determine accuracy of categorization of error. For proof of this, reference was made to the Medication Variance Committee of 6/31/12. Minutes indicated, under the Pharmacy section, that a "review of medication variances forms was conducted and no discrepancy was determined." This was not consistent with a subsequent review of medication variance forms by the Monitoring Team, in which seven of 10 were not appropriately categorized, according to State Office policy. Additionally, it	Noncompliance

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		would be important to record the number of reports reviewed per month. There was no quantification of data for this area. <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, which the Chief Nurse Executive chaired. The following describes some of the findings of this committee: ▪ Data in the form of graphs was provided for medication variances from September 2011 through May 2012. The following number of medication variances were reported in the prior six months: January 2012 - 147 (52 nursing errors, four prescriber errors, and 91 pharmacy errors); February 2012 – 163 (92 nursing errors, two prescriber errors, and 91 pharmacy errors); March 2012 – 233 (140 nursing errors, two prescriber errors, and 91 pharmacy errors); April 2012 – 182 (82 nursing errors, one prescriber error, and 99 pharmacy errors), and May 2012 - 180 errors (76 nursing errors, no prescriber errors, and 104 pharmacy errors). ▪ The few prescriber medication variances over the six months were related to medications prescribed when there was a history of allergy to the medication or a pharmacologically related medication, or an error in dosing. ▪ The pharmacy tracked internal departmental error rates per technician to assist in determining corrective measures. ▪ Most nursing medication errors were due to administration errors, with small numbers due to documentation or transcribing errors. ▪ No errors were considered serious, but all were between Categories A through E. For nursing, errors were further defined as omissions, wrong route, wrong patient, wrong time, and wrong dosage. For pharmacy technicians, errors were defined as wrong drug, wrong strength, wrong quantity, missing medication, and wrong person/wrong drug. ▪ Across the residential units, there was considerable variability in the number of medication variances reported. Units 1, 2, 3, and 5 reported few to no errors, which might suggest considerable under reporting. It is noted that nursing error underreporting remained a significant challenge. This also led to consistently incomplete information, which would make interpretation of progress in this area difficult to verify. ▪ Minutes of the Medication Variance Committee were submitted for 2/1/12, 2/17/12, 3/28/12, 5/2/12, and 6/27/12. As part of the agenda topics, review of medication station surveys and medication administration observations were presented. For January 2012, there were eight observations (five passed, and three failed). Of the three failures, none were due to medication passes, and	

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		three were due to incomplete check sheets for refrigerator temperatures. At the 3/28/12 meeting, it was agreed that 20% of the medication variances per month were to be sent to the Director of Pharmacy for review to determine agreement in categorization. At the 5/2/12 meeting, it was recommended that the Medical Director provide documentation (signature sheets, etc.) providing evidence that the prescriber medication variances were reviewed with the PCP. The medication station surveys were reviewed. More than 50% had concerns (unlocked lock boxes, auto refill concerns, etc.). April medication station surveys also were noted to have "multiple violations," but the discussion then referenced an attachment that was not submitted with the minutes. Two of five medication observations failed in March 2012. At the 5/2/12 meeting, it was noted that all pharmacy variances were caught before medications were dispensed from the Pharmacy. Multiple techniques reportedly had been implemented to improve the pharmacy technician error rate, although these were not listed or recorded. The Pharmacy directly addressed prescriber variances with the PCPs. The Clinical Pharmacist was reviewing four residences to attempt to reduce the medication loads in those buildings. At the 6/27/12 meeting, a review of a new policy concerning use of metric measurements (versus apothecary measurements) for medication ordering, dispensing, and administration was reviewed. There was clarification of when to complete medication variance reports, based on guidance from the State Office. The Committee recommended a decision tree outlining the process of submitting medication variances, based on this guidance. The committee also identified several barriers to providing accurate data. Specifically, not all overages at the time of the auto-fill were followed by Medication Variance Report completion. This led to skewing of data as not all excesses/shortages were reported at the time of the auto-fill count. Additionally, the small number of medication variances reported when compared to the total doses dispensed indicated "great potential that not all medication variances are being reported properly." There was the need for accurate data and proper submission processes to be followed in a timely manner. Again, there was repeat discussion that 20% of medication variances were to be reviewed by the Pharmacy (as previously discussed at the 3/28/12 meeting) to determine categorization agreement between the Pharmacy and Nursing Departments. As the recommendation occurred a second time, it appeared that the 3/28/12 recommendation was not implemented. There was	

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		also the recommendation that findings should be documented in a formal report. Pharmacy also documented that due to skewed data accurate reports could not be created for corrective action plans other than re-education. No further information was provided concerning the reasons for the skewed data, but it remained problematic that there was no formal documented process internal to the Pharmacy Department to document concerns identified, action steps taken, dates of action steps, follow-up monitoring findings, etc. Given the number of internal pharmacy technician errors, a detailed monthly monitoring report should be forwarded to Facility Administration and the QA Department demonstrating areas of concern, steps taken, and measurement of improvement. Without data and documentation, there was no proof of any internal corrective action plans or steps taken that subsequently improved internal pharmacy performance, the positive impact of any steps taken, or steps attempted that did not improve the medication compliance rate, but which would have provided valuable information to the Pharmacy Director. From observation of the 8/22/12 meeting, there was considerable discussion of the data presented. The following observations and concerns were noted by the Monitoring Team: ▪ Medication variances from the Nursing, Pharmacy, and Medical Departments were reviewed. The analysis of data indicated that the majority of medication variances occurred in the Pharmacy Department. ▪ There was also realization that there was probable significant underreporting in several of the residences by nurses. ▪ Many of the medication variances in the Pharmacy Department were identified internally before the medication carts were distributed, and did not cause a medication error. It is recommended that the Pharmacy track pharmacy errors that leave the pharmacy separately from those that are resolved internal to the department. ▪ For the month of July 2012, seven medication errors were reported to have occurred as a result of Pharmacy as dispensing errors. However, there was no response from Pharmacy as to the review of their findings. ▪ There appeared to be need for increased cooperation to determine accuracy of the auto-fill. Despite the policy to have a nurse check the medication cart on arrival, and complete documentation concerning any discrepancies, the Pharmacy received several forms that were not completed, although the nurse subsequently requested additional medication. It did not appear from the committee discussion that Nursing Administration was aware of this lack of documentation compliance from the Nursing Department. ▪ For prescriber variances, the Medical Director followed up with the PCP and	

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		provided guidance to the PCP. Although the committee indicated that the Medical Director and PCP completed a signature sheet for such dialogues, this information was not provided for verification. ▪ Committee minutes indicated that the category of medication errors from September 2011 forward ranged from Category A to E. ▪ Omissions were the most common error identified, although the definition provided in the committee handout did not appear to provide clarity to the term. ▪ Once the data was presented, there was a brief discussion about next steps. There did not appear to be a clear next step determined by this committee. It did appear that Nursing Administration was going to concentrate on units for which there were a low error rate reported. Since the Monitoring Team's last visit, there did not appear to be any implementation of steps to reduce Nursing or Pharmacy Department errors. There appeared to be no progress made on reducing true errors, implementing systems approaches to reduce true errors, tracking returned medications, or systems to improve reporting of errors to ensure completeness of the data. For nursing, emphasis remained on data collection. Some work had been done to improve the tracking and review mechanisms the Facility used for medication variances, including: ▪ As part of the agenda, the 4/25/12 P&T Committee meeting summarized the activity of the Medication Variance Committee during the prior quarter. A new database had been established and a new, more accurate method of tracking variances had begun. The information would include shift and location of the nursing medication variances. Prescriber variances, pharmacy variances, and nursing variances were to be tracked. Training had occurred. The new method of tracking variances began on 3/1/12. It was anticipated that the number of medication variances would initially increase, reflecting a change in the way variances were to be counted. The goal was for improved accuracy in reporting medication variances, with resulting improved tracking and trending. During this meeting, data reported included medication variances from the prior six months. This listed 533 pharmacy medication variances, 30 prescriber medication variances, and 306 nursing medication variances. However, there was concern that nursing errors continued to be under-reported, making this data incomplete and a continuing challenge. ▪ From the Medication Variance Committee, a sub-committee was created to review ways to improve data reporting and data collection. This committee began to meet on 4/3/12. ▪ Additionally, on 3/13/12, the Clinical Pharmacist chaired a meeting for creation of an Excel database for monitoring the medication variance reports.	

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		Medication Error Reports Copies of the last 10 medication error forms were submitted for review. According to the documentation, there was one Class A medication error, seven Class B medication errors, two Class C medication errors, and no Class D medication errors. However, the forms were not completed using appropriate categorization according to the State Office policy. All seven Class B errors were omissions of medication. These are classified by State Office policy as Class C medication errors. Therefore, there actually were no Class B errors and nine Class C errors. Follow-up of the errors was documented in six of 10 errors. However, for many of these medication error forms, the response was "Monitor for further occurrences." This did not appear to provide adequate guidance or corrective action steps. Further, it was unclear what the Nursing Department's rationale was to wait for another occurrence before providing corrective action. There was no mention of tracking the employee, competency-based evaluation, providing counseling, retraining, etc., for eight of the 10 forms submitted. Counseling was documented for two reports, although it did not give a date or time, or by whom the counseling was provided. Medication Observation Monitoring The Nurse Educator completed medication administration observations that were submitted for 5/14/12 (two passes), 5/15/12 (two passes), and 6/13/12 (two passes). It was noted that two of six were not scored. Issues identified included medications were not stored properly, the lack of notation of crushed medication and/or specialized instructions on the Medication Administration Record (MAR), and the pill crusher was not cleaned per medication administration policy. It was not clear how this data was collected and analyzed for trends and feedback to the nursing staff. It is recommended that Pharmacy document and track efforts/pilot programs originating from the Pharmacy, especially involving medication variances. The role of the Pharmacy was not clear in assisting the Nursing Department in some aspects of medication variance reduction, and it would be helpful for internal tracking as well as for the Facility Administration to have this information readily available in a quarterly format. From observation of the Medication Variance Committee, it was not clear the programs the Pharmacy Department had in place to identify causes of medication variances in the residences, in order to assist in medication variance reduction. There was no adequate process to determine the cause of returned medications. Nursing was still not consistently completing the pharmacy form for medication cart checks on arrival to the residences, but this communication did not occur until the Medication Variance	

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		Committee meeting, rather than when the incomplete forms were discovered. Although certain residences were identified as needing reliable information concerning medication variances (some residences documented there were few to no medication variances suggesting significant underreporting), the Pharmacy Department provided no recommendations related to processes to assist nursing to address this. If additional monitoring (spot MAR and medication cart checks after a medication pass in a residence, for example) occurred or if additional pilot programs occurred in cooperation with nursing, this was not identified. Pharmacy did not appear to provide practical options in determining the many causes of returned medications. Although the Pharmacy Department is not responsible for nursing medication variances, they do play a major role in identifying weaknesses and vulnerabilities in the system and putting into place systems improvements. A quarterly report documenting and summarizing their researching various causes of medication variances, as well as under reporting of medication variances, and systems implementations to address weaknesses would provide evidence that the Pharmacy Department was providing leadership and partnership in this area. The Facility should provide evidence of Pharmacy Department investigations of medication variances, identifying causes, and eradicating issues leading to medication variances, with introduction of systems improvements to reduce medication variances. Additionally, when there is a system improvement such as a new protocol, process, etc., for medication variances, or other aspects of safe pharmacy practices, and it originates from the Pharmacy Department, this should be formalized in writing. The Pharmacy Department appeared to have met and collaborated to resolve problems, and developed resolution, but at times there was no written document to confirm decisions and new processes put into place.	

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

1. For computations completed by the laboratory to ensure appropriate dosage, that the labs should be current, as defined by Pharmacy Department policy. (Section N.1)
2. A more user-friendly database should be developed for tracking dates of QDRR completion. (Section N.2)
3. In reviewing medication variance reports for appropriate categorization, the pharmacy should indicate the number of reports reviewed per month. (Section N.8)
4. For internal Pharmacy medication variances by pharmacy technicians, a monthly monitoring report should be forwarded to Facility Administration and the QA Department demonstrating areas of concern that were identified, steps taken, dates of steps taken, and measurement of progress/improvement (i.e., monitoring data). (Section N.8)
5. The Pharmacy should document and track efforts/pilot programs originating from the pharmacy, especially involving medication variances. The Pharmacy Department should play an aggressive role in identifying causes of returned medications, as well as underreporting of medication variances in residences, and develop/implement system changes to reduce the occurrence of medication variances. These action

steps for researching causes and implementing changes should be summarized in quarterly reports. (Section N.8)

6. Additionally, when there is a system improvement, such as a new protocol, process, etc., for medication variances, or other aspects of safe pharmacy practices, and it originates from the Pharmacy Department, this should be formalized in writing. (Section N.8)
7. For any analysis, a brief description should be provided in bullet form, describing the precise sample, sample population, sample size, and how the sample was derived (random, high risk, etc.). (Facility Self-Assessment)
8. The threshold compliance scores for the Pharmacy Monitoring Tool should be reviewed. (Facility Self-Assessment)
9. The implementation of the Pharmacy Monitoring Tool should be reviewed, with a focus of the appropriate use of its components, in order to provide more applicable information for quality improvement. When all sections of the Pharmacy Monitoring Tool are used to review new order drug alerts, further explanation of the rationale should be included. It is also recommended that the QA Department review appropriate implementation of this tool. (Facility Self-Assessment)
10. Expanding the number of pharmacy auditors to include the other pharmacists would allow verification of findings. Inter-rater reliability would need to be established. (Facility Self-Assessment)
11. As an internal pharmacy monitoring tool, creating a few subcategories with clear criteria might assist the Pharmacy Department and Quality Assurance Department in sampling focused areas of patient intervention. (Facility Self-Assessment)

SECTION O: Minimum Common Elements of Physical and Nutritional Management	
	Steps Taken to Assess Compliance: The following activities occurred to assess compliance: ▪ **Review of Following Documents:** o Presentation Book for Section O; o The following documents for 13 individuals in Sample #1 (i.e., Individual #413, Individual #311, Individual #362, Individual #162, Individual #184, Individual #378, Individual #452, Individual #183, Individual #212, Individual #38, Individual #492, Individual #385, and Individual #468) that included individuals identified with PNM concerns; who received enteral nourishment; and/or had experienced a change of status as evidenced by admission to the Facility Infirmary, emergency room (ER), and/or hospital, including: Occupational Therapy/Physical Therapy (OT/PT) comprehensive assessment, OT/PT assessment of status, OT/PT update in individual record, Nutrition assessments, Aspiration Pneumonia/Enteral Nutrition (APEN) assessment, Speech Language Pathology (SLP) comprehensive assessment, SLP assessment of status, SLP update in individual record, Head of Bed Elevation (HOBE) assessment, annual Individual Support Plan and Individual Support Plan Addendums for past year, Integrated Risk Action form, Interdisciplinary Team Risk Action Plan/ Integrated Care Plan, Integrated Progress Notes for past six months, OT/PT/SLP/Registered Dietician (RD) consultations for past year, Aspiration Trigger Sheets for past six months, Physical Nutritional Management Plan (PNMP) and dining plans with supporting written and pictorial instructions, for individuals hospitalized within this sample the Hospital Liaison Nurse reports across the past six months, therapeutic/pleasure feeding plan, individual-specific monitoring for the past six months, PNMT Post Hospitalization assessment, documentation of staff successfully completing Physical Nutritional Management (PNM) foundational training, documentation of staff successfully completing individual-specific training, supporting documentation to substantiate an individual's progress with PNM difficulties, incident reports and Facility investigations for choking incidents, PNMP Clinic minutes, monthly review of OT/PT direct intervention, quarterly review of OT/PT programs, supporting documentation for implementation of OT/PT direct interventions, and supporting documentation for implementation of OT/PT programs; o The following documents for six individuals in Sample #2 (i.e., Individual #538, Individual #253, Individual #409, Individual #297, Individual #70, and Individual #467) on the active Physical and Nutritional Management Team (PNMT) caseload who were assessed or reviewed in the last six months, and four individuals who had been discharged from the PNMT in the past six months (i.e., Individual #23, Individual #6, Individual #498, and Individual #103): PNMT assessment, PNMT action plan and supporting documentation, HOBE assessment, APEN assessment, annual ISP and ISPAs for past year, IRRF prior to referral to PNMT, IRRF completed by PNMT and IDT upon referral, Integrated Progress Notes for past six months, Aspiration Trigger Sheets for past six months, PNMP and dining

	plans with supporting written and pictorial instructions, the Hospital Liaison Nurse reports for individuals hospitalized within this sample across the past six months, therapeutic/pleasure feeding plan, individual-specific monitoring for the past six months, PNMT Post Hospitalization assessment, Nursing Care Plan/Integrated Care Plan, documentation of staff successfully completing PNM foundational training, documentation of staff successfully completing individual-specific training, supporting documentation to substantiate an individual's progress related to PNM difficulties, and PNMT Discharge and supporting documentation; o List of Physical and Nutritional Management Team members and curriculum vita; o List of all individuals seen by the PNMT and corresponding caseload; o List of all individuals assessed by the PNMT and the date of assessment; o List of all individuals discharged by the PNMT; o Physical Nutritional Management Policy and Procedure; o List of continuing education sessions participated in by PNMT members; o Agenda, curriculum, attendance rosters, and certificates of completion for PNMT staff; o Minutes and documentation of attendance for PNMT meetings; o List of changes in PNMT evaluation form; o Policy and procedures addressing identification of PNM health risk levels, including criteria for establishment of risk levels; o List of individuals with PNM needs; o List of individuals without PNM need; o Wheelchair/Mobility/Assistive Equipment Work Orders; o Completed PNMPs and Dining Plans; o List of tools PNMP Coordinators use to monitor staff compliance; o List of individuals for whom PNM monitoring tools were completed during last quarter; o Tools utilized for validation of staff responsible for PNM monitoring; o Inter-Rater Reliability Scores; o Dining Plan (template) with changes; o PNM and PNMT related database reports, and spreadsheets generated by Facility; o List of individuals on modified/thickened liquids; o List of individuals who require mealtime assistance; o List of individuals who receive nutrition through non-oral methods; o List of individuals whose diets have been downgraded or changed to a modified texture or consistency; o List of individuals with Body Mass Index (BMI) equal to or greater than 30; o List of individuals with BMI equal to or less than 20; o List of individuals who have had an unplanned weight loss of 10% or greater over a six months period; o List of individuals who have had a choking incident during the past six months; o List of individuals who have had an aspiration and/or pneumonia incident during past six months; o List of individuals who have had a fall during the past six months;

	o List of individuals who have had a decubitus/pressure ulcer during the past six months; o List of individuals who have experienced a fracture during the past six months; o List of individuals who have had a fecal impaction during the past six months; o List of individuals who are non-ambulatory or require assisted ambulation; o List of individuals with poor oral hygiene; o List of individuals who received a feeding tube since the last review; o List of individuals who are at risk of receiving a feeding tube; o List of individuals who have received a Modified Barium Swallow Study (MBSS) or other diagnostic swallowing evaluation during the past year; o Schedule of meals by home; o Schedule of all PNM-related meetings occurring during the week of the onsite review; o Curricula on PNM used to train new staff responsible for directly assisting individuals; o Agenda and curriculum for competency-based annual refresher training related to PNM; o Facility Self-Assessment and Provision Action information; o List of completed PNMT Nursing Post Hospitalization Assessment/Evaluations; o The following documents for Individual #409 and Individual #297 on the PNMT caseload were submitted prior to the onsite review: PNMT Minutes, PNMT Assessments, Integrated Risk Rating forms, APEN Assessments, HOBE Assessments, PNMT Action Plans, Staff Competency-based Check-offs, PNMT Monitoring Forms, individual PNMPs, PNMT Nursing Post Hospitalization Assessments, and ISPA meeting documentation related to integration of PNMT assessments and Action Plans; o Quality Assurance/Quality Improvement (QA/QI) meeting minutes related to PNM, PNMT, and the Habilitation Therapy (HT) Department; o Minutes from the HT Department meetings for the past six months; o External PNM consultant reports since last review; o Changes to Physical Nutritional Management Plan templates since last review; o Raw data for Section O monitoring; o QA/QI Quarterly Section Review for Section O for last two quarters; o List of individuals who require positioning assistance associated with swallowing activities; o List of individuals who have difficulty swallowing; o Facility policy or criteria for individuals who require a PNMP; o Facility policy for implementation of PNMPs off-campus; o Number of new staff who successfully completed New Employee Orientation (NEO) PNM foundational performance check-offs (n) over number of staff in new employee orientation over last six months (N); o Number of current staff who have successfully completed PNM performance check-offs (n) over number of current staff (N); o Number of current staff who have completed annual refresher training (n) over number of staff required to complete annual refresher training (N); o Pneumonia Avatar tracking; o Samples of physical nutritional management competency performance check-offs for new

	employee orientation; o Samples of PNM competency performance check-offs for current staff; o Policy for pulled/relief staff; and o Performance check-offs completed for most recent PNMP Coordinator hired. ▪ **Interviews with:** o Bobbie Holden, OTR, Habilitation Therapy Director; o Debbie Sessions, CCC/SLP, dedicated PNMT Coordinator; o Amy Gleaton, Lead OT, PNMT OT; o Tammy Bayer, RN, dedicated PNMT RN; o Tricia Reyes, MS, RD, LD, PNMT RD; o Nicole Spalding, RD, LD, PNMT RD; and o Karen Mayfield, Lead PT, PNMT PT. ▪ **Observations of:** o Infirmary and residences in Infirmary, 6480 and 6521; and o HT Department meeting on 8/20/12.
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section O, dated 8/8/12. In its Self-Assessment, for each sub-section, 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. For Section O, in conducting its self-assessment, the Facility: ▪ Did use monitoring/auditing tools. However, the activities presented in the Self-Assessment did not consistently correlate with the Settlement Agreement Monitoring Tool. The activities reported appeared to relate to the content in Monitoring Team's reports, but it was unclear how some of this data was being collected. Based on a review of the Facility Self-Assessment, the monitoring/audit templates and instructions/guidelines, a sample of completed monitoring/auditing tools, inter-rater reliability data, as well as interviews with staff: o The monitoring/audit tools the Facility used to conduct its self-assessment included: Settlement Agreement Monitoring Tool for Section O. o This monitoring/audit tool did not include adequate indicators to allow the Facility to determine compliance with the Settlement Agreement. The Facility is encouraged to review the Monitoring Team's report to identify indicators that are relevant to making compliance determinations. o The monitoring tools did include adequate methodologies, such as observations, record review and staff interview. For example, the Settlement Agreement Monitoring Tool guidelines instructed the reviewer to review a PNMT assessment, staff training records, complete observation(s) of individual's PNMP being implemented, and conduct staff interviews to ask staff why the individual requires PNMP interventions. o The Self-Assessment identified the sample(s) sizes. However, the Facility had not identified the number of individuals/records reviewed in comparison with the number of individuals/records in the overall population (i.e., n/N for percent sample size). o The monitoring/audit tools did not have adequate instructions/guidelines to ensure consistency in monitoring and the validity of the results.

	○ The following staff/positions were responsible for completing the audit tools: Facility therapists (i.e., OTs, PTs, and SLPs) and a Program Compliance Monitor. ○ The staff responsible for conducting the audits/monitoring had not been deemed competent in the use of the tools. ○ Adequate inter-rater reliability had not been established between the various Facility staff responsible for the completion of the tools. ▪ Did use other relevant data sources and/or key indicators/outcome measures. For example, the Facility had reviewed lists of individuals with PNMPs, had compared these to other lists, and conducted reviews to identify additional individuals that required PNMPs. However, as the Facility refines its self-assessment processes, it should identify and use other relevant sources of information. For example, the Facility should develop include data about competency-based training and performance check-offs for new employees and current staff. ▪ The Facility consistently did not present data in a meaningful/useful way. Specifically, the Facility's Self-Assessment: ○ Did not present findings consistently based on specific, measurable indicators. ○ Did not consistently measure the quality as well as presence of items. ○ Did not distinguish data collected by the QA Department versus the program/discipline. ▪ The Facility rated itself as being in compliance with none of the subsections of Section O. This was consistent with the Monitoring Team's findings. ▪ The Facility data identified areas of need/improvement. However, for these areas of need, the Facility Self-Assessment did not provide an 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.
	Summary of Monitor's Assessment: The core Physical and Nutritional Management Team members included a PNMT Coordinator/Speech Language Pathologist (SLP), Registered Nurse (RN), Physical Therapist (PT), Occupational Therapist (OT), and two Registered Dieticians (RDs). The PNMT Coordinator/SLP and RN were dedicated members. The OT, PT, and two RDs had extensive caseloads beyond their responsibilities for individuals on the active PNMT caseload. The Facility had not completed an analysis to determine appropriate caseloads for PNMT members or other clinicians, based on acuity and other factors. However, the other responsibilities of the PNMT members appeared to impact the functioning of the PNMT. Based on review of attendance records, the PNMT was meeting without the required membership as outlined in the Settlement Agreement. At the time of the review, the Facility had just finalized the PNMT policy. Consequently, the IDTs had not been provided training on the policy. A review of individuals who had been hospitalized since the last review revealed the Facility IDTs were not consistently referring individuals to the PNMT that should have been referred, and/or the PNMT was not consistently initiating an assessment within five working days. A review of PNMT assessments and actions plans identified multiple missing components. In addition, individuals the PNMT discharged did not have adequate discharge plans as multiple components were missing.

	Lists presented by the Facility to identify individuals having physical and nutritional management problems were not accurate (i.e., individuals who require mealtime assistance, individuals at high and medium risk for PNM concerns, individuals who had difficulty swallowing). The HT Director acknowledged there were no Facility policies and/or procedures to maintain, update, and sustain these lists. In addition, the At Risk Coordinator stated she did not yet have confidence in the accuracy of the Facility's individual risk ratings. The Facility was in the process of implementing an individual-specific PNMP revision schedule home by home, which was to be completed by February 2013. In addition, since the last review, the HT Department had developed PNMPs for an additional 73 individuals, which was a positive development. However, a review of the list of individuals without PNMPs and their risk ratings showed that some additional individuals needed a PNMP. In addition, there was no Facility policy that specifically addressed the criteria that would require the development of a PNMP as presented in the State PNM Policy. The State PNM policy stated: "all individuals who require physical nutritional management services will be furnished with a PNMP or mealtime and positioning/dining plan. All individuals who cannot feed themselves, are at risk for choking or aspiration, and who require positioning associated with swallowing will be identified and provided with plans and supports sufficient to meet their needs." The Monitoring Team, HT Director and members of the PNMT team completed direct observations of the implementation of PNMP strategies in the Infirmary and residences for individuals on the PNMT caseload. The HT Director and members of the PNMT had to intervene with staff during every observation to correct staff's approach for wheelchair positioning, alternate positioning, bathing, transfers, and medication administration. These observations revealed that staff was not competent in implementing individuals' PNMPs. However, in reviewing monitoring data for these same individuals, the Facility's monitoring did not identify similar problems. At new employee orientation staff were responsible for completing performance check-offs for physical management. However, there were no performance check-offs to test staff competency for nutritional management/support skills. The Facility had not implemented an effectiveness monitoring system to assess the progress of individuals with PNM difficulties, or provide evidence that interventions were modified if an individual was not making progress. More specifically, individuals' Risk Action Plans did not generate individual-specific clinical data to substantiate an individual's progress or to assess if the individual was better or worse; monthly progress notes were not completed to report on the effectiveness of an individual's supports and services; individuals' PNMPs and aspiration trigger data sheets did not have individual-specific triggers identified, and aspiration pneumonia trigger data sheets were not completed as required on a daily basis. On a positive note, on 5/17/12, the Facility had developed and implemented Mandatory Training regarding Aspiration Pneumonia and Enteral Nutrition. The Facility was in the process of implementing a new APEN process. However, the current Aspiration Pneumonia Enteral Nutrition (APEN) assessments for individuals

	who received enteral nutrition were not following the State and/or Facility-established template and content guidelines; including the participation of recommended disciplines; and/or providing justification that the continued use of the tube was medically necessary or assessing the individual's potential to receive a less restrictive form of enteral nutrition or transition to oral intake, if appropriate.

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O1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide each individual who requires physical or nutritional management services with a Physical and Nutritional Management Plan ("PNMP") of care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan. The PNMP will be reviewed at the individual's annual support plan meeting, and as often as necessary, approved by the IDT, and included as part of the individual's ISP. The PNMP shall be developed based on input from the IDT, home staff, medical and nursing staff, and the physical and nutritional management team. The Facility shall maintain a physical and nutritional management team to address individuals' physical and nutritional management needs. The physical and nutritional management team shall consist of a	As noted above with regard to the documents reviewed section, two samples were selected for the review of Section O. These included: ▪ **Sample #1 (IDT Caseload) -** 13 individuals identified with PNM concerns who received enteral nourishment, and some of whom had experienced a change of status related to PNM difficulties as evidenced by an admission to the Facility Infirmary, emergency room and/or hospital, including: Individual #413, Individual #311, Individual #362, Individual #162, Individual #184, Individual #378, Individual #452, Individual #183, Individual #212, Individual #38, Individual #492, Individual #385, and Individual #468. ▪ **Sample #2 (PNMT Caseload) -** six individuals on the current PNMT caseload who were assessed or reviewed in the last six months, including: Individual #538, Individual #253, Individual #409, Individual #297, Individual #70, and Individual #467. This sample also included four additional individuals who had been discharged from the PNMT in the past six months, including: Individual #23, Individual #6, Individual #498, and Individual #103. 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. 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 through O.7 of the Settlement Agreement. In addition, this provision specifically requires that: "the Facility shall provide each individual who requires physical or nutritional management services with a Physical and Nutritional Management Plan ('PNMP') of care consistent with current, generally accepted professional standards of care… The 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 status of these requirements is discussed with regard to Section O.3.	Noncompliance

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<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>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.</td><td><u>PNMT Membership</u>
The Facility provided a list of core Physical and Nutritional Management Team members, including a PNMT Coordinator/Speech Language Pathologist, Registered Nurse, Physical Therapist, Occupational Therapist, and two Registered Dieticians. The PNMT Coordinator and Registered Nurse were the only dedicated PNMT members.

The following chart provides the caseload of core PNMT members at the time of the review:

<table>
<tr><th>Core PNMT Members</th><th>Current Caseloads</th></tr>
<tr><td>PNMT Coordinator/Speech Language Pathologist</td><td>Dedicated member and supported 11 individuals on the PNMT caseload</td></tr>
<tr><td>Registered Nurse</td><td>Dedicated member and supported 11 individuals on the PNMT caseload</td></tr>
<tr><td>Occupational Therapist</td><td>OT Lead, supported 314 individuals and 11 individuals on the PNMT caseload</td></tr>
<tr><td>Registered Dietician</td><td>Supported one-half of the ABSSLC census of 411 and 11 individuals on the PNMT caseload</td></tr>
<tr><td>Registered Dietician</td><td>Supported one-half of the ABSSLC census of 411 and 11 individuals on the PNMT caseload</td></tr>
<tr><td>Physical Therapist</td><td>PT Lead, supported 128 individuals and 11 individuals on the PNMT caseload</td></tr>
</table>

As noted in the chart above, the OT, PT and RDs had extensive caseloads beyond their responsibilities for individuals on the active PNMT caseload. At the time of the Monitoring Team's review, no analysis of caseloads or staffing needs had been completed. The HT Director should initiate an analysis of the current clinician staffing and the clinicians' caseloads. This analysis should take into account the scope and severity of individuals' needs (e.g., individuals' high and medium PNM risk indicators) as well as the various duties of clinicians to determine if the current staffing as well as the caseload distribution were adequate and appropriate.

<u>Ancillary PNMT Members</u>
With regard to PNM ancillary members, the Facility's draft Physical Nutritional Management Team Supplemental to State Policy Number 012.2 for Physical Nutritional Management stated: "as needed, the PNMT will consult with a medical doctor, practitioner, or physician's assistant." The Facility's current PNMT Medical Liaison reported his resignation to the Monitoring Team during the onsite review.</td><td></td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		Continuing Education The Facility's draft Physical Nutritional Management Team Supplemental to State Policy Number 012.2 for Physical Nutritional Management stated: "at least every two years, core team members will participate in continuing education directed toward evaluation and management of high risk conditions. It is recommended that core team members direct part of their professional continuing education requirements in areas that relate to PNMT responsibilities." As stated in the previous report, the HT Director should re-evaluate the timeline of "at least every two years" for continuing education, which was not adequate for PNMT members. The Facility PNMT policy should also include the Settlement Agreement requirement that: "all members of the team should have specialized training or experience demonstrating competence in working with individuals with complex physical and nutritional management needs." Attendance rosters, course certificates of completion, and agendas were submitted. Based on review of this documentation, five of the six core PNMT members (i.e., PNMT Coordinator/SLP, PT, RN and two RDs) 83%) attended community continuing education courses. The following summarizes the training core PNMT members attended: ▪ On 4/10/12, the PNMT PT attended Wrist and Hand Injuries; ▪ On 5/24/12, the PNMT Coordinator/SLP and one RD attended The Elderly: Nutritional Needs, Challenges, Screening and Solutions; ▪ On 6/4/12, the PNMT RN, PNMT Coordinator/SLP, and one RD attended From Metabolism to Epidemiology: Understanding Dietary Sugars and Health; ▪ On 6/7/12, the PNMT RN, PNMT Coordinator/SLP, and one RD attended Attacking Urinary Tract Infections with Cranberry and Prebiotic Therapy; and ▪ On 7/25/12, the PNMT Coordinator/SLP, PNMT RN, and PNMT RD attended Dysphagia: A Growing Concern in Healthcare. The PNMT OT did not submit any documentation for continuing education courses during the past six months. **PNMT Meeting Minutes** The draft Facility PNMT policy stated PNMT review meetings would occur at a minimum of once a week. PNMT meetings would also occur: ▪ When an individual's risk level changed; ▪ When nutritional/health problems arose; ▪ After a Modified Barium Swallow study or other medical diagnostic tests were performed; ▪ Before final treatment decisions were made; ▪ To perform follow-up activities; and ▪ At any phase in the physical nutritional management process.	

#	Provision	Assessment of Status	Compliance
		Attendance by core PNMT members for 39 meetings conducted during the time frame from 2/22/12 to 7/3/12 was: ▪ PNMT Coordinator/SLP: 100% ▪ RN: 95%; ▪ OT: 74%; ▪ PT: 79%; ▪ RD: 87%; and ▪ RD: 33%. The PNMT meeting minutes reported PNMT members not present were "excused." However, the attendance of some PNMT members (i.e., PT, OT, and RD) was not adequate. For a number of meetings, the PNMT did not have the required membership as outlined in the Settlement Agreement. Attendance by ancillary PNMT members for PNMT meetings conducted during the time frame from 2/22/12 to 7/3/12 was as follows: ▪ The Facility PNMT medical liaison attended two PNMT meetings (5%) (i.e., 5/21/12 and 6/27/12). However, PNMT Follow-up logs reported meetings with the Facility medical liaison to finalize individuals' PNMT assessments. The PNMT should re-evaluate how they document PNMT meetings, for example, to include meetings with the Facility medical liaison. **PNMT Facility Policy** A draft Facility PNMT policy was submitted to the Facility Policy Review Committee on 4/13/12. Based on interview, the HT Director reported the Facility PNMT policy had been approved on 8/15/12. **PNMT Systemic Issues** A review of individuals' PNMT Follow-up Logs and interviews with PNMT members revealed multiple systemic issues, including: ▪ IDTs not making referrals to the PNMT; ▪ IDT referrals to the PNMT not forwarded in a timely manner; ▪ Aspiration trigger sheets not being consistently completed for individuals on the active PNMT caseload; ▪ Individuals admitted to the hospital without PNMT notification; ▪ Recommendations made to physicians without a timely response from physician(s); ▪ Individual Risk Ratings not current and updated; ▪ Environmental issues impacting respiratory health not addressed; ▪ Monthly weights not being recorded; ▪ Formula administration for individuals at greater than the prescribed rate	

#	Provision	Assessment of Status	Compliance
		during observations; and ▪ Recurrent issues with staff non-compliance with PNMP (i.e., positioning, tooth brushing schedule, etc.). The PNMT Follow-up Logs did not indicate how these issues would be resolved. The PNMT should provide documentation on resolution of systemic issues, and report issues to the Facility Administration in a timely fashion to enable resolution of issues. The PNMT should work with Facility Administration to establish formal pathways to present and resolve systemic issues. PNMT meeting minutes should report on identification and resolution of systemic issues.	
O2	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall identify each individual who cannot feed himself or herself, who requires positioning assistance associated with swallowing activities, who has difficulty swallowing, or who is at risk of choking or aspiration (collectively, "individuals having physical or nutritional management problems"), and provide such individuals with physical and nutritional interventions and supports sufficient to meet the individual's needs. The physical and nutritional management team shall assess each individual having physical and nutritional management problems to identify the causes of such problems.	**Facility's Lists of Individuals with PNM Problems** The Facility produced the following lists which identified individuals with PNM concerns: ▪ The Facility's list of individuals requiring mealtime assistance reported 100 individuals (24% of the census) were found to require mealtime assistance. However, 323 individuals were reported as having PNMPs that included dining plan strategies. Consequently, this Facility list was not accurate. ▪ Twenty-nine individuals (7% of the census) were identified at high risk and 209 individuals (51% of census) were identified at medium risk for aspiration as reported by ABSSLC Integrated Risk Ratings, updated 7/9/11. The State recently had revised the criteria for high risk of aspiration to include all individuals who received enteral nutrition. As a result of this change, IDTs will need to revise the risk rating for aspiration for individuals who receive enteral nutrition. ▪ Twenty individuals (5% of the census) were recognized at high risk and 281 (68% of the census) at medium risk for choking. The Facility reported one serious choking incident for Individual #507 that occurred on 8/19/12. This individual had been rated at high risk for choking. ▪ The Facility's list of individuals who had difficulty swallowing, not dated, identified 422 individuals. ▪ The Facility list of individuals who required positioning assistance associated with swallowing, not dated, identified 329 individuals (80% of the current census). At the time of the review, the HT Director acknowledged there were no Facility policies and/or procedure(s) to define the criteria for the development of these lists, and/or a formal process for the maintaining, updating and sustaining the accuracy of these lists. In addition, the At Risk Coordinator indicated the list of individuals' risk ratings was not accurate, because the Facility had not developed a maintainable system to report risk ratings in a timely manner. Consequently as noted above, the multiple lists the Facility presented to identify individuals having physical and nutritional management problems	Noncompliance

#	Provision	Assessment of Status	Compliance
		were not accurate. The Facility should develop a sustainable system to maintain and update these lists to ensure their validity. A basic component of compliance with this provision is the accurate identification of individuals with PNM concerns. Without an accurate list(s), it would be difficult for the Facility to ensure that it provides such individuals with adequate physical and nutritional interventions. **PNMT Referral Process and Initiation of Assessment** The draft Facility PNMT policy indicated the PNMT referral was the first phase of the PNMT process. The IDT was to refer an individual to the PNMT when: ▪ The person had been diagnosed with aspiration pneumonia; ▪ The person's risk level was determined to be in the highest range of one or more categories, and the IDT had not been able to effect a change in the risk level using an IDT action plan. Given that many risk ratings will not change, even with appropriate intervention, the Facility should consider revising this to state that a referral would be made if the IDT had not been able to achieve a stable health status for the individual as opposed to changing a risk level; ▪ The person's health or risk status changed or deteriorated, even though an IDT action plan has been developed and implemented; ▪ The person had continued hospitalizations even though an IDT action plan was in place; and/or ▪ Whenever the IDT was giving consideration to initiation of enteral feeding. These referral criteria were adequate. However, the Facility IDTs and PNMT were not following these referral criteria. A review of individual records revealed that the IDTs had not referred individuals to the PNMT and/or the PNMT had not made a timely self-referral. In addition, the Facility IDTs had not been provided training on the PNMT referral process at the time of the review. The Facility Hospitalization list reported 121 individuals who had been discharged from the hospital since the last review. Fifty-four of the 121 individuals (45%) did not have a discharge diagnosis listed. Consequently, the Monitoring Team was not able to discern how many individuals had been discharged with a PNM-related concern. The Facility should establish a sustainable system to accurately report hospital discharge diagnoses, and to ensure appropriate referrals were made to the PNMT based on these diagnoses (e.g., aspiration pneumonia). Seven individuals (i.e., Individual #184, Individual #378, Individual #452, Individual #212, Individual #38, Individual #492, and Individual #468) in Sample #1 and six individuals (i.e., Individual #538, Individual #253, Individual #409, Individual #297, Individual #70, and Individual #467) in Sample #2 had been hospitalized since the last review. These individuals were reviewed to determine if a referral had been made to the PNMT, if appropriate. Only two of these individuals had hospitalizations related to PNM	

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		concerns. The review of these individuals' records found: ▪ In none of the two records in Sample #1 of individuals who had an Infirmary admission and/or hospitalization indicating a change in status that should have initiated a referral to the PNMT (i.e., Individual #468 and Individual #183) (0%) was evidence found of an IDT referral to the PNMT and/or a PNMT self-referral within five working days of the ISPA meeting. For example: o Individual #468 had been admitted to the hospital twice for respiratory distress (i.e., 3/23/12 and 4/25/12). The purpose of an ISPA meeting, dated 5/18/12, was a PNMT/IDT meeting to discuss treatment for allergy/asthma. It was unclear from the ISPA meeting documentation if Individual #468 had been referred to the PNMT. The meeting minutes did not discuss why PNMT members were in attendance. Individual #468 met several of the criteria for referral to the PNMT. Her IDT had rated her at high risk for choking, aspiration, and respiratory compromise; her health status had deteriorated even though the IDT had an action plan, and she had continued hospitalizations. The records did not show the IDT and/or PNMT had initiated a referral to the PNMT. o Individual #183 was admitted to the Infirmary to rule out aspiration pneumonia. However, no ISPA meeting had been conducted to discuss if he had received a diagnosis of aspiration pneumonia. The Facility PNMT policy stated if there was a diagnosis of aspiration pneumonia, an individual referral to the PNMT was required. Six individuals from Sample #2 were reviewed to determine if the PNMT had initiated an assessment within five working days. ▪ In three of six individual records reviewed in Sample #2 (i.e., Individual #70, Individual #297, Individual 409) (50%), the PNMT self-referral and/or IDT referral met the timeline criteria for the initiation of an assessment (i.e., five working days) established in the draft Facility PNMT policy and State At-Risk Individuals policy. However, these assessments were not completed in a timely manner and action plans were not implemented until the assessment was completed. These delays in the completion of the assessments were problematic for individuals identified at highest risk for PNM concerns. For example: o Individual #409's PNMT assessment was initiated on 4/9/12, but not finalized until 5/22/12; o Individual #297's assessment was initiated on 3/22/12, and finalized on 4/27/12; and o Individual #70's assessment was initiated on 2/13/12, and finalized on 3/22/12. For the remaining individuals, there was no referral date provided to determine if an assessment had been initiated within five working days. Individual #538,	

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		Individual #467 and Individual #253's PNMT assessments did not note a referral date. These examples showed the Facility's IDTs were not consistently referring individuals to the PNMT. Furthermore, the PNMT was not reporting a self-referral date and consistently initiating an assessment within five working days. The Facility draft PNMT policy provided direction to the IDTs for referral and the PNMT for self-referral. These examples highlight the need for a finalized PNMT policy and the provision of training to the IDT and the PNMT on the Facility PNMT policy. **PNMT Assessment** At the time of the review, the active PNMT caseload was 11 individuals. The draft Facility PNMT policy outlined the PNMT's responsibilities for the comprehensive assessment, treatment/training and review phases of the PNM process. The Monitoring Team reviewed the content of PNMT assessments and action plans for six of the 11 individuals on the active PNMT caseload (55%) as defined above with regard to Sample #2 and found: ▪ None of the six individual PNMT assessments reviewed (0%) were adequate to identify the physical and nutritional interventions and supports sufficient to meet the individual's needs. For example: o None of the six individual PNMT assessments reviewed (0%) followed the State and/or Facility-established PNMT assessment template. PNMT assessments reviewed were missing components from the Facility PNMT assessment format. o In none of six individual PNMT assessments reviewed (0%), the assessment identified the cause of the individual's physical and nutritional management problems. PNMT assessments did not provide an adequate analysis to identify the cause of the individual's PNM concerns. o In three of the six individual PNMT assessments reviewed (i.e., Individual #409, Individual #297, and Individual #70) (50%), a PNMT self-referral and/or IDT referral date was noted. o In one of the six individual PNMT assessments reviewed (i.e., Individual #409) (17%), the assessment reviewed and updated the individual's risk rating(s), as appropriate. o In none of six individual PNMT assessments reviewed (0%) was there documentation of adequate PNMT assessment of an individual's PNM-related high and medium risk levels. The assessments outlined information obtained from a record review, but did not provide an adequate assessment of the individual's current status. In addition, the PNMT assessments did not provide an assessment that identified the	

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		comprehensive supports that would be necessary to mitigate the risk indicators. The assessment also did not identify the clinical indicators that would signal a healthy and/or unhealthy status for the individual. o In three of the six individual PNMT assessments reviewed (i.e., Individual #409, Individual #297, and Individual #70) (50%), a HOBE assessment had been completed following the State-established assessment template. However, the HOBE assessment format did not include an assessment of a recommended safe range for dental procedures. A therapist has the clinical expertise to establish a safe elevation range while an individual is positioned. The therapist should work in collaboration with the dentist to achieve the goal of a safe elevation range during dental procedures. o In none of the six individual PNMT assessments reviewed (0%) were individual-specific clinical baseline data established to assist teams in recognizing changes in health status. o In one of the six individuals' PNMT assessments (i.e., Individual #70 (17%), individualized clinical criteria defined when nursing staff should contact the PNMT. Given that multiple components as identified above were not present, PNMT assessments were not adequate. **<u>PNMT Action Plan</u>** The draft Facility PNMT policy stated the PNMT responsibilities during the treatment/training phase would include: ▪ Meeting with the IDT to discuss assessment findings including measurable objectives; ▪ Developing action steps to integrate assessment findings and recommendations into the ISP, including the APEN, Nursing Care/Health Management Plans, Behavior Support Plans, etc.; ▪ Establishing clinical indicators and timelines for reassessment to determine whether the action plan was successful and/or needed to be amended; ▪ Designing and performing and/or directing interventions, supports and monitoring until the risk indicators indicate the individual is at a lower risk status or his/her health is stable; and ▪ Ensuring the PNMT, appropriate staff, and PNMP Coordinators receive and conduct competency-based training on recommendations, expectations and monitoring throughout the process. However, a review of individuals' PNMT action plans did not show that the PNMT adhered to the preceding components of the treatment/training phase and/or that the	

#	Provision	Assessment of Status	Compliance
		action plans included essential components discussed below. The Monitoring Team reviewed the six individuals' PNMT action plans and found: ▪ In none of the six individuals' PNMT action plans reviewed (0%), the plan adequately addressed the individual's identified PNM problems as presented in the PNMT assessment. ▪ In one of the six individuals' PNMT action plans reviewed (i.e., Individual #297) (17%), the HOBE recommendations were integrated into the PNMT action plan. ▪ In none of the six individuals' PNMT action plans reviewed (0%), adequate preventative interventions were included in the plan to minimize the conditions of identified risk indicators. Although there were some preventative measures, they were not adequate to address all of the individuals' needs and/or were not completed. For example, the action plans for individuals who experienced respiratory distress did not provide aggressive interventions to minimize their respiratory concerns. ▪ In none of the six individuals' PNMT action plans reviewed (0%) were there appropriate, functional, and measurable objectives to allow the PNMT to measure the individual's progress and efficacy of the plan. ▪ In none of the six individuals' PNMT action plans reviewed (0%), the plans included the specific clinical indicators to be monitored. For example, action plans did not identify clinical indicators to be monitored by nursing and/or the PNMT members that would indicate the individual's health status was stable and/or the individual was experiencing a change of status. ▪ In six of the six individuals' PNMT action plans reviewed (100%), the frequency of monitoring was included. However, the frequency of monitoring was not adequate. For example, the PNMT nurse was to monitor every two weeks, which not sufficient for individuals at high risk. ▪ In none of the six individuals' PNMT action plans reviewed (0%), the action plan was integrated into the ISP. ▪ For one of the six individuals reviewed (i.e., Individual #409) (17%), a PNMT/IDT meeting had been conducted to discuss the Integrated Risk Rating Form, PNMT assessment, and action plan. ▪ In none of six individuals' documentation reviewed (0%), supporting documentation was present to confirm implementation of PNMT action plan within 14 days of the plan's finalization. Given that multiple components as identified above were not present, individuals' PNMT action plans were not adequate. **<u>PNMT Follow-up and Problem Resolution</u>** A review of PNMT follow-up meetings for individuals on the active caseload of the PNMT in Sample #2 showed:	

#	Provision	Assessment of Status	Compliance
		▪ In none of the six individuals' PNMT action plans reviewed (0%), action plan steps had established timelines. Action plans provided a timeline start date but did not provide a timeframe for completion of action steps. ▪ In none of the six individuals' PNMT action plans reviewed (0%), action plan steps had been completed within established timeframes. It was difficult to discern when action plan steps had been completed. ▪ In none of the six individuals' PNMT action plans reviewed (0%), when risk to the individual was warranted, the PNMT took immediate action. For example, individuals' Aspiration Trigger Data Sheets were not completed and/or individual-specific triggers had not been integrated into the form. These forms were developed and implemented to alert staff to an individual's change in status and subsequently, alert PNMT members. The PNMT should have been aggressive in ensuring staff implemented these forms as well as modifying the forms to reflect individuals' triggers. ▪ In none of the six individual records reviewed (0%), documentation was present for adequate closure of PNMT action plan steps. **Individuals Discharged by the PNMT** The Facility draft PNMT policy noted: "the PNMT would transfer responsibility for implementation of recommendations and supports to the IDT when all issues had been resolved and the individual's health status is stable according to the clinical indicators and ratings." The PNMT would be responsible for developing a Discharge Plan to include: ▪ Outline of needed supports and interventions to be implemented by the IDT to ensure the individual's continued health stability; and ▪ Notification thresholds that would necessitate re-referral to the PNMT for further follow-up. The PNMT would meet with the IDT to review, revise, and approve the Discharge Plan, develop action steps the IDT would complete, and finalize the transfer of responsibilities to the IDT. The PNMT provided a list of individuals, undated, and their current status. Since the last review, the PNMT had discharged five individuals (i.e., Individual #23, Individual #6, Individual #457 [deceased], Individual #498, and Individual #103). An additional three individuals had been discharged, but a discharge date was not provided (i.e., Individual #429, Individual #226, and Individual #100). The Monitoring Team reviewed the records of four of these individuals: Individual #23, Individual #6, Individual #498, and Individual #103. Findings regarding these four individuals were as follows: ▪ In one of the four individuals' records reviewed (i.e., Individual #6) (25%), an ISPA meeting occurred. ▪ In none of the four individuals' records reviewed (0%), the ISPA meeting	

#	Provision	Assessment of Status	Compliance
		provided objective clinical data to justify the discharge. ▪ In none of the four individuals' records reviewed (0%), the PNMT recommendations were integrated into the ISP or an ISPA. ▪ In none of the four individuals' records reviewed (0%), there was adequate criteria for referral back to the PNMT. Discharge plans noted individuals should be referred back to the PNMT for a diagnosis of aspiration pneumonia and/or hospital admission. These referral criteria did not support a proactive approach. Referral criteria to the PNMT should provide individual-specific clinical indicators that would alert staff to a health status change. The Facility should provide additional guidance through the development of procedures to further define the PNMT discharge process to include, at a minimum: status of efficacy of implemented PNMT recommendations, justification for an individual to be discharged from the PNMT through the provision of objective clinical data to document stable or improved health, integration of the PNMT recommendations into the ISP, and individual-specific objective clinical data for referral back to the PNMT.	
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.	**Identification of Individuals Requiring a PNMP** The Facility provided a list that identified individuals with PNMPs, updated 8/7/12. The list noted 321 of 411 (78%) individuals had a PNMP. Since the last review, PNMPs had been developed for an additional 73 individuals. The Facility provided a list entitled Persons Who Do Not Have a PNMP, not dated, which identified 94 of 411 individuals (23%) without a PNMP. The two lists the Facility provided added up to 415 individuals instead of 411. The Monitoring Team did not compare all names to determine the discrepancies. However, a review of some of these 94 individuals' risk rankings (i.e., last updated on 7/9/12) showed that some of these individuals had PNM needs as evidenced by a high and/or medium risk ranking in choking, aspiration, respiratory compromise, weight, gastrointestinal problems, osteoporosis, skin integrity, falls, and/or fractures. However, these individuals did not have a PNMP. In addition, there was no Facility policy that specifically addressed the criteria that would require the development of a PNMP as presented in the State PNM Policy. The State PNM policy stated: "all individuals who require physical nutritional management services will be furnished with a PNMP or mealtime and positioning/dining plan. All individuals who cannot feed themselves, are at risk for choking or aspiration, and who require positioning associated with swallowing will be identified and provided with plans and supports sufficient to meet their needs." The following concerns were noted for individuals who received a high and/or medium PNM risk ranking, but did not have a PNMP: ▪ An individual's high and/or medium risk rating for aspiration indicates the need for a PNMP. Individual #323's IDT ranked her as being at high risk for aspiration, but she did not have a PNMP. ▪ Individuals at high risk for choking have a need for a PNMP. Individual #371	Noncompliance

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and Individual #179 were ranked at high risk for choking and did not have PNMPs.
▪ Individuals at high and/or medium risk for falls had a need for a PNMP. However, individuals were identified as not having PNM needs, but were ranked at high risk for falls (i.e., Individual #126 and Individual #300).
▪ Individuals at high and/or medium risk for skin integrity required a PNMP. However, individuals were identified without a PNMP, but were ranked at medium risk for skin integrity (i.e., Individual #207 and Individual #30).
▪ Individuals at high and/or medium risk for weight indicated the need for a PNMP. However, individuals ranked at high risk for weight did not have a PNMP (i.e., Individual #87, Individual #126, and Individual #319).

It was positive that since the Monitoring Team's last review, the Facility had developed PNMPs for an additional 73 individuals. However, based on the examples above, some individuals who had been identified as not having a PNMP did, in fact, have PNM needs and required a PNMP. As stated in the Monitoring Team's last report, the HT Director should define through policy and/or procedures the PNM criteria for individuals who require a PNMP. The criteria should define the high and/or medium PNM risk indicators that require the development and implementation of a PNMP. The PNM criteria should be utilized to review the list of 94 individuals without a PNMP to determine which of these individuals meet the PNM criteria, and should be provided with an adequate PNMP.

<u>PNMP Format and Content</u>
The HT Department presented a PNMP Rollout Schedule. This process involved updating individuals' PNMPs to reflect the revised PNMP format. In addition, current staff was to complete competency-based training and performance check-offs for core PNM competencies. Individuals residing in Residence 6480 had their PNMPs revised and current staff had received competency-based training. The following chart presents the projected timelines for completion of this process:

<table>
<tr><th>Residences</th><th>Projected Completion Date for PNMP Revision</th></tr>
<tr><td>6972, 6500, and 6521</td><td>By 8/18/12</td></tr>
<tr><td>6510, 5962, and 6400</td><td>By 10/19/12</td></tr>
<tr><td>5971, 5961, 6370, and 6450</td><td>By 12/28/12</td></tr>
<tr><td>6330, 6350, 6360, 6390, 6690, 6690, 6710, 6720, 6730, 6740, 6750, and 6760</td><td>By 2/15/13</td></tr>
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This timeline continued to extend the time for the Facility to ensure the provision and implementation of adequate PNMPs for individuals having physical or nutritional
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		management problems. As discussed with the HT Director during the onsite review, the PNMPs completed in the new format should be audited to ensure the PNMPs contain essential components. An external consultant report, dated, 5/12, noted the development of a PNMP audit tool during the consultant visit. The Facility PNMP audit tool should be reviewed to ensure the essential components discussed in this report with regard to Section O.3 were represented in the Facility PNMP audit tool. If not, these essential components should be incorporated in the audit tool. A review of 13 individuals' PNMPs who received enteral nutrition and/or had experienced a change in status related to PNM concerns (i.e., Individual #413, Individual #311, Individual #362, Individual #162, Individual #184, Individual #378, Individual #452, Individual #183, Individual #212, Individual #38, Individual #492, Individual #385, and Individual #468) in Sample #1 found: ▪ Thirteen of the 13 individuals (100%) had a PNMP. ▪ Thirteen of the 13 individuals' PNMPs (100%) were current within the last 12 months. ▪ None of the 13 individuals' annual ISPs (0%) noted that the appropriate disciplines were present to approve and integrate the PNMP in the ISP. In Section O.1, the Settlement Agreement requires that PNMPs be developed based on input from the IDT, home staff, medical and nursing staff, and the physical and nutritional management team, as appropriate. o Medical staff were present in seven of 13 annual ISP meetings (54%); o Nursing staff were present in 13 of 13 annual ISP meetings (100%); o Registered dietician staff were present in six of 13 annual ISP meetings (46%); o Physical therapists were present in six of 13 annual ISP meetings (46%); o Occupational therapists were present in two of 13 annual ISP meetings (15%); o Speech language pathologists were present in four of 13 meetings (31%); o Psychologists were present in none of 13 annual ISP meetings (0%); o Dental staff were present in three of 13 annual ISP meetings (23%), and o Direct support professionals were present in 13 of 13 meetings (100%). ▪ None of the 13 individuals' PNMPs (0%) were integrated into the ISP (e.g., PNMP strategies integrated into nursing care plans, skill acquisition programs, BSPs). ▪ None of the 13 individuals' PNMPs (0%) noted individual-specific risks and related triggers. ▪ In one of 12 individuals' PNMPs (Individual #212) (8%), adequate positioning instructions were included for wheelchair positioning, including written and pictorial instructions and safe elevation ranges. Individual #184 was	

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		ambulatory. More specifically, the wheelchair positioning instructions did not provide adequate instructions for staff to achieve a safe elevation range. For example, Individual #183's PNMP did not provide instructions for wheelchair positioning with the exception of receiving enteral nutrition. ▪ In nine of 11 individuals' PNMPs (82%), there were adequate alternate positioning instructions, including written and pictorial instructions and safe elevation ranges. Individual #311 and Individual #184 were able to reposition themselves. Individual #362 and Individual #183's PNMPs did not address alternate positions. ▪ In ten of 11 individuals' PNMPs (91%), bedtime positioning options were noted. Individual #311 and Individual #184 were able to re-position themselves in bed. Individual #183's PNMP did not address bedtime positioning. ▪ In 13 of 13 individuals' PNMPs (100%), there were transfer instructions (i.e., mechanical lift, two-person, pivot). ▪ None of the 13 individuals in Sample #1 received medication and/or food orally. ▪ One of 13 individuals' PNMPs (i.e., Individual #183) (8%) noted safe positioning elevation ranges to be utilized during dental appointments. A therapist has the clinical expertise to establish a safe elevation range while an individual is positioned. The therapist should work in collaboration with the dentist to achieve the goal of a safe elevation range during dental procedures. ▪ Two of 13 individuals' PNMPs (i.e., Individual #184 and Individual #385) (15%) stated the time an individual needed to remain upright after eating and/or receiving enteral nutrition. ▪ Thirteen of 13 individuals' PNMPs (100%), medication administration strategies included positioning options with safe elevation ranges. ▪ Thirteen of 13 individuals' PNMPs (100%) included strategies for oral hygiene, including positioning with safe elevation ranges. ▪ One of 13 individuals' PNMPs (i.e., Individual #183) (8%) included the reasons for an individual's prescribed adaptive equipment. ▪ Thirteen of 13 individuals' PNMPs (100%) included bathing/showering positioning instructions to achieve a safe elevation range. ▪ Thirteen of 13 individuals' PNMPs (100%) included adequate personal care instructions, with elevation strategies during checking and changing. ▪ Thirteen of 13 individuals' PNMPs (100%) stated how an individual would communicate with staff. ▪ Thirteen of 13 individuals' PNMPs (100%) included strategies for how staff was to communicate with an individual. A review of six individuals' PNMPs on the PNMT caseload (i.e., Individual #538, Individual #253, Individual #409, Individual #297, Individual #70, and Individual #467) in Sample #2 found:	

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		▪ Six of the six individuals (100%) had a PNMP. ▪ Six of the six individuals' PNMPs (100%) were current within the last 12 months. ▪ None of the six individuals' annual ISPs (0%) noted that the appropriate disciplines were present to approve and integrate the PNMP into the ISP. o Medical staff were present in four of six annual ISP meetings (67%); o Nursing staff were present in six of six annual ISP meetings (100%); o Registered dietician staff were present in three of six annual ISP meetings (50%); o Physical therapists were present in three of six annual ISP meetings (50%); o Occupational therapists were present in none of six annual ISP meetings (0%); o Speech language pathologists were present in three of six meetings (50%); o Psychologists were present in one of six annual ISP meetings (17%); o Dental staff were present in two of six annual ISP meetings (33%) and o Direct support professionals were present in five of six meetings (83%). ▪ None of the six individuals' PNMPs (0%) were integrated into the ISP (e.g., PNMP strategies integrated into nursing care plans, skill acquisition programs, BSPs). ▪ None of six individuals' PNMPs (0%) noted individual-specific risks and related triggers. ▪ In none of six individuals' PNMPs (0%) were there adequate positioning instructions for wheelchair positioning, including written and pictorial instructions and safe elevation ranges. There were not adequate instructions for safe elevation range. ▪ In one of six individuals' PNMPs (i.e., Individual #253) (17%), there were adequate alternate positioning instructions including written and pictorial instructions and safe elevation ranges. There were not adequate instructions for safe elevation range. ▪ In one of five individuals' PNMPs (Individual #253) (20%), bedtime positioning options were noted. Individual #70's PNMP stated she repositioned herself in bed. ▪ In six of six individuals' PNMPs (100%), there were transfer instructions (i.e., mechanical lift, two-person, pivot). ▪ None of the individuals in this sample ate and/or received medication orally. ▪ Two of six individuals' PNMPs (i.e., Individual #538 and Individual #297) (33%) noted safe positioning elevation ranges to be utilized during dental appointments. A therapist has the clinical expertise to establish a safe elevation range while an individual is positioned. The therapist should work in collaboration with the dentist to achieve the goal of a safe elevation range during	

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		dental procedures. ▪ One of six individuals' PNMPs (i.e., Individual #70) (17%) stated the time an individual needed to remain upright after eating and/or receiving enteral nutrition. ▪ In five of six individuals' PNMPs (i.e., Individual #538, Individual #409, Individual #297, Individual #70, and Individual #467) (83%), medication administration strategies included positioning options with safe elevation ranges. ▪ Three of six individuals' PNMPs (i.e., Individual #538, Individual #253, and Individual #297) (50%) included strategies for oral hygiene, including positioning with safe elevation ranges. ▪ Two of six individuals' PNMPs (i.e., Individual #538 and Individual #297) (33%) included the reasons for an individual's prescribed adaptive equipment. ▪ Five of six individuals' PNMPs (i.e., Individual #538, Individual #253, Individual #409, Individual #297, and Individual #70) (83%) included bathing/showering positioning instructions to achieve a safe elevation range. There were not adequate instructions for safe elevation range. ▪ Four of six individuals' PNMPs (i.e., Individual #538, Individual #253, Individual #409, and Individual #297) (67%) included adequate personal care instructions, with elevation strategies during checking and changing. There were not adequate instructions for safe elevation range. ▪ Six of six individuals' PNMPs (100%) included strategies for how staff was to communicate with an individual. ▪ Six of six individuals' PNMPs (100%) stated how an individual would communicate with staff. Areas of noncompliance in PNMP strategies were not significantly different from individuals in Sample #1 or Sample #2. The following concerns were noted: ▪ PNMPs were not adequate as essential components were missing. ▪ HOBE assessments had not been completed to establish safe elevation ranges in wheelchair and alternate positions, bathing/showering, personal care, oral care, dental appointments, or other activities that were likely to provoke swallowing difficulties. Individuals' PNMPs should have HOBE assessment data integrated to provide staff instructions for safe elevation ranges in daily activities. ▪ The absence of clinicians (i.e., OT, PT, SLP, and RD) during the annual ISP meetings negatively impacted the discussion related to the integration of PNMP and dining plans into the ISP, risk assessment, and multiple support plans. These clinicians were the authors of the PNMPs and their contribution was critical to the team understanding the purpose of the individual's PNMP.	

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		Implementation of Individuals' PNMP Off-Campus (i.e., community outing, hospitalization) Seven individuals (i.e., Individual #184, Individual #378, Individual #452, Individual #212, Individual #38, Individual #492, and Individual #468) in Sample #1 and six individuals (i.e., Individual #538, Individual #253, Individual #409, Individual #297, Individual #70, and Individual #467) in Sample #2 had been hospitalized since the last review. A review of Hospital Liaison reports for these individuals noted the following concerns: ▪ Hospital Liaison Reports noted the presence of an individual's PNMP, and at times, included information showing the PNMP strategies were not being implemented as prescribed. However, they did not specifically identify this as a concern, and provide information about what was done to correct the issue. For example, Individual #212's PNMP noted elevation of her head and upper body to 25 to 30 degrees at all times. The Hospital Liaison Report, dated 3/30/12, stated: "[Individual #212] is semi side laying on her R [right side] with HOB [head of bed] elevated to 45 degrees." Individual #468's PNMP prescribed elevation of her head and upper body at 30 to 40 degrees. The Hospital Liaison Report, dated 3/30/12, noted: "[Individual #468] is laying R [right] semi side with Hob elevated 20-30 degrees." There was no notation that her elevation was incorrect and/or her elevation had been corrected. These were examples of individuals' PNMPs not being implemented while off-campus. The implementation of PNMPs in the hospital should be of highest priority. The Facility should develop policy/procedures to address the implementation of PNMPs off-campus. These procedures should address, but not be limited to, community outings, transportation to the emergency room, and monitoring responsibility for staff compliance. **Change in Status Update for Individuals' PNMPs Conducted by the IDT and/or Individuals on the PNMT Caseload** Individuals' revised PNMPs were reviewed to determine if an ISPA meeting had been conducted to address the proposed revisions. For the individuals in Sample #1, eight of the 13 individuals' PNMPs had been revised after their annual ISP meeting (i.e., Individual #362, Individual #184, Individual #452, Individual #183, Individual #492, Individual #385, Individual #468, and Individual #378). ▪ None of the eight individuals (0%) had an ISPA meeting conducted to discuss and approve PNMP revisions. ▪ None of the eight individuals' records (0%) had supporting documentation to show that the individuals' revised PNMPs had been implemented (i.e., IPN notes, individual-specific monitoring).	

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		For the individuals in Sample #2, five of the six individuals' PNMPs (i.e., Individual #538, Individual #253, Individual #409, Individual #70, and Individual #467) had been revised after their annual ISP meeting. ▪ None of the five individuals had an ISPA meeting(s) (0%) to discuss and approve PNMP revisions. ▪ None of the five individuals' records (0%) had supporting documentation to show that the individuals' revised PNMPs had been implemented (i.e., IPN notes, individual-specific monitoring). When revisions occur to a PNMP, an ISPA meeting should be convened to provide IDT members the opportunity to discuss the revisions, make adjustments, if necessary, and agree on the final revisions.	
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.	**Monitoring Team's Observation of Staff Implementation of Individuals' PNMPs** The Monitoring Team, members of the PNMT (i.e., PNMT Coordinator, and Nurse) and HT Director completed direct observations in the Infirmary and residences for four individuals on the PNMT caseload, including: Individual #538, Individual #253, Individual #409, and Individual #467. These observations found: ▪ In none of the three observations of individuals (0%) were staff following the instructions for wheelchair positioning (i.e., Individual #409, Individual #467, and Individual #538). ▪ In none of the two observations of individuals (0%) were staff following the instructions for alternate positioning in bed (i.e., Individual #253 and Individual #467). ▪ In none of two observations of a mechanical lift transfer (0%) were staff following the transfer instructions (i.e., Individual #253). ▪ In none of the observation during bathing was staff providing handling techniques to minimize the risk of skin breakdown or using adequate handling techniques (0%) (i.e., Individual #253). ▪ In none of the one observation of an individual (0%) during medication administration was the nurse following the PNMP instructions (i.e., Individual #467. The PNMP provides the foundation for health and safety. Observations of these four individuals revealed that PNMPs were consistently breached. The HT Director and members of the PNMT had to intervene with staff during every observation to correct staff's approach for wheelchair positioning, alternate positioning, bathing, transfers, and medication administration. These observations substantiated that staff were not competent and/or compliant in implementing foundational and/or individual-specific PNMP strategies. The PNMT and IDT members should provide additional support to staff	Noncompliance

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		to enhance their competency in the implementation of PNMPs, most importantly, for those individuals at highest risk.	
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.	**NEO Orientation** The HT Director, an Occupational Therapist and Physical Therapist(s) provided training for new employees. New employee training for PNM had been increased by two hours for a total of ten hours of instruction. New staff were responsible for completing the following performance check-offs for physical management: stand/pivot transfer, two-person assist from the floor into escorting, rolling and repositioning in bed, two-person manual lift, mechanical lift, bathing trolley, and bathing table safety. The content of the performance check-offs were relevant and appropriate to test staff competencies for physical management/support skills. However, there were no performance check-offs to test staff competency for nutritional management/support skills (i.e., dining plans, adaptive mealtime equipment, mealtime positioning, food textures, fluid consistencies, and mealtime presentation techniques). The Facility should develop performance check-offs for core nutritional management/support skills. Based on information the Facility provided, since the Monitoring Team's last review, 319 new employees received training. A total of 206 new employees completed lifting training, 261 new employees completed Physical Management and Preventing Aspiration, and 258 attended Deaf Awareness. However, the Monitoring Team could not discern how many of these employees had successfully passed performance check-offs. The Facility should provide the total number of new employees who required training (N) and the number of new employees who have successfully completed foundational PNM training and performance check-offs (n) to yield a training compliance percentage. **PNM Core Competencies for Current Staff** A PNMP training form was submitted as the sole core competency performance check-off for current staff. The training form provided 16 areas of competency to be reviewed with staff. However, this form was not adequate to test staff competency for PNM core competencies. For example, indicator number four for wheelchair positioning instructions would require multiple steps to test staff competency related to wheelchair and/or alternate positioning. Current staff should be responsible for successfully completing the physical management performance check-offs that new employees complete. In addition, performance check-offs for core nutritional management/supports skills that still required development and implementation for new employee orientation should be implemented for current staff as well. The Facility reported that 323 current staff had successfully completed the performance check-offs for PNM foundational skills in the past six months. However, this training was not adequate, as noted above. In the future, the Facility should provide the total number	Noncompliance

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		of current staff who required training (N) and the number of current staff who have completed foundational PNM training (n) to yield a percent of training compliance. **Annual Refresher Training** Based on interview, the Facility's annual refresher training addressing lifting was to be expanded. The Facility reported that 432 current employees had completed annual refresher training for lifting. The Facility should consider expanding Annual Refresher training to include testing of core competencies for mealtimes. Again, the Facility should provide the total number of current staff who required annual refresher training (N) and the number of current staff who have completed foundational PNM training (n) to yield a percent of training compliance. **Individual-specific PNMP Training** At the time of the review, there was no formal process for the provision of individual-specific competency-based training for PNMPs, dining plans, and other intervention plans. This was problematic. **Training of Relief/Pulled Staff** The Facility Policy for Ensuring Levels of Supervision and Staff Sufficiency, revised 1/10/12, stated: "float staff will be trained by DSP [Direct Support Professional] II, DSP III, or lead DSPs to ensure they are competent and knowledgeable about the home to which they have been floated." Furthermore: "when float staff arrive on the home, float staff receive an in-service from the Shift Leader on the Information Cards for any individual he/she will be responsible for and the routine for that home." At the time of the onsite review, current staff, with the exception of Residence 6480, had not completed training and performance check-offs in core PNM competencies. Observations completed by the Monitoring Team substantiated that current and/or relief/pulled staff that provided supports to individuals on the PNMT caseload required additional support to implement PNMPs correctly. **Trainer Competencies** PNMP Coordinators had assumed the responsibility of competency-based training and implementation of performance check-offs for current staff. PNMP Coordinators had provided this training to the staff in Residence 6480 after PNMPs had been revised to conform with the new PNMP format. Based on interview, the Facility had not formalized a train-the-trainer process for the PNMP Coordinators. The Facility should develop and implement train-the-trainer competency check-offs for PNMP Coordinators to substantiate their competency as trainers.	
O6	Commencing within six months of the Effective Date hereof and with	**Facility Monitoring of Staff Competency with PNMPs** The primary monitoring form the HT Department staff used was the Compliance	Noncompliance

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	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.	Monitoring form. As reported in the Monitoring Team's previous report, therapists had been using this form. On 4/25/12, PNMP Coordinators and Habilitation Therapy Technicians began using the Compliance Monitoring form. Reportedly, all individuals with a PNMP were monitored two times per month. As stated in previous reports, the HT Department staff 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 by therapists (i.e., content experts) for monitors (i.e., PNMP Coordinators, Habilitation Therapy Technicians) to achieve accurate scoring and a high level of inter-rater agreement; ▪ Identification of PNM risk factors with high and/or medium risk ranking (i.e., aspiration pneumonia, respiratory compromise, choking) which require individual-specific 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. The HT Department staff had developed a monitoring database. It included adequate indicators to provide data to track and trend monitoring data. The HT Director was to be responsible for analyzing monitoring data. The development of a monitoring database was a positive step forward. However, the Facility did not provide a monitoring report from this database. The Monitoring Team reviewed the monitoring results for the four individuals (i.e., Individual #538, Individual #253, Individual #409, and Individual #467) in Sample #2 who the Monitoring Team, the HT Director and members of the PNMT observed. Various Facility staff monitored these individuals' staff while they implemented the PNMPs. However, the Facility monitoring results were not congruent with observations conducted during the onsite review. The Monitoring Team requested individual-specific monitoring results for the past six months. As stated above, each individual with a PNMP	

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		was to be monitored two times per month. Each individual should have been monitored twelve times over a six-month period per the established HT Department frequency. The monitoring results were reviewed and the following concerns were noted: ▪ Individual #467's staff was monitored none of the required 12 times for PNMP compliance during the past six months (0%). No monitoring was conducted for oral care, mealtimes, snack, bathing, lifting/transfers, wheelchair and/or alternate positioning, medication administration, communication, and/or programming. ▪ Individual #538's staff was monitored six of the required 12 times (50%). The monitors were PNMP Coordinators and Habilitation Therapy Technicians. Five of the six monitoring forms were scored at 100% and one was scored at 90%. No compliance monitoring was conducted for medication administration, snack, oral care, bathing, communication, and/or programming. ▪ Individual 409's staff was monitored 18 times, six more than the required 12 times. The monitors were the PNMP Coordinators and Habilitation Therapy Technicians. Thirteen monitoring forms were scored at 100% compliance and five at 90%. No compliance monitoring was conducted for medication administration, oral care, bathing, communication, and/or programming. ▪ Individual #253's staff was monitored one of the required 12 times (8%). A Habilitation Therapy Technician completed the monitoring form. The compliance score was 90%. No compliance monitoring was performed for medication administration, oral care, oral care, bathing, lifting/transfer, communication, and/or programming. The monitoring data for these individuals reflected 90% to 100% staff compliance with PNMPs. The Facility's monitoring results were not in alignment with the Monitoring Team's observations. Consequently, the Monitoring Team did not have confidence in the individual-specific monitoring data presented. These monitoring results would lead the Facility to the conclusion that there were no problems with staff compliance with PNMPs. However, the Monitoring Team, HT Director, and members of the PNMT witnessed multiple breaches in the implementation of individuals' PNMPs for the four individuals observed. These monitoring results would not be useful in identifying problematic trends that needed to be addressed. The Facility should be able to have confidence in monitoring data to allow it to substantiate identified problematic trends, and, as a result, develop corrective action plans to address the trends. In addition, no evidence was presented to confirm inter-rater reliability between monitors. Inter-rater reliability should be established for the monitoring tools to ensure that all auditors/monitors were consistently determining compliance using the same process and criteria.	

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O7	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement a system to monitor the progress of individuals with physical or nutritional management difficulties, and revise interventions as appropriate.	**Effectiveness of Monitoring to Assess the Progress of Individuals with Physical or Nutritional Management Difficulties** The State At-Risk Individuals policy in the Risk Review section indicated: "each discipline or program staff identified as responsible in the plan must review the support plans that address identified risk to assess the effectiveness of the support for which they are responsible. This review must be completed as indicated by an individual's risk severity or status change, in order to assess effectiveness. Documentation of the review will be recorded in the Integrated Progress Notes." To achieve compliance within this provision members of the IDT and/or PNMT should conduct effectiveness monitoring. Effectiveness monitoring should not be confused with compliance monitoring. A compliance monitoring system, as required in Section O.6, provides information on the status of staff compliance with PNMPs. The purpose of effectiveness monitoring is to report on the efficacy of the interventions developed to minimize and/or reduce high and/or medium PNM risk indicators. Effectiveness monitoring should answer the question of whether the individual is better or worse. A review of individuals' Risk Action Plans and IPNs in Sample #1 found: ▪ None of the 13 individuals' records (0%) contained evidence of effectiveness monitoring by therapists to assess the efficacy of risk action plan interventions for individuals with PNM difficulties. ▪ None of the 13 individuals' records (0%) contained evidence that interventions were changed due to a lack of an individual's progress. The following concerns were noted: ▪ IDT members had not conducted effectiveness monitoring to assess the progress of an individual's risk action plan interventions. ▪ Individuals' Risk Action Plans did not generate individual-specific clinical data, which should be used to substantiate an individual progress and to assess if the individual was better or worse. ▪ Individuals' IPNs did not include assessment an individual's clinical indicators to provide an update on health stability and/or instability. ▪ Monthly progress notes were not completed to report on the effectiveness of an individual's supports and services as identified in a risk action plan. **PNMT Monitoring to Assess Individuals' Progress** The draft Facility PNMT policy discussed effectiveness monitoring responsibilities throughout the policy. For example, the policy required: ▪ Identification of monitors and monitoring schedules and re-evaluation of schedules as determined by risk level and outcomes (i.e., Purpose of PNMT); ▪ Monitoring and reassessment of the individual's health status until the	Noncompliance

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		individual was determined to be stable or at lower risk (i.e., Purpose of PNMT); ▪ Observation and reassessment of the individual in a variety of settings to ensure the treatment and supports were appropriate to effect positive change (i.e., Purpose of PNMT); ▪ Performance of monitoring as assigned (i.e., Responsibilities of the PNMT); ▪ Training of monitors in expected responsibilities and outcomes (i.e., Responsibilities of the PNMT); ▪ Performance of monitoring until the risk indicators indicate that the individual is at a lower risk status or his or her health is stable (i.e., Treatment/Training Phase); ▪ Focused monitoring on identified clinical indicators and measurable outcomes as stated in the action plan (i.e., Review Phase); ▪ Identification of monitoring issues during assessment and development/ revision of action plans until all issues have been resolved and the risk has been lowered according to the risk rating (i.e., Review Phase); ▪ Completion of PNMT Monitoring based on Action Plans/Steps and individual risk/health status, including: o Risk/Health Status Monitoring – conducted onsite, including individual observation, review of medical records, trigger sheets, and staff/nursing interview. Results will be documented in IPNs. Based on the Monitoring Team's review of the records for individuals in Sample #2: ▪ None of the six individuals' records (0%) contained evidence that the progress of individuals with PNM difficulties was monitored to assess the efficacy of the risk plan interventions. ▪ None of the six individuals' records (0%) contained evidence that interventions were changed due to a lack of progress. The following concerns were noted: ▪ Individual-specific triggers had not been integrated into Aspiration Trigger Data Sheet(s) to alert staff to a change in status. Aspiration Trigger Data sheets were not consistently completed. ▪ PNMPs did not have individual-specific triggers. ▪ Individuals' PNMT action plans did not consistently specify individual-specific clinical indicators to define an individual's stable and/or unstable health status. Individuals' PNMT Follow-up Log and IPNs consistently stated that the PNMT was conducting monitoring of IPNs, orders, and trigger sheets. However, these monitoring results were not definitive in reporting if the data obtained during an assessment showed the individual's health status was stable and/or unstable. In addition, the monitoring results did not address the efficacy of the recommended interventions to minimize the individual's PNM risks.	

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		▪ Individuals did not receive individual-specific effectiveness monitoring. ▪ IPNs did not include a report on the effectiveness of an individual's supports and services as identified in a risk action plan. The Facility should implement an effectiveness monitoring system to evaluate and report on the progress of individuals' risk action plans supports and services, and revise interventions, as appropriate.	
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.	**Individuals Who Receive Enteral Nourishment** Based on interview with the HT Director, an administrative assistant in the Food Department was responsible for maintaining and updating the list of individuals who received enteral nutrition. However, there was no Facility policy and/or procedure(s) to formalize a system to maintain and update this list. Due to the concerns with the lists noted below, the Facility should develop and implement procedures to maintain and update the list of individuals who receive enteral nutrition. Two lists were submitted that identified individuals who received enteral nutrition: ▪ Enteral Feedings Including Pleasure Eating/Drinking as of 7/3/12 identified 90 individuals who were fed by tube. The list reported the name of the individual, case number, their home, gastrostomy or jejeunostomy tube placement date, type of tube, method of tube feeding, and pleasure eating and drinking. However, there were 92 individuals listed. Two individuals (i.e., Individual #216 and Individual #182) were recognized as eating by mouth. However, these individuals had a feeding tube, but were not included in the final count on the Facility list. ▪ Enteral Feedings Including Pleasure Eating/Drinking as of 8/10/12 acknowledged 92 individuals were fed by tube. Since 7/3/12, two individuals had died (Individual #257 and Individual #457) and two individuals had received a feeding tube (i.e., Individual #538 and Individual #467). As noted above, Individual #216 and Individual #182 were not counted in the preceding Facility list but were counted in this updated list. Consequently, there was a discrepancy in how the Facility calculated the number of individuals who received enteral nutrition. The Facility should maintain an accurate accounting of individuals who receive enteral nutrition. **Individual(s) Who Received a Feeding Tube** The draft Facility PNMT policy stated: "an individual must be referred to the PNMT whenever the IDT 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 nutrition before the IDT proceeds with recommendations of initiation of enteral nutrition."	Noncompliance

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		Since the last review two individuals had received a feeding tube, including: Individual #538 (gastrostomy tube in 7/12) and Individual #467 (gastrostomy tube in 8/12). They were referred to the PNMT. However, these individuals should have been referred by the IDT and/or self-referred by the PNMT in a timelier manner to address their nutritional decline, which resulted in the placement of a feeding tube. The following concerns were noted: ▪ Individual #467's PNMT assessment was initiated on 7/23/12. It indicated a "self-referral [was made] by the PNMT due to IDT consideration of enteral nutrition due to weight loss, severe oral dysphagia and moderate pharyngeal dysphagia per 6/2012 MBS [Modified Swallow Study], and poor oral intake." However, a review of Individual's IPNs showed meal refusals from March forward and up to the placement of her feeding tube on 8/7/12. The IDT should have initiated an assessment when Individual #467 was experiencing consistent meal refusals during mealtimes and continued to lose weight. The Facility PNMT policy should further define nutritional clinical indicators (i.e., meal refusals, low BMI, unplanned weight loss of two or three pounds across consecutive months, etc.), which would alert the IDT to initiate a referral to the PNMT. ▪ Individual #538's PNMT assessment stated: "[Individual #538] has been refusing meals and lost 7 lbs. [pounds] in the past month. Her PCP notified the PNMT that enteral nutrition might need to be considered. PNMT initiated assessment on 6/11/12." The PNMT assessment identified 16 meal refusals in March, an additional 20 in April, 13 in May, and from June 1 through 14, there were eight meal refusals. These meal refusals from month to month should have initiated a referral to the PNMT, because the IDT was not being successful in maintaining her nutritional status. Individual #538's nutritional status continued to decline without timely intervention by the PNMT. Individuals who experience nutritional decline as defined in the Facility PNMT policy should be presented during the Medical Morning meetings and a determination made with regard to referral to the PNMT, if appropriate. The Facility should revise the draft Facility PNMT policy to define the clinical nutritional indicators that place an individual at risk of receiving a feeding tube. When an individual experiences an ongoing nutritional decline, the IDT should refer an individual at risk of receiving a tube to the PNMT prior to placement of a feeding tube and/or after an emergency tube placement. **<u>APEN Data Collection Tools</u>** Since the Monitoring Team's last review, the draft State At-Risk Individuals policy and procedures, dated 5/24/12, presented a revised process for completing an APEN assessment. The Aspiration Pneumonia/Enteral Nutrition (APEN) was identified as a	

#	Provision	Assessment of Status	Compliance
		data collection tool that should be completed at least annually if the individual: ▪ Had aspiration pneumonia during the past year; and/or ▪ Received enteral nutrition or medication. The APEN Data Sheet instructions indicated: "for individuals who receive enteral nutrition, the APEN should be used to help identify potential for return to oral eating and establish medical necessity of continuing enteral nutrition." The analysis and related rationale was to be documented in the individual's Integrated Risk Rating (IRR) form. The purpose of the APEN was to "provide a vehicle for recording the data needed to guide the team in determining appropriate risk assignment." Multiple disciplines were to contribute APEN data. The Nurse Case Manager was responsible for bringing the completed form to the ISP meeting. The IDT would utilize the APEN data for a "comprehensive discussion of enteral nutrition, aspiration and other related risk factors." The IDT was to "formulate plans based on the discussion and analysis to determine the best course of treatment or action for individuals who have had aspiration pneumonia and to assess individuals for possible return to oral eating." However, these revisions had not been formally implemented. The Monitoring Team will review the implementation of the revised APEN process during the next review. As a result, this review reflects review of the old APEN assessment format, because that was what was currently available for review. The Facility list(s) of individuals who received enteral nutrition did not indicate the date of the most current APEN assessment. The Facility list(s) should include the date of the APEN assessment to track if these assessments are completed at least annually for individuals who receive enteral nutrition. The Facility At Risk Coordinator developed and, on 5/17/12, implemented Mandatory *Training regarding Aspiration Pneumonia and Enteral Nutrition*. All QDDPs, RN Case Managers, Nurse Managers, Living Area Direct RNs, Occupational Therapists, Dieticians, Clinical Pharmacists, and Medical Primary Care Providers were required to attend. Speech Language Pathologists and Physical Therapists should have been required to attend this mandatory training. The training presented information on the following: Settlement Agreement requirements, purpose of an APEN, when to initiate an APEN assessment, IDT members responsible for completing an APEN assessment, paperwork documentation before, during and after an IDT meeting, responsibility of IDT to meet for a change of status (i.e., new placement of a feeding tube), requirements of APEN assessment information, and examples of a completed APEN assessment and action plan. The development and provision of this training was a positive development. However, a review of APEN assessments did not substantiate an improvement in these assessments from the last review.	

#	Provision	Assessment of Status	Compliance
		Thirteen individuals in Sample #1, whose IDTs were supporting them, received enteral nourishment, including: Individual #413, Individual #311, Individual #362, Individual #162, Individual #184, Individual #378, Individual #452, Individual #183, Individual #212, Individual #38, Individual #492, Individual #385, and Individual #468. Individuals in this sample that did not have an APEN assessment completed included: Individual #378 and Individual #38. A review of the remaining 11 individuals' APEN assessments (i.e., for these individuals, the new APEN Data Sheet was not in use yet), action plans, and ISPs found: ▪ None of the 11 individuals' APEN assessments (0%) followed the Facility-established template and content guidelines. ▪ Ten of the 11 individuals' APEN assessments (i.e., Individual #413, Individual #311, Individual #362, Individual #162, Individual #184, Individual #452, Individual #183, Individual #212, Individual #492, and Individual #468) (91%) were completed within a 12-month period. ▪ None of the 11 individuals' APEN assessments (0%) indicated that there was input from appropriate IDT members as outlined in the Facility-established APEN assessment format. APEN assessments reviewed did not have a signature sheet and/or required disciplines were not in attendance. ▪ None of the 11 individuals' APEN assessments (0%) provided justification that the continued use of the tube was medically necessary. The assessment, or moving forward, the IRRF or ISP, should provide clinical justification and an analysis of why the tube remains a medical necessity. APEN assessments results addressed the individual's risk for aspiration pneumonia. The assessment did not assess the medical necessity of a tube or assess the individual's potential to receive a less restrictive form of enteral nutrition or transition to oral intake, if appropriate. ▪ None of the 11 individuals' APEN action plans (0%) were integrated in the ISP and/or an ISPA. ▪ None of the 11 individuals' APEN recommendations and action plans (0%) were implemented. ▪ None of the 11 individuals' APEN assessments (0%) recommended the implementation of a plan to return the individual to oral feeding, if appropriate. Six of the individuals in Sample #2, who the PNMT supported, received enteral nourishment, including: Individual #538, Individual #253, Individual #409, Individual #297, Individual #70, and Individual #467. Individual #467 recently had received a gastrostomy tube and an APEN assessment had not been completed. A review of five individuals' APEN assessments (i.e., for these individuals, the new APEN Data Sheet was not in use yet), action plans, and ISPs found: ▪ None of the five individuals' APEN assessments (0%) followed the Facility-established template and content guidelines.	

#	Provision	Assessment of Status	Compliance
		▪ Four of the five individuals' APEN assessments (i.e., Individual #253, Individual #409, Individual #297, and Individual #70) (80%) were completed within a 12-month period. ▪ None of the five individuals' APEN assessments (0%) indicated that there was input from appropriate IDT members as outlined in the Facility-established APEN assessment format. ▪ None of the five individuals' APEN assessments (0%) provided justification that the continued use of the tube was medically necessary. The assessment, or moving forward, the IRRF or ISP, should provide clinical justification and an analysis of why the tube remains a medical necessity. ▪ None of the five individuals' APEN action plans (0%) were integrated in the ISP and/or an ISPA. ▪ None of the five individuals' APEN recommendations and action plans (0%) were implemented. ▪ None of the five individuals' APEN assessments (0%) recommended the implementation of a plan to return the individual to oral feeding, if appropriate. As documented above, there was no discernible difference between the content of APEN assessments and action plans for the individuals in Sample #1 or Sample #2. These assessments and action plans did not meet the requirements of the Settlement Agreement to: "evaluate each individual fed by a tube to ensure that the continued use of the tube is medically necessary" and "where appropriate, the Facility shall implement a plan to return the individual to oral feeding." **Pathway to Return to Oral Intake and/or Receive a Less Restrictive Approach to Enteral Nutrition** The Facility did not have written procedures for returning an individual to a less restrictive approach to receiving enteral nutrition or, if appropriate, a return to oral eating. The Facility list for Enteral Feedings including Pleasure Eating/Drinking as of 7/3/12 identified Individual #184 in Sample #1 as receiving pleasure feedings. None of the individuals in Sample #2 participated in a formal therapeutic/pleasure feeding program. A review of Individual #68's records found: ▪ None of the one individual who had returned to oral intake (0%) had a plan to return to oral feeding. ▪ Because no plan had been developed, its implementation could not be assessed. ▪ None of the one individual who returned to oral intake (0%) had received a mealtime assessment. ▪ Because no plan existed, none of the one individual's plans (0%) identified individual-specific triggers for when the plan should be stopped.	

#	Provision	Assessment of Status	Compliance
		▪ Because no plan existed, none of the one individual's plan (0%) identified monitoring oversight for staff compliance with the plan. ▪ Because no plan existed, none of the one individual's plans (0%) were monitored as outlined in the plan. ▪ Because no plan existed, none of the one individual's plans (0%) were modified, if appropriate. The Facility should establish procedures for IDTs and/or PNMT members to follow for individuals who were recommended to receive a less restrictive method of enteral nutrition and/or return to oral intake.	

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 clinician staffing and the clinicians' caseloads. This analysis should take into account the scope and severity of individuals' needs (e.g., individuals' high and medium PNM risk indicators) as well as the various duties of clinicians to determine if the current staffing as well as the caseload distribution are adequate and appropriate. (Section O.1)
2. With the departure of the current medical liaison, the Facility should identify a medical liaison to provide the PNMT with a resource for medical consultation. (Section O.1)
3. As recommended in the previous report, the HT Director should re-evaluate the timeline of "at least every two years" for continuing education for PNMT members. The Facility PNMT policy should include the Settlement Agreement requirement that: "all members of the team should have specialized training or experience demonstrating competence in working with individuals with complex physical and nutritional management needs." (Section O.1)
4. The HT Director should provide direction to PNMT members to ensure PNMT members attend continuing education courses in specialized areas to enhance their competence in working with individuals with complex physical and nutritional management needs. (Section O.1)
5. The PNMT should re-evaluate how they document PNMT meetings, for example, to include meetings with the Facility medical liaison. (Section O.1)
6. The Facility should provide training to the IDTs on the Facility PNMT policy. (Section O.1)
7. The PNMT should work with Facility Administration to establish formal pathways to present and resolve systemic issues. PNMT meeting minutes should report on identification and resolution of systemic issues. (Section O.1)
8. Lists the Facility maintains to identify individuals having physical and nutritional management problems should be accurate. The Facility should develop and implement a sustainable system to maintain and update these lists to ensure their validity. (Section O.2)
9. The Facility should establish and implement a sustainable system to accurately report hospital discharge diagnoses. (Section O.2)
10. PNMT assessments should be sufficient to identify physical and nutritional interventions and supports to meet the individuals' needs. They should follow the Facility-established PNMT assessment template; provide an adequate analysis to identify the cause of the individual's PNM concerns; include a PNMT self-referral and/or IDT referral date; update the individual's risk rating(s), as appropriate; address HOBE assessment data; establish individual-specific clinical baseline data to assist teams in recognizing changes in health status; and identify individual-specific clinical criteria to alert nursing staff to contact the PNMT. (Section O.2)
11. PNMT action plans should include: the individual's identified PNM problems as presented in the PNMT assessment; integration of HOBE assessment data; preventative interventions to minimize the conditions of identified risk indicators; appropriate, functional, and measurable objectives to allow the PNMT to measure the individual's progress and efficacy of the plan; and specific clinical indicators to be monitored.

(Section O.2)

12. The Facility should provide additional guidance through the development of procedures to further define the PNMT discharge process to include, at a minimum: status of efficacy of implemented PNMT recommendations, justification for an individual to be discharged from the PNMT through the provision of objective clinical data to document stable or improved health, integration of the PNMT recommendations into the ISP, and objective clinical data for referral back to the PNMT. (Section O.2)
13. The HT Department should further define in Facility policy and/or procedure the PNM criteria for individuals who require a PNMP. These criteria should define the PNM high and/or medium risk rankings that should require the development of a PNMP. The PNM criteria should be utilized to review the Facility's list of 94 individuals with "no PNM needs" to determine which of these individuals meet the PNM criteria and should be provided with a PNMP sufficient to meet their needs. (Section O.3)
14. The Facility should develop policy/procedures to address the implementation of PNMPs off-campus. (Section O.3)
15. The Facility should review the PNMP audit tool to ensure the tool includes the essential components of PNMPs reviewed in this report. (Section O.3)
16. When revisions to PNMPs occur, an ISPA meeting should be convened to provide IDT members the opportunity to discuss the revisions, make adjustments, if necessary, and agree on the final revisions. (Section O.3)
17. The PNMT and IDT members should provide additional training and/or support to staff to enhance their competency in the implementation of PNMPs, particularly for those individuals at highest risk. (Section O.4)
18. When providing data on training, the Facility should provide the total number of employees who required training (N) and the number of employees who have completed training (n) to yield a percent of training compliance. (Section O.5)
19. The Facility should provide additional training and/or support to relief/pulled staff to ensure PNMPs are implemented as prescribed. (Section O.5)
20. The Facility should develop and implement train-the-trainer competency check-offs for PNMP Coordinators to substantiate their competency as trainers. (Section O.5)
21. As recommended in previous reports, the HT Department staff 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 by therapists (i.e., content experts) for monitors (i.e., PNMP Coordinators, Habilitation Therapy Technicians) to achieve accurate scoring and a high level of inter-rater agreement;
    c. Identification of PNM risk factors with high and/or medium risk ranking (i.e., aspiration pneumonia, respiratory compromise, choking) which require individual-specific 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 and therapy programs.
22. The Facility should implement an effectiveness monitoring system to evaluate and report on the progress of individuals' risk action plans supports and services, and revise interventions as appropriate. (Section O.7)
23. The Facility should develop a sustainable system to maintain and update an accurate list(s) of individuals who receive enteral nutrition. (Section O.8)

24. The Facility list(s) identifying individuals who receive enteral nutrition should include the date of the APEN assessment to track if these assessments were completed, at least annually. (Section O.8)
25. The Facility should revise the draft Facility PNMT policy to define the clinical nutritional indicators that place an individual at risk of receiving a feeding tube. When an individual experiences an ongoing nutritional decline, the IDT should refer an individual at risk of receiving a tube to the PNMT prior to placement of a feeding tube and/or after an emergency tube placement.
26. The Facility should establish procedures for IDTs and/or PNMT members to follow individuals recommended to receive a less restrictive method of enteral nutrition and/or return to oral intake. (Section O.8)

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 Self-Assessment, Action Plans, and Provision Action Information; o For the following 13 individuals, including individuals identified with PNM concerns, and/or who had experienced a change of status as evidenced by admission to the Facility Infirmary, emergency room, and/or hospital, and/or received direct therapy intervention(s): Individual #19, Individual #528, Individual #394, Individual #197, Individual #293, Individual #18, Individual #493, Individual #215, Individual #159, Individual #67, Individual #150, Individual #16, and Individual #507, the following documents: Occupational Therapy/Physical Therapy comprehensive assessment, assessment of status, update in individual record, Nutrition assessments, Aspiration Pneumonia/Enteral Nutrition assessment, Speech Language Pathology comprehensive assessment, assessment of status, update in individual record, Head of Bed Elevation assessment, annual Individual Support Plan and Individual Support Plan Addendums for past year, Integrated Risk Action form, Interdisciplinary Team Risk Action Plan/ Integrated Care Plan, Integrated Progress Notes for past six months, OT/PT/SLP/RD consultations for past year, Aspiration Trigger Sheets for past six months, Physical Nutritional Management Plan, dining plans with supporting written and pictorial instructions, the Hospital Liaison Nurse reports for individuals hospitalized within this sample across the past six months, therapeutic/pleasure feeding plan, individual-specific monitoring for the past six months, PNMT Post Hospitalization assessment, documentation of staff successfully completing Physical Nutritional Management foundational training, documentation of staff successfully completing individual-specific training, supporting documentation to substantiate an individual's progress with PNM difficulties, incident reports and Facility investigations for choking incidents, PNMP Clinic minutes, monthly review of OT/PT direct intervention, quarterly review of OT/PT programs, supporting documentation for implementation of OT/PT direct interventions, and supporting documentation for implementation of OT/PT programs; o Facility Policies and Procedures related to the provision of OT/PT supports and services implemented since Monitoring Team's last visit; o Organizational chart of Habilitation Therapy Department; o Current OT, Certified Occupational Therapy Assistant (COTA), PT, Physical Therapy Assistant (PTA), and Assistive Technology (AT) staff, corresponding caseloads, and CVs for new hires; o Continuing education completed by OTs and PTs, since Monitoring Team's last onsite visit; o List of individuals who use wheelchair as primary mobility; o List of individuals with transport wheelchairs; o List of individuals with other ambulation assistive devices;

	○ List of individuals with orthotics and/or braces; ○ Physical Nutritional Management Maintenance Log; ○ OT/PT Assessments and Updates (templates) with changes made since Monitoring Team's last review; ○ Completed OT/PT Assessments for newly admitted individuals since Monitoring Team's last review; ○ Tracking Log of completed individual assessments; ○ Wheelchair seating and PNM clinic assessment (templates); ○ Individual-specific mealtime monitoring schedule; ○ Monthly individual-specific PNMP check sheet; ○ Monthly Home Equipment check sheet; ○ Compliance Monitoring form template; ○ PNMP Clinic minutes; ○ Competency-based performance check-off sheets for PNM core competencies and individual-specific PNMPs along with dining plans and other intervention plans; ○ Summary reports and monitoring results related to OT/PT; and ○ List of individuals receiving direct OT and/or PT services and focus of intervention. ▪ **Interviews with**: ○ Bobbie Holden, OTR, Habilitation Therapy Director; ○ Amy Gleaton, Lead OT, PNMT OT; ○ Karen Mayfield, Lead PT, PNMT PT, PT, DPT, ○ Lindsey Tierce, PT, DPT; ○ Luke Palmer, PT, DPT; and ○ Leslie Riggins, BBS, SLPA. ▪ **Observations of**: ○ Infirmary and residences in Infirmary, 6480 and 6521; and ○ HT Department meeting on 8/20/12;
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section P, dated 8/8/12. In its Self-Assessment, for each sub-section, 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. For Section P, in conducting its self-assessment, the Facility: ▪ Did use monitoring/auditing tools. The activities presented in the self-assessment did not consistently correlate with the Settlement Agreement Monitoring Tool. The activities reported appeared to relate to the content in Monitoring Team's reports, but it was unclear how some of this data was being collected. Based on a review of the Facility Self-Assessment, the monitoring/audit templates and instructions/guidelines, a sample of completed monitoring/auditing tools, inter-rater reliability data, as well as interviews with staff: ○ The monitoring/audit tools the Facility used to conduct its self-assessment included: Settlement Agreement Monitoring Tool for Section P.

	○ This monitoring/audit tools did not include adequate indicators to allow the Facility to determine compliance with the Settlement Agreement. The Facility is encouraged to review the Monitoring Team's report to identify indicators that are relevant to making compliance determinations. ○ The monitoring tools did include adequate methodologies, such as observations, record review and staff interview. For example, the monitoring tool guidelines instructed the reviewer to review individual-specific assessments, conduct observations to determine if staff were following PNMP instructions, and interview staff to explain why the individual needs OT/PT interventions. ○ The Self-Assessment did identify the sample(s) sizes. However, the Facility had not identified the number of individuals/records reviewed in comparison with the number of individuals/records in the overall population (i.e., n/N for percent sample size). ○ The monitoring/audit tools did not have adequate instructions/guidelines to ensure consistency in monitoring and the validity of the results. ○ The following staff/positions were responsible for completing the audit tools: Facility therapists (i.e., OTs and PTs), and Program Compliance Monitor. ○ The staff responsible for conducting the audits/monitoring had not been deemed competent in the use of the tools. ○ Adequate inter-rater reliability had not been established between the various Facility staff responsible for the completion of the tools. ▪ Did use other relevant data sources and/or key indicators/outcome measures. For example, the Facility had reviewed staff training rosters. However, additional indicators could be developed, particularly in relation to outcomes for individuals. ▪ The Facility consistently did not present data in a meaningful/useful way. Specifically, the Facility's Self-Assessment: ○ Did not present findings consistently based on specific, measurable indicators. ○ Did not consistently measure the quality as well as presence of items. ○ Did not distinguish data collected by the QA Department versus the program/discipline. ▪ The Facility rated itself as being in compliance with none of the sub-sections of Section P. This was consistent with the Monitoring Team's findings ▪ The Facility data did identify areas of need/improvement. However, for these areas of need, the Facility Self-Assessment did not provide an 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.
	Summary of Monitor's Assessment: Based on acuity, an OT/PT Evaluation Priority List had been developed to create a schedule for the completion of individuals' OT/PT comprehensive assessments. The development of an OT/PT priority assessment list was a positive step forward in prioritizing individuals with OT/PT needs. Based on interview with the Director of Habilitation Services and therapists, this system was also to be utilized in assigning OT and PT caseloads based on acuity. However, at the time of the review, this priority list for assessments had not yet been implemented.

	Based on a review of individuals' OT/PT assessments, they were missing important essential components and, consequently, were not considered adequate OT/PT assessments. However, some of these assessments included some promising practices. OT/PT direct interventions and/or programs were not integrated into individuals' ISPs. In addition, monthly progress notes were not adequate to provide the results of effectiveness review/monitoring of the individual's progress with direct and/or indirect OT/PT supports. Individuals with PNMPs and dining plans were not monitored at the Facility's reported monitoring frequency of two times per month using the Compliance Monitoring form. The monitoring also did not address the status of their identified occupational and physical therapy needs, and the effectiveness of their OT and PT therapy programs. Furthermore, all prescribed adaptive equipment was not assessed for its condition, availability and effectiveness.

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td>P1</td><td>By the later of two years of the Effective Date hereof or 30 days from an individual's admission, the Facility shall conduct occupational and physical therapy screening of each individual residing at the Facility. The Facility shall ensure that individuals identified with 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.</td><td><u>Current Staffing</u>
The Facility had six OT and four PT positions allocated. The Director of Habilitation Services had increased contract hours for two Occupational Therapists, and an additional OT was scheduled to begin employment on September 1, 2012. At the time of the review, the Director of Habilitation Services supervised a contract Occupational Therapy Lead, Physical Therapy Lead, and a Physical Therapist. The OT Lead supervised three contract Occupational Therapists and nine Home Program Technicians. At the time of the review, there was one OT vacancy. The Physical Therapy Lead supervised a full-time Physical Therapist and a Physical Therapy trainee. An additional Physical Therapist supervised 10 PNMP Coordinators. There was one PT vacancy.

Based on the documentation provided, the following chart represents the caseload of the Facility OTs and PTs including current therapy vacancies:

<table>
<tr><th>Occupational Therapists</th><th>Current Caseload</th></tr>
<tr><td>OT #1 (Contract)</td><td>Contracted for 35 hours per week, OT Lead, core PNMT OT, supported 11 individuals on the PNMT active caseload, and supported an additional 314 individuals in Residences 5961 (26 individuals), 5962 (26), 5971 (23), 5972 (24), 6330 (21), 6350 (18), 6360 (20), 6370 (22), 6400 (18), 6450 (22), 6480 (24), 6500 (24), 6510 (24), and 6521 (22)</td></tr>
<tr><td>OT #2 (Contract)</td><td>Contracted for 40 hours per week, supported 107 individuals in Residences 6390 (seven</td></tr>
</table>
</td><td>Noncompliance</td></tr>
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#	Provision	Assessment of Status	Compliance

	individuals), 6690 (15), 671 (14), 6720 (15), 6730 (15), 6740 (14), 6750 (15), and 6760 (12)
OT #3 (Contract)	Contracted for 32 hours per week and primary responsibility was completion of assessments
OT #4 (Contract)	Contracted for 15 hours per week
OT #5	Vacant position at time of review, but will be filled September 1, 2012
OT #6	Vacant position
Physical Therapists	**Current Caseload and Responsibilities**
PT #1	PT Lead, core PNMT member, supported 11 individuals on the PNMT active caseload and supported an additional 128 individuals in Residences 5971 (23 individuals), 5972 (24), 6360 (20), 6370 (22), 6390 (seven), 6400 (18), and 6710 (14)
PT #2	Supported 162 individuals in Residences 5962 (26), 6330 (21), 6350 (18), 6450 (22), 6500 (23), 6521 (22), 6680 (15), and 6720 (15)
PT #3	Supervised 10 PNMP Coordinators and supported 130 individuals in Residences 5961 (26), 6480 (24), 6510 (24), 6730 (15), 6740 (14), 6750 (15), and 6760 (12)
PT #4	Vacant position at time of review

Each of these therapists held a license to practice in the state of Texas.

At the time of the review, the Director of Habilitation Services did not indicate what an adequate caseload for OTs and PTs at Abilene would be. Based on interview, the Director of Habilitation Services was planning to revise the current OT and PT caseloads. In doing so, the Director of Habilitation Services indicated she would take into account acuity as it related to an individual's risk ratings and change of health status, individuals that were supported by the PNMT, and those that had a PNMP. Individuals would be assigned a numerical value that will indicate their level of need. For example, an individual assigned a higher numerical value would require more services and supports from a therapist. This was a good attempt to better distribute the therapists' caseloads. However, the OT/PT caseload restructuring did not have a projected date of completion. The Monitoring Team agrees that the Facility should complete an analysis, including consideration of the various requirements of the job, as well as the acuity of the individuals to determine appropriate OT and PT caseloads.

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		Continuing Education Documentation of continuing education courses the OTs and PTs completed was submitted. Based on documentation submitted, in the past six months, no State-sponsored webinars had occurred. Clinicians attended the following continuing education courses: ▪ On 2/24/12, the Director of Habilitation Services, OT Lead, PT Lead, and two PTs attended Wheelchair Seating and Positioning Strategies; and ▪ On 4/12/12, the Lead PT and two PTs attended Wrist and Hand Injuries. Attendance sheets and continuing education certificates of completion were submitted for these courses. These OTs and PTs attended appropriate continuing education courses. **New Admissions** Since the Monitoring Team's last review, the only individual that had been admitted to ABSSLC was admitted shortly before the Monitoring Team's onsite review. As a result, a 30-day assessment was not yet due. **OT/PT Assessments** Based on acuity, an OT/PT Evaluation Priority List had been developed to create a schedule for the completion of individuals' OT/PT comprehensive assessments. The following criteria were used to assign an individual-specific numerical value: ▪ One point was awarded for having a PNMP; ▪ Ten points for each high PNM risk rating; ▪ One point for each medium PNM risk rating; ▪ Two points for being on the PNMT active case load; ▪ One point for being on the PNMT inactive case load; and ▪ One point for a change of status. The PNM risk ratings utilized were aspiration, choking, falls, fractures, osteoporosis, and skin integrity. The development of an OT/PT priority assessment list was a positive step forward in prioritizing individuals with OT/PT needs. Based on interview with the Director of Habilitation Services and therapists, this system was also to be utilized in assigning OT and PT caseloads based on acuity. However, at the time of the review, this priority list for assessments had not been implemented. The Monitoring Team will review the implementation of the OT/PT priority assessment schedule during the next review. An OT/PT assessment should include the following essential components: ▪ Signature and date by the clinician upon completion of the written report; ▪ Date showing it was completed at least 10 days prior to the annual ISP meeting; ▪ Diagnoses and relevance to functional status; ▪ Individual preferences, strengths, and needs;	

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		▪ Medical history and relevance to functional status; ▪ Health status over the last year; ▪ Medications and potential side effects relevant to functional status; ▪ Documentation of how the individual's risk levels impact his/her performance of functional skills; ▪ Functional description of motor skills and activities of daily living with examples of how these skills are utilized throughout the day; ▪ Evidence of observations by OTs and PTs in the individual's natural environments (e.g., day program, home, work) ▪ Discussion of the current supports and services provided throughout the last year and effectiveness, including monitoring findings; ▪ Discussion of the expansion of the individual's current abilities; ▪ Discussion of the individual's potential to develop new functional skills; ▪ Comparative analysis of health and impact on functional status over the last year; ▪ Comparative analysis of current functional motor and activities of daily living skills with previous assessments; ▪ Identification of need for direct or indirect OT and/or PT services, as appropriate; ▪ Reassessment schedule; ▪ Monitoring schedule; ▪ Recommendations for direct interventions and/or skill acquisition programs as indicated for individuals with identified needs; ▪ A recommendation regarding the individual's appropriateness for community placement; and ▪ Manner in which strategies, interventions, and programs should be utilized throughout the day. Thirteen individuals' OT/PT comprehensive assessments (i.e., Individual #19, Individual #528, Individual #394, Individual #197, Individual #293, Individual #18, Individual #493, Individual #215, Individual #159, Individual #67, Individual #150, Individual #16, and Individual #507) were reviewed to determine if the comprehensive assessment was current. Eight of the thirteen individuals (62%) had a current OT/PT assessment. Those that did not included: ▪ Individual #394 – assessment date of 6/15/05; ▪ Individual #215 – assessment date of 2/3/05; ▪ Individual #507 – assessment date of 6/20/06; ▪ Individual #67 – assessment date of 5/13/03; and ▪ Individual #150 – assessment date of 7/15/03. Consequently, these five individual's OT/PT assessments were not reviewed. The remaining eight individual's OT/PT assessments were reviewed for the presence of the	

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		essential components of an assessment. This review found: ▪ Seven of eight individuals' OT/PT assessments (88%) were signed and dated by the clinician upon completion of the written report. Individual #16 had an annual evaluation addendum, which reported an original evaluation date of 10/25/10. The Monitoring Team requested an OT/PT comprehensive assessment. However, the Facility did not provide the comprehensive OT/PT assessment for Individuals #16; ▪ None of eight individuals' OT/PT assessments (0%) were dated as having been completed at least 10 days prior to the annual ISP; ▪ None of eight individuals' OT/PT assessments included diagnoses and relevance to functional status; ▪ Three of eight individuals' OT/PT assessments (i.e., Individual #197, Individual #18, and Individual #493) (38%) included individual preferences, strengths, and needs; ▪ None of eight individuals' OT/PT assessments (0%) included medical history and relevance to functional status; ▪ Three of seven individuals' OT/PT assessments (i.e., Individual #19, Individual #528, and Individual #293) (43%) addressed health status over the last year. Individual #197 had been newly admitted; ▪ Three of eight individuals' OT/PT assessments (i.e., Individual #293, Individual #18, and Individual #493) (38%) listed medications and discussed the potential side effects relevant to functional status; ▪ Three of eight individuals' OT/PT assessments (i.e., Individual #293, Individual #18, and Individual #493) (38%) provided documentation of how the individuals' risk levels impacted their performance of functional skills; ▪ One of eight individuals' OT/PT assessments (i.e., Individual #197) (13%) included a functional description of motor skills and activities of daily living with examples of how these skills were utilized throughout the day; ▪ None of eight individuals' OT/PT assessments (0%) provided evidence of observations by OTs and PTs in the individuals' natural environments (e.g., day program, home, work); ▪ None of seven individuals' OT/PT assessments (0%) reviewed the current supports and services provided throughout the last year and effectiveness, including monitoring findings. Individual #197 had been newly admitted; ▪ One of eight individuals' OT/PT assessments (i.e., Individual #197) (13%) discussed the expansion of the individual's current abilities; ▪ One of eight individuals' OT/PT assessments (i.e., Individual #197) (13%) presented the individual's potential to develop new functional skills; ▪ One of seven individuals' OT/PT assessments (i.e., Individual #19) (14%) gave a comparative analysis of health and impact on functional status over the last year. Individual #197 had been newly admitted;	

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		▪ None of seven individuals' OT/PT assessments (0%) offered a comparative analysis of current functional motor and activities of daily living skills with previous assessments. Individual #197 had been newly admitted; ▪ Seven of eight individuals' OT/PT assessments identified the need for direct or indirect OT and/or PT services, as appropriate, or justified the rationale for not providing it. Individual #16 did not have a comprehensive assessment; ▪ None of eight individuals' OT/PT assessments (0%) had a reassessment schedule; ▪ None of eight individuals' OT/PT assessments (0%) supplied a monitoring schedule; ▪ Seven of eight individuals' OT/PT assessments (88%) had recommendations for direct interventions and/or skill acquisition programs. As noted, above the Facility did not provide Individual #16's comprehensive assessment; ▪ Four of eight individuals' OT/PT assessments (i.e., Individual #19, Individual #293, Individual #18, and Individual #493) (50%) made a recommendation about the appropriateness for community transition. ▪ None of eight individuals' OT/PT assessments (0%) defined the manner in which strategies, interventions, and programs should be utilized throughout the day. Although some of these assessments included some promising practices, these eight individuals' OT/PT assessments were missing essential components and, consequently, were not adequate comprehensive OT/PT assessments. The Facility should review the revised OT/PT assessment template and content guidelines to ensure these essential components are addressed. The OTs and PTs should consider each of these elements as they complete assessments to ensure assessments are comprehensive as required by the Settlement Agreement. The Facility had developed a Habilitation Therapy audit tool. However, at the time of the review, no assessments had been audited. The audit tool should be reviewed to ensure the essential components of assessments discussed in this section are present in the audit tool.	
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	**Integration of OT/PT Direct Intervention(s) and Indirect OT/PT Program(s) in the ISP** The primary OT/PT intervention provided to individuals was the Physical Nutritional Management Plan. PNMP content and format are discussed with regard to Section O.3 and staff compliance with PNMPs is reviewed with regard to Section O.5. Thirteen individuals in the sample were reported to receive direct and/or indirect PT interventions. Three of the 13 individuals were provided direct OT and/or PT programs	Noncompliance

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	days of the plan's creation, or sooner as required by the individual's health or safety. As indicated by the individual's needs, the plans shall include: individualized interventions aimed at minimizing regression and enhancing movement and mobility, range of motion, and independent movement; objective, measurable outcomes; positioning devices and/or other adaptive equipment; and, for individuals who have regressed, interventions to minimize further regression.	(i.e., Individual #528. Individual #18 and Individual #150). Ten of the 13 individuals received indirect OT/PT interventions (i.e., Individual #19, Individual #394, Individual #197, Individual #293, Individual #493, Individual #215, Individual #159, Individual #67, Individual #16, and Individual #507). A review of these 13 individuals' records found: ▪ For three of the 13 ISPs reviewed (i.e., Individual #19, Individual #528, and Individual #394) (23%), a PT attended the annual meeting. ▪ For none of the 13 ISPs reviewed (0%), an OT attended the annual meeting. ▪ In none of the 13 ISPs reviewed (0%), the OT/PT intervention and/or plan was integrated in the ISP. ▪ In none of the 13 ISPs reviewed (0%) were skill acquisition programs recommended to promote skills learned in direct therapy intervention and/or plans. ▪ In none of the 13 ISPs reviewed (0%) were skills learned in therapy integrated into the individual's daily routine. The following concerns were noted: ▪ Individual #16's IDT ranked her at medium risk for aspiration, choking, and respiratory compromise. A physician consultation, dated 4/17/12, requested: "please evaluate if head of bed can be elevated to optimize respirations." The PT reported: "it is recommended that orders be written to elevate the head of bed. The bed at this time has been elevated to 5° [degrees] by placing blocks under the legs at the head of the bed." However, Individual #16 had a dining plan, but did not have a PNMP. Individual #16's dining plan provided staff instructions for tooth brushing. Individual #16 should have had a PNMP to provide staff with strategies to minimize her risk factors. Furthermore, an HOBE assessment should have been completed to assess safe elevation ranges for mealtime, bedtime, tooth brushing and bathing. ▪ Individual #159 did not have a PNMP, but did have a dining plan. However, on 4/30/12, Individual #159 sustained a serious fracture. The most current Integrated Risk Rating form was dated 3/13/12, and her risk rating for fractures was low. The IDT should have re-assessed Individual #159's risk rating as a result of her fracture (i.e., change in status). Her recent fracture would have changed her risk rating to high. In addition, Individual #159 should have had a PNMP to provide staff strategies to minimize her risk of fractures during her daily routines. For adequate integration of OT/PT direct interventions and/or indirect therapy programs, the individuals' ISPs should include: attendance by an OT and/or PT unless the team provides adequate justification for their not attending; identification of the direct intervention and/or OT/PT program; as appropriate, skill acquisition programs	

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		to promote reinforcement of new skills learned; and as appropriate, integration of skills learned from the direct interventions and/or OT/PT programs into the individual's daily routine. **<u>Direct OT/PT Interventions</u>** The direct OT and/or PT intervention plans for three individual (i.e., Individual #528, Individual #18, and Individual #150) were reviewed. Individual #150 did not have an intervention plan for her OT sensory program. The PT intervention plans for Individual #528 and Individual #18 did not provide measureable objectives to assess effectiveness of the intervention(s). Comprehensive progress notes related to OT and/or PT interventions should include: ▪ Information regarding whether the individual showed progress with the stated goal; ▪ Description of the benefit of the goal to the individual; ▪ A report on the consistency of implementation; and ▪ Recommendations/revisions to the OT/PT intervention plan as indicated related to the individual's progress or lack of progress. For none of these three individuals (0%) was documentation of OT and PTs' reviews comprehensive. The progress notes did not incorporate the essential components outlined above. **<u>Indirect OT/PT Programs</u>** At the time of the review, the primary indirect OT/PT support was the PNMP. For individuals who received indirect OT and/or PT programs (i.e., PNMPs), monthly documentation from the OT and PT should include: ▪ Information regarding whether the individual showed progress with the stated goal(s); ▪ A description of the benefit of device and/or goal(s); ▪ Identification of the consistency of implementation; and ▪ Recommendations/revisions to the direct intervention and/or program as indicated in reference to the individual's progress or lack of progress. For none of these 13 individuals in the Sample who received indirect OT and PT supports (0%) was documentation of OT and PTs' review comprehensive. There were no progress notes. However, such notes should have incorporated the essential components outlined above. The completion of monthly progress notes should provide effectiveness review/monitoring of the individual's progress with direct and/or indirect OT and PT	

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		supports.	
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.	**Competency-Based Training** The status of the Facility's compliance with competency-based training and monitoring for continued staff competency and compliance of direct support professionals was addressed with regard to Sections O.5, and O.6. No evidence of individual-specific competency-based performance check-offs for the implementation of indirect OT or PT programs was provided.	Noncompliance
P4	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall develop and implement a system to monitor and address: the status of individuals with identified occupational and physical therapy needs; the condition, availability, and effectiveness of physical supports and adaptive equipment; the 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.	**Monitoring System** The DADS Occupational/Physical Therapy Services Policy #014 stated: "the State Center shall implement a system to monitor and address: ▪ The status of individuals with identified occupational and physical therapy needs; ▪ The condition, availability and appropriateness of physical supports and assistive equipment; ▪ The effectiveness of treatment interventions that address the occupational therapy, physical therapy, and physical and nutritional management needs of each individual; and ▪ The implementation of programs carried out by direct support staff." However, as acknowledged by the Facility's self-assessment findings and the Monitoring Team's findings presented with regard to Sections O.6 and O.7 and within this section, the Facility's current monitoring systems did not adequately address these policy components. Ten of the individuals within this sample had PNMPs. Three of the individuals had dining plans (i.e., Individual #197, Individual #159 and Individual #16). Individual #197 had a dining plan, but did not have any prescribed adaptive equipment. A review was conducted of the individuals' Compliance Monitoring and PNMP Clinic forms, resulting in the following findings: ▪ None of the 13 individuals (0%) were monitored using the Compliance Monitoring form at the Facility established frequency of two times per month. ▪ None of all of the twelve individuals' prescribed adaptive equipment (0%) was assessed by therapists for condition, availability, and effectiveness during the PNMP Clinic. A PNMP Clinic had been conducted for four individuals (i.e., Individual #19, Individual #528, Individual #18, and Individual #67). However, the clinic did not report on the effectiveness of the equipment. In addition, mealtime adaptive equipment was not reviewed. This finding was based on the	Noncompliance

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		fact that not all equipment was reviewed and the equipment's effectiveness was not reviewed. ▪ None of these thirteen individuals (0%) were monitored for the status of their identified occupational and physical therapy needs. ▪ None of the 13 individuals (0%) were monitored for the effectiveness of their therapy OT/PT programs. 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 format did not identify medium and high risk indicators that might impact therapeutic interventions and/or the risk indicator rating was not current; ▪ The PNMP Clinic forms 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 condition, availability, 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. As stated in the Monitoring Team's last report, the PNMP Clinic should incorporate an interdisciplinary assessment of the 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. At the time of the review and stated in the previous report, no standard wheelchair cleaning and maintenance protocol was in place. Home staff should clean wheelchairs, and Assistive Technology 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.	

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		As stated in the Monitoring Team's last report, 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.	

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

1. The Facility should complete an analysis, including consideration of the various requirements of the job, as well as the acuity of the individuals to determine appropriate OT and PT caseloads. (Section P.1)
2. The Facility should review the revised OT/PT assessment template and content guidelines to ensure essential elements are addressed. The OTs and PTs should consider each of these elements as they complete assessments to ensure assessments are comprehensive as required by the Settlement Agreement. In addition, the OT/PT assessment audit form should include these elements. (Section P.1)
3. For adequate integration of OT/PT direct interventions and/or indirect therapy programs, the individuals' ISPs should include: attendance by an OT and/or PT; identification of the direct intervention and/or OT/PT program; as appropriate, skill acquisition programs to promote reinforcement of new skills learned; and as appropriate, integration of skills learned from the direct interventions and/or OT/PT programs into the individual's daily routine. (Section P.3)
4. The Facility should ensure comprehensive progress notes related to OT/PT direct interventions and indirect programs include:
    a. Information regarding whether the individual showed progress with the stated goal;
    b. A description of the benefit of the goal to the individual;
    c. A report on the consistency of implementation; and
    d. Recommendations/revisions to the direct intervention or OT/PT program as indicated related to the individual's progress or lack of progress. (Section P.3)
5. 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)
6. 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)
7. 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)
8. 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)

9. Individuals who receive OT/PT direct interventions and/or programs should be monitored for the following:
    a. The condition, availability and effectiveness of their prescribed adaptive equipment;
    b. The status of their identified occupational and physical therapy needs; and
    c. The effectiveness of their OT and PT therapy programs. (Section P.4)

SECTION Q: Dental Services	
	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 dental care; o For the past six months, minutes from the statewide Dental 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, including name, date of extraction, and number of teeth extracted; ▪ Have been seen for dental emergencies (e.g., abscess tooth, complications, etc.), including name, date of emergency visit and reason, whether individual complained of pain (yes or no), dentist documents confirmed pain (yes or no), and treatment documented. ▪ Have had preventative dental care; ▪ Have had restorative dental care including name, date of completed restorative work, and for each appointment completed, type of restorative work; and ▪ Were due for annual dental exams, whether they have had exams, and whether the dentist was able to complete those exams, including name, and date of completed annual exam; 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, for: Individual #81, Individual #119, Individual #440, Individual #207, Individual #151, Individual #105, Individual #373, Individual #437, Individual #156, Individual #232, Individual #49, Individual #153, Individual #18, Individual #157, Individual #273, Individual #397, Individual #141, Individual #383, Individual #148, Individual #245, and Individual #324; o In response to request for five most recent offsite oral surgery consults and progress notes in the past six months, two consults for: Individual #137, dated 2/16/12; and Individual #119, dated 2/7/12; 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 (e.g., 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/recommendations, including date of last full mouth x-rays; o List of those who were edentulous at time of the last onsite 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 (e.g., 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, including 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 for the last six months, including any ISPAs that documented discussion/action plans concerning dental refusals; o For five most recent emergency exams, integrated progress notes from start of emergency to closure, and copy of Dental Department evaluation and treatment for following individuals: Individual #267, Individual #488, Individual #545, Individual #140, and Individual #238; o Appointment schedule for those undergoing general anesthesia/conscious sedation, including individuals for whom general anesthesia was scheduled but the appointment was not completed, and the reason; 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.: Individual #422, Individual #276, Individual #505, Individual #507, Individual #241, and Individual #384; o For the past six months, correspondence concerning restraint and sedation use of office visit (to QDDP, team, psychologist, etc.); o Complete dental records for prior three years at ABSSLC, including progress notes (prophylactic, annual, emergency, restorative, etc./forms) completed, x-ray consult reports, restraint checklist, oral surgeon consults, etc., for one individual most recently seen from each residential unit for: Individual #23, Individual #19, Individual #393, Individual #362, Individual #300, Individual #269, Individual #77, Individual #81, Individual #426, Individual #355, Individual #107, Individual #467, Individual #56, Individual #17, Individual #497, Individual #166, Individual #287, Individual #397, Individual #1, Individual #508, Individual #133, and Individual #498; o For 10 individuals given dental pre-treatment sedation, 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 #242, Individual #455, Individual #276, Individual #505, Individual #198, Individual #63, Individual #527, Individual #510, Individual #69, and Individual #304; o Current list of HRC-approved dental medical restraints with sedation, including type of sedation, such as by mouth (PO) sedation, IV, or general anesthesia; o 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: Individual #267, Individual #530, Individual #48, Individual #462, and Individual #133; o For those completing annual exams in past six months, oral hygiene rating in each exam listed per individual and date of exam; o List of those who receive suction tooth-brushing treatment; o List of those who have been identified as benefiting from suction tooth-brushing treatment, but who are not receiving suction tooth-brushing at time of the Monitoring Team's visit (waiting for equipment, training, care plan revision, etc.); o Copy of 10 annual dental assessments completed in last 30 days and for the prior year of these same individuals for: Individual #479, Individual #158, Individual #472, Individual #466, Individual #368, Individual #360, Individual #270, Individual #154, Individual #312, and Individual #170; o List of dental record annual examinations/assessments and treatment plan record completed in last six months, and the date of previous dental record annual examination/assessment and treatment plan record for all individuals, including copies of these annual exams with odontogram; o Copy of 10 most recent annual dental summaries provided for the ISP; o The most recent/current Facility oral hygiene data (#s and % good, fair, poor ratings); o For those individuals for which care plans/ISP indicate they brush their own teeth, the most recent two oral hygiene scores, with dates of the scores; o List of those individuals that floss their own teeth; o List of individuals provided instructions on flossing with dates of training; o For those that are edentulous, list of those with dentures; o For those edentulous without dentures, list reasons with documentation as indicated; o Summary information on desensitization plans since the Monitoring Team's last visit;

	○ For those undergoing total intravenous anesthesia (TIVA), any incident of injury in 24 hour following TIVA administration in prior six months; ○ For those with documented pneumonia, for each individual, a list including the date pneumonia documented, date of last dental visit, type of procedure/visit completed, and type of anesthesia (TIVA, oral, local, none, etc.) in past six months; ○ Presentation Book for Section Q; ○ Oral hygiene level past six months for those with teeth; ○ Oral hygiene level for all for all of 2011 for those with teeth; and ○ Oral hygiene level for first six months of 2011 for those with teeth. ▪ **Interviews with**: ○ Jerry Griffin, DDS, Dental Director; and ○ Pamela Acevedo, Dental Hygienist.
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section Q, dated 8/8/12. In its Self-Assessment, for each sub-section, 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. For Section Q, the Facility completed the Texas Health Monitoring Instrument: Dental Services, but it was not mentioned in the Self-Assessment section. It was the only formal auditing tool the Facility used for dental services. This auditing tool included a number of indicators to allow the Facility to determine compliance with the Settlement Agreement. However, it was not comprehensive and the Facility utilized other databases to augment the self-assessment process. Inter-rater reliability had not been established, although there were a series of meetings to discuss how to score the tool. During the prior quarter, there was improvement in agreement between the QA Department and the Dental Department. The Dental Department reviewed a number of databases. Examples included the annual exam report, clinical summary of preventative procedures, emergency logs, employee training databank of oral hygiene training for direct support professionals, attendance tracking of refusals and no shows, desensitization priority list, and desensitization tracking worksheet. For Section Q.1, the Facility reviewed 11 different data sets. The number and percent compliance was provided for each of these 11 datasets. For Section Q.2, the Facility reviewed seven data sets. The number and percent compliance was provided for each of these seven datasets. The Facility consistently presented data in a meaningful way. Specifically, the Facility's Self-Assessment presented findings based on specific measurable indicators. From the brief entries, the Facility consistently included a measure of quality with the review. The facility rated itself as not being in compliance with Section Q. This was consistent with the Monitoring Team's findings.
	Summary of Monitor's Assessment: The Dental Department had developed a number of databases that appeared to be complete and accurate. The Dental Department used these to ensure compliance with the Settlement Agreement, but also as their own internal monitoring measurements to ensure the provision of quality dental care. Annual assessments were timely, emergency dental logs demonstrated prompt care,

	and for any outstanding issues, there was a monthly review to ensure closure of all cases. The annual assessments appeared to be complete except for documentation of tooth brushing instruction and recommendations for community living. A review of dental records indicated a lack of a periodontal chart in those with teeth. Many odontograms remained incomplete, but some progress had been made in this area. The level of risk did not appear to be part of most dental records. Oral hygiene appeared to continue to improve. It was noted that a high percentage (41%) of the population was edentulous. A total of 37% of the population used suction tooth brushing. Oral sedation was used at a very low rate, and a monitoring system for vital signs pre- and post-procedure was in place. Missed appointments were tracked closely. The Dental Department tracked IDT response to missed appointments and the development of ISPAs in response to missed appointments, but this was an area that needed improvement. Desensitization plans and plans for improved cooperation had some success, but each step of success needed to be quantified in the form of measurable parameters. Although the Facility remained out of compliance with both subsections, significant progress had been made towards compliance.

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Q1	Commencing within six months of the Effective Date hereof and with full implementation within 30 months, each Facility shall provide individuals with adequate and timely routine and emergency dental care and treatment, consistent with current, generally accepted professional standards of care. For purposes of this Agreement, the dental care guidelines promulgated by the American Dental Association for persons with developmental disabilities shall satisfy these standards.	The Dental Department included the Dental Director, an additional staff dentist, two dental assistants, two dental hygienists, and one dental clerk. A list of Dental Department staff current in CPR was submitted, dated July 2012. The six clinical dental staff (i.e., two dentists, two dental assistants, and two dental hygienists) (100%) were current in CPR certification. <u>Annual Assessments</u> A list of those individuals having annual examination appointments was submitted for the time period from January 1, 2012 through June 30, 2012, in a document entitled "Annual Exam Report 6 Months," dated July 9, 2012. Of these, 233 were listed with a prior annual examination dates. Of these, 229 had an annual examination date completed within 365 days of the prior annual exam. One was completed, but was late. Three remained incomplete and overdue. This was a compliance rate of 98%. The Dental Department documented that during the time period from 7/9/2011 through 7/9/2012, all of the individuals residing at ABSSLC had seen a dentist. Separately, copies of the 10 most recent annual dental assessment that were completed in the 30 days prior to the Monitoring Team's visit along with the prior year's completed assessment were submitted. For 10 out of 10 (100%) of these individuals, an annual	Noncompliance

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		dental assessment had been completed within 365 days. ▪ Ten of 10 (100%) included an intraoral exam. ▪ Ten of 10 (100%) included an extraoral exam. ▪ Three of 10 individuals (30%) were edentulous. ▪ Ten of 10 included an oral hygiene plan. Four of 10 utilized a vacuum toothbrush. ▪ Ten of 10 (100%) included an oral hygiene index rating. ▪ Four of 10 (40%) included documentation of toothbrush instruction. ▪ Ten of 10 (100%) included comments on behavior and cooperation. ▪ Ten of 10(100%) included a treatment plan. ▪ None of 10 (0%) included a recommendation related to potential transition to the community. ▪ Ten of 10 (100%) included information about positioning during dental evaluations/procedures. ▪ Ten of 10 (100%) documented desensitization level of priority. Copies of the completed annual assessments for 22 individuals were submitted. Each included the annual assessment from the IPN entry, and the dental progress note (DPN) entry from the dental office record. All 22 of 22 submitted individual annual assessments had an identical/similar entry in both the dental office record and active record (100%). Additionally, during the time period from January 1, 2012 through June 30, 2012, there were no new admissions for which an initial dental exam would have been required in the first month. The Facility submitted a list of those who were currently edentulous. The list of names totaled 168. There were no individuals that became edentulous in the past six months. Based on a census of 411 individuals, this totaled 41% of the population. The Facility submitted the complete dental records for the prior three years for one individual from each residential unit, as a separate measure of completeness and timeliness in dental documentation. Twenty-two records were submitted, and the following findings were based on the review of this material: ▪ For 21 out of 22 (95%), the most recent annual dental assessment was within 365 days of the prior assessment. ▪ Twelve of 22 (55%) were edentulous. ▪ For those with teeth, periodontal probe results were completed/documented in 10 of 10 records (100%). ▪ A permanent dentition chart was submitted for three of 10 individuals (30%). ▪ The dental treatment plan was documented in 22 of 22 records (100%).	

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		▪ None of 22 (0%) had a current annual dental summary submitted. ▪ One of 22 had information submitted concerning missed appointments in the prior year. ▪ Ten of 22 had information submitted concerning the completion of dental x-rays. It was noted that 12 were edentulous. ▪ The level of cooperation and need for sedation/restraint was documented in 22 of 22 (100%) records. ▪ The oral hygiene index rating was recorded in 22 of 22 (100%) records. ▪ Restorations were recorded in seven of 22 (32%) records in the prior two years. Extractions were noted in six of 22 records (27%). ▪ The level of risk for dental needs was recorded in none of 22 (0%) records. ▪ Toothbrush/oral care instruction was recorded in 13 of 22 (59%) records. ▪ The recommendations for oral hygiene (i.e., tooth-brushing recommendations/flossing, etc.) were recorded in 22 out of 22 (100%) records. ▪ A statement of appropriateness for community transition was recorded in one out of 22 (5%) records. It is recommended that a periodontal chart be included in the dental record for applicable individuals, or other graphs/charts/documents that are useful in serially measuring progress in treating and eliminating periodontitis. As periodontitis can lead to tooth loss, and as ABSSLC had a high rate of edentulousness, the Facility should be aggressive in tracking all causes that could lead to tooth loss, including tracking of periodontal disease. This might lead to additional training in tooth brushing, more frequent monitoring, etc. The Dental Department also needs to ensure that when toothbrush and oral care instruction is provided, that it is recorded in the record. Additionally, there should be attention to developing a recommendation related to the individual's appropriateness for transition and outlining the dental needs of the individual from a Facility or community dental practice perspective. The reason for not including a copy of the annual dental summary utilized by the IDT was not determined. It might have been considered only an electronic document and not part of the active record. However, the completion of this document is one of the criteria in the three-year dental record review. <u>Oral Hygiene</u> The Dental Department provided training on oral hygiene. A course entitled "Basic Oral Hygiene for Direct Care Staff" utilized a presentation entitled "Basic Oral Hygiene Training 2010." The training roster documented that training compliance was 100% between 1/1/12 and 6/30/12 for direct support professionals and other Facility department staff listed. It was not clear the intended audience (e.g., new hires or all direct support professionals), but 533 staff completed the oral hygiene training in-service. In the future, in providing training compliance information, the Facility should	

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		include the number of staff trained (n) and the number of staff that require training (N) to provide the percentage of training compliance (n/N). An oral hygiene index score was completed on each individual at the time of the annual exam. The most recent oral hygiene scores were submitted. According to this document, a total of 355 individuals were evaluated from January through June 2012, 73% had a good oral hygiene score, 21% had a fair oral hygiene score, and 6% had a poor oral hygiene score. This included individuals that were edentulous. The Dental Department was asked to provide data on those with teeth (separate from the data on the edentulous population) for the current half-year, and prior time periods to determine any trends. It was noted that 41% of the population was edentulous and appeared to have generally good ratings, which could potentially skew and hide any trend of oral hygiene in the remainder of the population. Although the Dental Department was able to provide the requested oral hygiene ratings for the first six months of 2012 and the first six months of 2011, they were not able to obtain this same information for the last six months of 2011. They were able to provide the entire year of 2011. The following represents the data generated for this separately requested information for individuals that had teeth:	

Oral Hygiene Ratings for Previous Six months to One-Year time period %, for those individuals with teeth			
Rating	1/1/12 to 6/30/12	1/1/11 to 12/31/11	1/1/11 to 6/30/11
Good	63%	58%	54%
Fair	29%	33%	34%
Poor	8%	9%	12%

The trend indicated gradual improvement in the good oral hygiene rating, and a slow decrease in the poor oral hygiene rating.

However, the data was problematic. From a list dated July 9, 2012, entitled "ABSSLC Clinical Summary Annual Exam Data with Oral Hygiene Rating," appointments from January 2, 2012 through June 26, 2012 were listed. Of these, 234 individuals completed the appointment and allowed an oral hygiene rating to be completed. However, the Dental Department provided oral hygiene rates for individuals (including individuals that were edentulous) based on 355 evaluations from January through June 2012, from a document entitled: "ABSSLC Dental Oral Hygiene Values six months for 355 individual evaluated Jan-Jun 2012." For the same time period, a document entitled "With Teeth ABSSLC 2012 Oral Hygiene Values 6 months" listed 249 individuals. The reason for the difference in the numbers in the same time period was not clarified. It might have

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		indicated oral hygiene values recorded at the time of the annuals as well as other visits. It would be important to define the type of dental visit from which the data was derived and use that same criteria for each six-month period, and define the dental staff determining the oral hygiene score (i.e., oral hygiene scores during annuals by the dentist, oral hygiene scores at the most recent visit with any type by dentist, or oral hygienist, etc.) It also was not clear if an average of the scores was used when the individual had more than one visit in six months with an oral hygiene rating recorded at different visits during the six months, or if the score represented the most recent score or the highest score of any score in the six months. Inter-rater reliability needs to be determined between dentists in determining oral hygiene scores with more than one dentist in the Department, and if dental hygienists are also determining oral hygiene scores, these staff members should be included in inter-rater reliability testing. Data should be provided concerning inter-rater reliability. *Suction Tooth-brushing* As part of preventive oral care, suction tooth brushing was provided to those at risk for aspiration, had a history of aspiration, or silently aspirated. The criteria included individuals that could not manage thin liquids safely, were unable to spit, and/or that could not brush independently. A list, dated 6/27/12, indicated 151 individuals received suction tooth brushing, which was 151 out of 411 (37%) of the population. All individuals identified as benefiting from suction tooth brushing had received this procedure. There was no individual who was waiting for suction tooth-brushing equipment, etc. *Flossing* A total of 21 individuals were identified as candidates for self-flossing or flossing with assistance. For 21 of these 21, progress in acquiring this skill and in using the skill was described in the DPN and IPNs. Flossing materials were dispensed with the individual back to the home when applicable. However, the Facility indicated that as of June 2012, no individual was independently capable of flossing his/her own teeth. *Tooth Brushing* A total of 59 individuals had care plans/ISPs that included brushing one's own teeth. For these individuals, the Dental Department calculated the oral hygiene scores based on the two most recent values. These varied from one month apart to six months apart. There were some irregularities in the data (e.g., one indicated an exam occurred 9/6/12, which was a future date). For some, the earlier score date occurred after the later score date, indicating the need for monitoring of the data. It was assumed that the oral hygiene sample for value one was earlier than for value two, but there were many errors in the dates listed. Overall, the scores of the prior rating indicated that for the earlier sample, there were 57 individuals who had a self tooth-brushing plan. Of these, 40 (70%) had a	

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		good oral hygiene index rating, 11 (19%) had a fair oral hygiene index rating, and six (11%) had a poor rating. For the later sample, there were 58 individuals. Of these, 34 (59%) had a good oral hygiene index rating, 12 (21%) had a fair rating, and 12 (21%) had a poor rating. It is recommended that the accuracy of the database be monitored. It is also recommended that the data reflect at least three to six months between values, to determine the long-term impact of self- brushing. Based on the submitted information, it appeared that the oral hygiene rating of those with self-brushing plans had worsened over time. It is recommended that the Dental Department review progress of those that are self-brushing, to provide additional support and assistance, and or change the self-brushing plan in order to improve the oral hygiene index ratings. <u>X-rays</u> The Dental Department indicated that all individuals at ABSSLC had completed a left and right oblique x-ray of the dentition. There were three individuals that had obtained full mouth sets of films, through the hospital setting under general anesthesia. The Dental Department listed the challenges and risks of obtaining a diagnostic peri-apical, bite-wing, or full mouth sets of x-rays: the procedure can cause gagging and choking for those at risk for aspiration, the procedure increases uncooperative behavior in attempting to obtain these films, the procedure increases oral secretions which increases risk of aspiration, it increases risk of injury to individual and staff due to sudden unexpected movements, there is a potential risk of swallowing or aspirating dental films, and there is a potential for damage to the film holder and lacerations due to the breakage. The Dental Department indicated that the oblique films (placed extra-orally) provide adequate diagnostic quality and less risk without sedation and general anesthesia. These x-rays are utilized as a screen, which then may indicate the need for intra-oral peri-apical x-rays. <u>Preventive, Restorative, Emergency Dental Services</u> Information submitted indicated 168 individuals residing at ABSSLC were edentulous, for a rate of 168 out of 411 (41%). Ten of 168 individuals that were edentulous had dentures (nine full and one partial) for a rate of 6%. The remaining 158 individuals that were edentulous did not have dentures. Reasons given were documented on the Dental Examination Record. For each, one or more of the following was given as a reason for not having dentures: poor upper ridge, poor lower ridge, poor ridges, poor denture experience, inadequate muscle coordination, and torus/tori. For one individual with dentures, the oral hygiene index was scored with the individual being edentulous rather than with dentures. There was also no mention of treatment on daily denture care or dentures/partial dentures. For one individual that was edentulous, the treatment plan indicating whether dentures were or were not indicated was left blank. When utilizing this form, it is recommended that it be completed accurately and consistently.	

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		Overall, with regard to preventative, restorative, and emergency care, the Dental Department did provide the breadth of services required to care for the individuals at ABSSLC. In the prior six months, 535 individuals were seen for prophylactic care visits. Additionally, 135 of the annual exams were also recorded as completing prophylactic care, as a multi-purpose visit. There were 230 annual exams completed (including the 135 annuals already mentioned). Nineteen individuals underwent 23 visits for restorative care. Thirty-six individuals were seen and treated for dental emergencies at 46 visits, and nine individuals underwent dental extractions of one to five teeth. *Oral Sedation* The Dental Department submitted information concerning the use of oral sedation. In January 2012, no individual had oral sedation. In February 2012, there were three visits for two individuals that were administered oral sedation. In March 2012, there were four visits for four individuals that were administered oral sedation. In April 2012, there was one visit for one individual that was administered oral sedation. In May 2012, there were two visits for two individuals that were administered oral sedation. In June 2012, there was one visit for one individual that was administered oral sedation. In July 2012, there were two visits for two individuals that were administered oral sedation. 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: ▪ Ten out of the 10 (100%) confirmed nothing by mouth status or nothing per G-tube. No individual was documented to not need NPO status. ▪ Ten (100%) listed the medication administered, the dose, and the route. However, it was difficult to find this in some cases, and it is recommended it be included in the dental progress notes in all cases. Also, there was one medication error in which Lorazepam was to be held, but was given. It was not clear from the documentation submitted whether the prescribed Halcion was also administered. Some of the documentation listed Halcion and some listed two medications. ▪ Seven of nine (78%) included documentation of vital sign measurements in the home or attempts at measurements. By protocol/policy, one individual was a minor and medication was not administered in the home. For two individuals, documentation of vital sign measurements in the home was not submitted. ▪ Ten (100%) listed pre-procedure vital signs in the dental office. ▪ Ten (100%) had an examination note on the date of the visit. ▪ Ten (100%) documented intra-procedure vital signs, or attempts at obtaining intra-procedure vital signs. ▪ Ten (100%) documented post-procedure vital signs. ▪ Adequate documentation regarding effectiveness of sedation was found in 10 of	

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		the 10 (100%) of the active records. ▪ None (0%) included documentation of Dental Department follow-up the next business day. ▪ None (0%) included documentation of a post dental procedure IPN note. ▪ One of 10 (10%) included documentation of current sedation consent. ▪ Ten included a restraint checklist. *General Anesthesia/TIVA* The Dental Department submitted information concerning the use of general anesthesia. Per month, the following number of individuals received general anesthesia: January 2012 – four, February 2012 – four, March 2012 - three, April 2012 – none, May 2012 – none, June 2012 – none, and July 2012 – five. Additionally, four individuals received general anesthesia/TIVA in the off-campus hospital setting during this time. For one off-campus appointment with general anesthesia, there was injury to the lip due to the individual chewing on the lower right lip after the dental treatment, associated with the administration of local anesthesia and numbness. According to the Dental Department, there was healing without sequelae and a good outcome from the dental procedure. The Facility was asked to provide the active record for five individuals who had undergone general anesthesia in 2012. Two of the individuals whose records were submitted underwent oral sedation, not general sedation. For the remaining four individuals, three occurred at ABSSLC and one occurred at the area hospital. The date range of these procedures was from 3/9/12 through 5/29/12. The procedures under general anesthesia included one or more aspect of dental care. The list varied in each case, and included the following: restorations and extractions. Review of these records revealed the following: ▪ Consent for the dental procedures/anesthesia was current (defined as completed and dated within 365 days of the procedure) in four of four (100%). ▪ A pre-operative medical clearance was submitted in none of four (0%) cases. ▪ A pre-operative anesthesia record/clearance was submitted in one of four (25%). ▪ Additional consultants provided reports for two of four cases. ▪ The intra-operative record and operative anesthesia record was submitted in four of four (100%). ▪ For those with teeth, a periodontal chart was submitted for none of four (0%). ▪ Pre-operative vital signs were recorded in four of four (100%) cases. ▪ An operative record narrative by the dentist was submitted for four of four (100%) cases. ▪ A recovery room note/monitoring flow sheet was submitted for four of four	

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		(100%). ▪ Post –operative vital signs were recorded in four of four (100%) cases. ▪ Pain medication was prescribed in one of one case in which extractions occurred. ▪ Follow up IPNs were submitted for four of four (100%) cases. *Extractions* For five individuals that underwent extractions on campus, the dental record was submitted. The following findings were made: ▪ From the submitted documentation, consent was current in five of five (100%). ▪ A second opinion dental consultation or dental IPN/DPN indicating the need for extractions was documented in five of five (100%). ▪ For none of the five cases, IV sedation was used. For none of the five cases, oral sedation was used. Five of five (100%) had a local anesthetic. For none, a combination of sedatives was utilized. ▪ A set of pre-procedure vital signs was obtained in five of five cases (100%). ▪ From one to two teeth were extracted at a visit. ▪ A set of post-procedure vital signs was obtained in five of five cases (100%). ▪ Pain medication was provided in five of five cases (100%). ▪ A follow-up phone call to the home was documented in none of five cases (0%). ▪ A follow-up visit was documented in five of five cases (100%). The most recent off-site consultation with oral surgery was requested for five individuals. Off-site consultation was submitted for two cases in which requests were made for a second opinion to rule out pathology or an opinion concerning pathology. In one case, the consultant completed a consultation report form, and in both cases completed a DPN and IPN. *Emergency Treatment* The Dental Department provided a "Dental Emergency Log" for the months January through June 2012. These logs reflected 48 emergencies. Per month, the following number of emergency visits were logged: January 2012 - eight, February 2012 – eight, March 2012 – 15, April 2012 – eight, May 2012 – six, and June 2012 – three. A resolution note was documented for 47 out of 48, indicating whether the case was closed or additional follow-up was needed. The Dental Emergency Log provided an initial date, but clarity as to the interpretation of the date was needed. It was assumed this was the date the Dental Department was contacted and not the date of the emergency, but there was no key provided to ensure the interpretation was accurate. Of the 48 individuals, information was incomplete or appeared to be a data entry error in seven cases. Based on the interpretation that the date recorded was the date of the contact, for the remaining 41 individuals, 38 were seen the same day as the emergency contact with the	

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		Dental Department. Two were seen within one business day. One individual was seen within three days. As a follow-up monitoring process, the Dental Director completed an "Emergency Dental Log Review" each month, to determine the status of all prior emergencies not initially closed and which needed further evaluation and follow-up. These reviews continued to track these individuals until the case was closed. Emergency treatment was reviewed for five individuals. The reasons for the emergency were as follows: refusing to eat, behavior changes, possible fistula, and toothache. The following findings are made based on this review: ▪ Three (60%) of records included information concerning the date the complaint occurred. ▪ Of these three, a dental office visit occurred the same day for three of three (100%). ▪ One record (20%) documented the presence or not of pain. ▪ Four of five records (80%) indicated no dental pathology causing symptoms. It was noted that four emergency visits chosen for review had vague complaints for which dental discomfort was ruled out. These did not address whether discomfort or pain existed, but did indicate the dental exam was unremarkable. ▪ Pain was treated in one of one (100%). ▪ Follow-up occurred for one of one individual (100%) with dental pathology. It is recommended that the emergency note include information such as when the problem was first noted in the home (or elsewhere), as well as clearly documenting whether discomfort/pain was elicited on exam, whether due to dental or non-dental reasons. As the Dental Department strives toward substantial compliance with this sub-section, the following are areas on which focus should be placed: ▪ It will be important to maintain the progress that has occurred in the Dental Department. ▪ Annual assessments should include documentation of tooth brushing instruction, as well as recommendations regarding the individual's appropriateness for community placement. ▪ The Facility should conduct a review of the reason for the large numbers of edentulous individuals and a plan to reduce tooth extractions, as well as tracking those newly edentulous per quarter and the reason for tooth extraction. ▪ There should be documentation that dentures are offered when applicable to those that are edentulous, and documentation for reasons for not offering dentures, when applicable. ▪ Dental records would benefit from a periodontal chart. ▪ There should be completion of odontograms in the dental record.	

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		▪ The annual dental summary should be part of the dental record. ▪ Oral hygiene should be tracked for the total population, and separately for those that are edentulous, and for those that have teeth ▪ For those that have a self tooth-brushing plan, oral hygiene should be tracked to ensure progress. For those in which there is poor hygiene, additional plans should be implemented to improve oral hygiene, or provide additional assistance in tooth brushing. ▪ For those undergoing oral sedation, a follow-up post-procedure visit or phone call and IPN would be appropriate for closure. ▪ For those undergoing oral sedation, there should be documentation of current sedation consent. ▪ For those undergoing general anesthesia/TIVA, there should be evidence of a pre-operative medical clearance or a note that it is not indicated. ▪ For those undergoing general anesthesia/TIVA, there should be a pre-operative anesthesia record/clearance completed or a note that it is not indicated. ▪ For emergency treatment, the dental note and IPN should indicate the date the complaint started, and whether pain exists on exam or pain does not exist on exam.	
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	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> Since the Monitoring Team's last visit, there were no new policies implemented. The most recent revision of the Dental Department policy/manual was dated 2/8/12, according to the Presentation Book. However, over the prior six months, a number of changes were made to the forms the Dental Department utilized: ▪ The Dental Assessment Record (Form 8509) and (Form 8509E) added an entry line: "osteoporosis/osteopenia Y/N, Bisphosphonate Y/N, Any contraindication to continue Bisphosphonate Therapy Y/N." ▪ The ABSSLC Annual Dental Summary was further refined. However, given that this form goes to the IDT, it would improve understanding to define the types of periodontal disease (I, II, III, IV). After the word "periodontal," it would be helpful to note that the words, high, medium and low refer to risk. The form, entitled Version F 7/19/12 otherwise appeared easy to comprehend and useful to the team once completed. ▪ Also included under the section "Revised Forms" were instructions "ABSSLC Pre-Treatment Dental Oral Sedation Instructions" (undated) and "Post Dental Oral	Noncompliance

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	assessment of the use of sedating medications and dental restraints.	Sedation Instructions" (undated), "ABSSLC Dental Pre-Sedation Evaluation Form 8680" (dated April 2012), which was to be completed by the dentists, and which also included a "post anesthesia recovery" section, the "ABSSLC Dental Anesthesia and Clinical Record for Oral Conscious Sedation Form 8682" (dated April 2012), the template for the IPN dental visit (dated 5/2012) and the template for the Dental Progress/Treatment Record (dated May 2012), both of which included a brief entry check box for level of sedation (effective, not effective, minimal, partly effective), and a space to list the sedatives used, and the Medical/Dental Restraint Checklist form (dated April 2012). <u>Provision of Dental Records to IDTs</u> A copy of the ten most recently completed annual dental summaries (with "date: 6/1/11-6/15/12") that were forwarded to the IDT for the ISP were submitted for review. These were computer generated. Contents were generally completed using a checkbox format. At the bottom of the document, there was room for typed comments. Information included refusals, missed appointments, appointments completed, rating of behavior, the date of the last annual assessment, oral hygiene rating, need for oral sedation or general anesthesia, restraint use and effectiveness, desensitization status, periodontal status, caries risk, frequency of follow-up, and comments focusing on type of toothbrush, toothpaste, and missed appointments. The periodontal section and caries section listed categories of high, medium, and low. The reference for the categories was not stated (i.e., it was unclear if this was a reference to risk level). A later key for periodontal type referred to the most recent assessment findings and used separate classification (mild, moderate, severe, end stage, and normal). A separate bordered area focused attention on the most recent assessment and work completed. There was a key to teeth numbering which did not appear to be utilized, but would have provided a visual map of the dentition to the IDT members. It was confusing to have this key for edentulous individuals. It would have been appropriate to cross it off or remove it from the document. Leaving it on the form and not utilizing it could have been interpreted that all teeth were present. Overall, the forms provided an important summary of dental information helpful to the IDT. However, a few areas on the format were unclear, which complicated interpretation. <u>Refusals/Missed Appointments</u> A document entitled "Absence Tracking 2012 by Month" was submitted. This was a combined list of refused and other missed appointments. Per month, the following was the number of missed appointments for all reasons: January 2012 – five, February 2012 – six, March 2012 – nine, April 2012 – six, May 2012 – nine, and June 2012 – seven. The total number of missed appointments was 42. It was documented that all had a completed follow-up visit. The follow-up was more than one month for four individuals,	

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		more than two months for three individuals, and more than three months for one individual. All the remainder had a follow-up in less than one month. Reasons listed for missed appointments included: staff shortage – six, behavioral concerns – 20, schedule conflict - six, cancelled by center – two, resident illness - four, and not scheduled on calendar – four. A document entitled "Absence tracking 2012 six month refusals" was submitted. This document included all the refusals from January 2012 through June 30, 2012. It listed 20 appointments for 15 individuals. Per month, the following was the number of missed appointments for refusals: January 2012 - two, February 2012 – two, March 2012 – four, April 2012 – five, May 2012 – three, and June 2012 – four. All were documented to have a follow-up visit completed. One individual had refused three appointments, and three individuals refused two appointments, but all were followed by a completed appointment. A document entitled "Absence Tracking 2012 six months non-refusals" was submitted. This document included all the non-refusals from January 2012 through June 30, 2012. It listed 22 appointments for 19 individuals. Per month, the following was the number of missed appointments for non-refusal reasons: January 2012 - three appointments, February 2012 - four appointments, March 2012 - five appointments, April 2012 – one appointment, May 2012 – six appointments, and June 2012 – three appointments. Reasons for the scheduled appointments that were missed included cleaning (19 appointments), annual exams (one appointment), extractions (no appointments), and restorations (one appointment). For the 22 appointments that were missed (non-refusals), a follow-up appointment was completed in 22 cases. For one individual, the completed appointment occurred more than 30 days after the original date of the missed appointment. For two individuals, the completed appointment occurred at or more than 60 days after the original date of the missed appointment For the 42 individuals that did not keep the appointment for refusal and non-refusal reasons, six of these appointments did not need IDT follow-up, because they were due to medical issues. For the remaining 36 missed appointments, 35 (97%) had documentation submitted concerning communication to the QDDP requesting the IDT review and resolve the reason for the missed appointment. The Dental Department submitted information concerning whether the no show appointments (both refusals and non-refusals) were followed by an IDT meeting with an ISPA created to address the no show appointment. Eleven of the 36 (31%) missed	

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		appointments were followed by an ISPA discussing the problem. No information was submitted for the other 25 missed appointments concerning the creation of an ISPA to address the missed appointment. The Dental Department submitted a list of homes for individuals with missed appointments, both refusals and non-refusals. The majority of the missed appointments for all reasons occurred in Residences 5962, 6370, 6400, 6450, 6720, 6730, 6740, and 6760. It is recommended that the Dental Department attend ISPAs to discuss individuals from these homes with missed appointments with the goal of improving the rate of completed dental appointments. Separately, the Dental Department submitted a list of ISPs attended by a member of the Dental Department. The list totaled 32 individuals and the ISP dates ranged from 1/3/12 to 7/10/12. The names were not necessarily the same names listed on the absence tracking sheet, because they might have represented missed appointments prior to 1/3/12. One ISP was submitted (for Individual #295), and briefly discussed the reasons for two of three missed appointments. For two missed appointments, the reason was for illness, but the third missed appointment did not indicate the cause for cancellation by the supervisor. The Dental Department also indicated that: "final minutes generally do not record dental missed appointments or develop strategies to address this behavior even if they were developed at the meeting." This appears to be a problematic systemic issue. When missed appointments are discussed and information shared/strategies developed, it should not be optional to not record the results of the discussion in the ISP/ISPA. Discussion should lead to conclusions and action steps that can then guide the IDT and the Dental Department. It is recommended the QDDP Coordinator review the current system of recording this information in the ISP to ensure it is not missed for future meetings, and that missed appointments are followed by the development and implementation of action plans, as appropriate. <u>Interventions to Minimize the Use of Sedating Medications and/or Restraints</u> Information was submitted concerning use of restraints for dental procedures. For the prior six months, the dental office did use mechanical restraints. From January 2012 through June 2012, there were two visits that utilized mechanical restraint (one in February 2012 and one in March 2012). From January 2012 through June 2012, according to the data provided, there were 1626 appointments. Of these, there were 11 appointments in which oral sedation was given (0.68%). A separate document entitled "Oral Sedation 2012" indicated there were 20 visits with oral sedation, versus the 11 noted in a separate document. If oral sedation was administered during 20 visits, this was a usage rate of 1.2%. For 11 on-campus and four off-campus appointments (total 15) for which general anesthesia/IV sedation was administered, this was a 0.92% usage	

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		rate. Separately, the Dental Department submitted a restraint and sedation log per individual. This included 78 individuals. Listed was the date of the restraint, in chronological order, and if it was a chemical restraint, it included the name, dosage and route, as well as effectiveness, and the reason for the restraint. The procedure undertaken at the time was also included. When applicable, reduction strategy information was included. This allowed the Dental Department to determine whether the prior medication and dosage was effective, and provided opportunity to consider a dosage reduction, if applicable, for a future visit, or whether a higher dosage or alternate medication was appropriate, based on prior effectiveness of chemical restraint use. An example of a completed "Medical Restraint Plan" for a dental chemical restraint was also included. It listed preventive action steps to avoid using a chemical restraint, a description of the behaviors requiring a chemical restraint, the most effective sedative, and appropriate documentation. Criteria for releasing the individual from enhanced monitoring, as well as instructions for direct support professionals, was also part of the plan. Finally, there was a section reviewing steps to be considered or in process to reduce future need for a chemical restraint. From the submitted information, it was not clear if all individuals for whom a chemical restraint was approved had a current "Medical Restraint Plan," because only one of 78 was submitted. With regard to desensitization: ▪ 100 individuals had been identified as requiring a desensitization plan or other cooperation plan to reduce the need for restraint. These 100 showed anxiety and were prioritized. ▪ As of 7/9/12, 49 individuals had been evaluated for desensitization. ▪ Of these, 35 had formal written plans developed. ▪ An additional seven had written strategies (i.e., individuals that refused to come to dental office). The strategies did not provide specific steps. They often utilized a reward system. These individuals started at weekly visits. ▪ The Dental Department provided a monthly report to the Psychology Department. This was for individuals that had plans that used the dental office regular chair or dental chair. The assigned dental hygienist completed detailed notes of each step of dental treatment and the response of the individual. ▪ From the "ABSSLC Desensitization Tracking Worksheet," the following was documented: improvement was noted in 20 individuals, slight improvement was noted in 12, and no improvement was noted in five. This report indicated that 37 desensitization plans were currently implemented. For the other 12 individuals that had been evaluated, they were in the process of having a needs assessment completed, or the plan was in the process of being written, etc.	

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		▪ There were no additional vacancies for further candidates. This would change at the time a few graduate from the desensitization plan. ▪ There was no missed appointment report for individuals with desensitization plan visits. The Facility provided a list of training appointments related to the implementation of the plans (i.e., the visits to the dental office as "practice" for actual appointments). It was noted that none of those individuals categorized as having desensitization plans had missed or refused their training appointments. Per month, the following provides the number of dental training visits for these individuals with specific individualized plans to improve cooperation: January 2012 - 113, February 2012 – 157, March 2012 – 57, April 2012 – 105, May 2012 - 125, June 2012 - 83. The total number of appointments kept for the individuals with individualized plans to improve cooperation totaled 640. There was no information concerning the involvement of the Psychology Department in assisting with the training visits or participating in plans, especially in those individuals which had difficulty leaving the residence, approaching the building in which the dental office was located, or entering the dental office doorway. Dental department staff completed the 640 visits. The Dental Department should begin to provide measures of success and progress in the current desensitization/improved cooperation plans (progress in completing a procedure, less time to complete a task, etc.). <u>Quality Assurance/Improvement Initiatives</u> The QA Department used the following monitoring tool to review the quality and completeness of dental care: Texas Health Monitoring Instrument: SA II.Q – Dental Services, revised 5/1/2012. Several documents were submitted to document the Dental Department's progress in self-monitoring, as well as the QA oversight of the Department. There were monthly meetings of the Dental Department Director, staff dentist and the quality assurance monitor. Minutes were submitted for meetings on 4/26/12, 5/26/12, and 6/26/12. Although a new dental monitoring tool had been proposed, the decision was made to use the old monitoring tool until revisions of the new tool corrected typographical errors and omissions. To assist in inter-rater reliability, information/audit instructions were shared among the attendees outlining the date and type of document to be reviewed, and location in the record. There was subsequent improvement in inter-rater reliability based on this guidance.	

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		The QA/QI Data Summary Report was submitted by the PCM on 3/2/12 for the second quarter of the 2012 fiscal year, and on 6/11/2012 for the 3rd quarter of the 2012 fiscal year. The information from the two reports demonstrated improvement in inter-rater reliability. This followed the series of meetings to review audit instructions. Each month 10 records were chosen at random (to include the entire campus). Of these, three were also reviewed by the PCM. The monitoring instrument included 18 indicators. Compliance was determined by individual score as well as a monthly summary, and a quarterly summary with comparison to the Dental Department data. Compliance was set at 70%. ▪ From the 3/2/2012 QA report, QA determined compliance to be 89% in December (the Dental Department score was 78%), 94% in January 2012 (the Dental Department score was 82%), and 93% in February (the Dental Department score was 74%). The first quarter QA composite average score was 84%, and the second quarter QA score was 92%. This was the opposite trend of the Dental Department score, which was 85% in the first quarter and 78% in the second quarter. As discussed in the Monitoring Team's previous reports, composite scores provide little, if any, meaningful information. ▪ Specific indicators that scored less than 70%, and the Facility indicated need for improvement included the following, identified by the number in the monitoring tool: Question #3: "The annual date of dental examination was within 365 days of admission and/or the last dental examination." Question #8: "Restorative care was provided including permanent or temporary restorations." Question #9: "If extractions were performed, the documentation contains a clinical justification including but not limited to periodontal conditions, requirements for denture construction, non-restorable tooth, or severe decay, or if none of the above reasons is applicable, other reason is documented." Question #10: "Individual attended all scheduled dental appointments." Question #11: "If not, was the missed appointment(s) due to Dental clinic issues (sick call-ins, scheduling issues, etc.)." Question #12: "The individual did not refuse to attend dental appointments." Question #13: "If refused, there is documentation that the interdisciplinary team reviewed refusals, assessed, and developed strategies to overcome individual's refusals to participate in dental appointments." Question #15: "Does the individual use (a) pre-sedation (b) restraints?" Question #16: "If yes to either of the above, there is a desensitization program and/or strategies to reduce the need for the use of pre-sedation and/or restraints in place." Question #17: "There is documentation that the desensitization plan and/or strategies to reduce the need for the use of pre-sedation and/or restraints are being implemented." Question #18: "If the individual is at risk for choking/aspiration, is there a physical nutritional support plan addressing and incorporating safe positioning for dental	

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		procedures." ▪ For the second quarter, there was significant disagreement between the Dental Department scores and the QA scores for 12 of the 18 indicators. However, monthly meetings and development of a guide improved the inter rater reliability scores over the following quarter. The 6/11/2012 QA/QI data summary provided monthly composite scores, the quarterly scores, and individual indicator scores for comparison to the Dental Department. ▪ For March 2012, the QA compliance score was 100% (the Dental Department score was 93%). For April 2012, the QA compliance score was 100% (the Dental Department score was 95%). For May 2012, the QA compliance score was 94% (the Dental Department score was 95%). The QA quarterly composite score was 98% (the Dental Department score was 94%). Again, this information had limited value. ▪ Specific indicators that scored less than 70% included: Question #2: "The comprehensive admission exam included the following: (e) summary of current dentition, including picture of teeth with status documented (i.e., missing teeth, fillings, etc.)." Question #15: "Does the individual use (a) pre-sedation (b) restraints?" Question #16: "If yes to either of the above, there is a desensitization program and/or strategies to reduce the need for the use of pre-sedation and/or restraints in place." Question #17: "There is documentation that the desensitization plan and/or strategies to reduce the need for the use of pre-sedation and/or restraints are being implemented." Question #18: "If the individual is at risk for choking/aspiration, is there a physical nutritional support plan addressing and incorporating safe positioning for dental procedures?" ▪ Compared to the prior quarter, there were six (versus 12) of 18 indicators in which the QA Department had significant disagreement with the Dental Department findings. This was an improvement. ▪ The QA Department stated that the indicators had not been weighted, and inter-rater reliability scores had not been computed as of the end of the third quarter of the fiscal year. However, the submitted documents indicated a continual striving to achieve inter-rater reliability. The Dental Department provided two quarterly reports to the Facility in the prior six months, dated 3/8/12, and 6/6/12. From the 3/8/12 document, action plans were to focus on reviewing monitoring data at monthly intervals to accurately evaluate the active record contents and provide inter-rater reliability data. Also, the Dental Department was to track all ISP and ISPAs that involve dental concerns to determine accuracy and completeness of recording the discussions, strategies and corrections. The 6/6/12 report listed other steps that had been implemented in the prior quarter, including:	

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		adding a completed tooth chart to the Annual Dental Summary, evaluating edentulous individuals to determine appropriateness of dentures, and ensuring oral sedation includes documentation of dosage and route. ISP content for dental concerns continued to be monitored and needed further improvement. The Dental Monitoring Tool indicators continued to score greater than 70%, and corrective action plans were not created due to the threshold level being surpassed. However, the rationale for choosing a 70% compliance threshold was not clear. This was a low compliance threshold. It should be reviewed and increased. Further, when reviewing the indicators to determine which should be weighted more heavily, the Dental Department should consider listing essential indicators needing one level of compliance and non-essential components needing another level of compliance, similar to the Medical Department scoring system. The Dental Department also provided a presentation to the Facility Administration. The department review included dental care in many clinical areas over the past year. This included general anesthesia use, oral sedation, mechanical restraint use, attendance tracking since 2010, and dental restorations and extractions since 2010. The presentation used a number of graphs to communicate the improvements in clinical care in the Dental Department. This was a helpful document.	

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

1. A periodontal chart should be included in the dental record for applicable individuals. (Section Q.1)
2. The Dental Department should ensure that when toothbrush and oral care instruction is provided, that it is recorded in the record. (Section Q.1)
3. In the dental assessments, the Dental Department should include recommendations about the appropriateness an individual transitioning to the community, and outline the dental needs of the individual from a Facility and/or community dental practice perspective. (Section Q.1)
4. In the future, oral hygiene scores should be analyzed separately for those with teeth and for those that are edentulous. (Section Q.1)
5. The Dental Department should review progress of those that are self-brushing, and, as appropriate, provide additional support and assistance and/or change the self-brushing plan in order to improve the oral hygiene index ratings. (Section Q.1)
6. The QA Department should review the Dental Examination Record to ensure completeness and accuracy. The Dental Department should have a similar internal monitoring system to ensure completeness and accuracy of this same document. (Section Q.1)
7. When oral sedation is given, documentation of route should be provided in the dental progress notes. (Section Q.1)
8. For emergency/acute care visits, the emergency note should include information such as when the problem was first noted in the home (or elsewhere), as well as clearly documenting whether discomfort/pain was elicited on exam, and if present, whether the pain or discomfort was of dental or non-dental origin. (Section Q.1)
9. Inter-rater reliability should be established between dentists in determining oral hygiene scores, given that there is more than one dentist in the Department, and if dental hygienists are also determining oral hygiene scores, these staff members should be included in inter-rater reliability testing. Data should be provided concerning inter-rater reliability. Oral hygiene rating data should include a description of the population from which the scores are derived (e.g., annuals only, etc.)
10. The Dental Department should attend ISPAs to discuss individuals from homes with the highest no show appointment rates, with the goal of

improving the rate of completed dental appointments. (Section Q.2)

11. The QDDP Coordinator should review the current system of recording the team's discussions related to missed appointments in the ISP to ensure it is not missed for future meetings, and that missed appointments are followed by the development and implementation of action plans, as appropriate. (Section Q.2)
12. The Dental Department should begin to provide measures of success and progress in the current desensitization/improved cooperation plans (e.g., progress in completing a procedure, less time to complete a task, less use of sedation, less use of restraints, less anxiety before or after the visit, etc.). (Section Q.2)
13. The compliance threshold for results of monitoring dental indicators should be reviewed and increased. (Section 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 For the following 29 individuals who had communication deficits, alternative and augmentative communication (AAC) system(s), and/or received direct and/or indirect communication supports: Individual #250, Individual #418, Individual #163, Individual #429, Individual #280, Individual #393, Individual #480, Individual #95, Individual #530, Individual #185, Individual #13, Individual #92, Individual #81, Individual #455, Individual #48, Individual #374, Individual #382, Individual #274, Individual #529, Individual #349, Individual #5, Individual #542, Individual #150, Individual #304, Individual #39, Individual #479, Individual #390, Individual #287, and Individual #109, the following documents: Communication Comprehensive assessment, Update and Assessment of Current Status from individual record, ISP and ISPAs for past year, Positive Behavior Support Plan, skill acquisition programs related to communication and supporting documentation for implementation (indirect supports), direct SLP therapy intervention plans and supporting documentation such as IPNs, monthly reviews by SLP, AAC programs and supporting documentation for implementation of indirect supports, individual-specific communication monitoring for past six months, and evidence of effectiveness monitoring for SLP interventions (direct) and programs (indirect); o Policy and procedures addressing the provision of speech and/or communication services and supports including changes since Monitoring Team's last visit; o Continuing education and other training completed by SLPs since the Monitoring Team's last visit with certificates of completion; o List of current SLP and audiology staff along with corresponding caseloads, and CVs for newly hired SLPs; o List of individuals with AAC devices; o Communication Master Plan List; o AAC Screening forms; o Speech language (SL) comprehensive assessments and updates (templates) used by SLPs along with any changes; o Tracking Log of SLP assessments completed since Monitoring Team's last review; o Monitoring forms used by SLPs, Speech Language Pathology Assistants (SLPAs), and PNMP Coordinators; o Copies of blank communication competency-based performance check-off sheets for new employees; o Inter-rater reliability compliance scores and corresponding audits; o List of individuals receiving direct speech services and focus of intervention; o Individuals with behavioral issues and coexisting severe language deficits, and risk level/status for challenging behavior; o List of individuals with PBSPs and replacement behaviors related to communication;

	○ Minutes for Communication committee meetings held since last review; ○ Minutes for Speech Department meetings held since last review; ○ List of all general common area communication devices; ○ OT/PT Assessments, ISPs, and PNMPs for four individuals most recently assessed by an SLP for whom AAC device was recommended; ○ Blank communication competency-based performance check-off for individual-specific communication programs; ○ External consultant reports since last review; ○ Completed audits of SLP documentation; ○ Behavior Support Committee minutes and attendance sign-in sheets for meetings held since last review; ○ American Speech Hearing Association (ASHA) certification for SLPs; and ○ Raw data for SLP audits. ▪ **Interviews with:** ○ Bobbie Holden, Director of Habilitation Services, OTR; ○ David Feemster, CCC/SLP, Lead SLP; ○ Donna Boulette, MS, CCC/SLP; ○ Evy Wright, MS, CCC/SLP; and ○ Leslie Riggins, BBS, SLP Assistant. ▪ **Observations of:** ○ Vocational area, day program, Senior Center, and residences; and ○ HT Department meeting on 8/20/12.
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section R, dated 8/8/12. In its Self-Assessment, for each sub-section, 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. For Section R, in conducting its self-assessment, the Facility: ▪ Did use monitoring/auditing tools. The activities presented in the self-assessment did not consistently correlate with the Settlement Agreement Monitoring Tool. The activities reported appeared to be related to the content in the Monitoring Team's reports, but it was unclear how some of this data was being collected. Based on a review of the Facility Self-Assessment, the monitoring/audit templates and instructions/guidelines, a sample of completed monitoring/auditing tools, inter-rater reliability data, as well as interviews with staff: ○ The monitoring/audit tools the Facility used to conduct its self-assessment included: Settlement Agreement Monitoring Tool for Section O. ○ This monitoring/audit tool did not include adequate indicators to allow the Facility to determine compliance with the Settlement Agreement. The Facility is encouraged to review the Monitoring Team's report to identify indicators that are relevant to making compliance determinations. ○ The monitoring tools included adequate methodologies, such as observations, record review and staff interview. For example, the monitoring tool guidelines instructed the

	reviewer to complete record reviews, conduct observations of an individual communicating, and for individuals with AAC devices the reviewer was to check to see the device was in working order and available for use. o The Self-Assessment identified the sample(s) sizes. However, the Facility had not identified the number of individuals/records reviewed in comparison with the number of individuals/records in the overall population (i.e., n/N for percent sample size). o The monitoring/audit tools did not have adequate instructions/guidelines to ensure consistency in monitoring and the validity of the results. o The following staff/positions were responsible for completing the audit tools: Speech Language Pathologists and Program Compliance Monitor. o The staff responsible for conducting the audits/monitoring had not been deemed competent in the use of the tools. o Adequate inter-rater reliability had not been established between the various Facility staff responsible for the completion of the tools. ▪ Did use other relevant data sources and/or key indicators/outcome measures. For example, the Facility had reviewed Individual Support Plans for information on how an individual communicates and implementation of assistive communication interventions that were functional and adaptable in a variety of settings. However, as the Facility refines its self-assessment processes, it should identify and use other relevant sources of information. ▪ The Facility consistently did not present data in a meaningful/useful way. Specifically, the Facility's Self-Assessment: o Did not present findings consistently based on specific, measurable indicators o Did not consistently measure the quality as well as presence of items. o Did not distinguish data collected by the QA Department versus the program/discipline. ▪ The Facility rated itself as being in compliance with none of the sub-sections of Section R. This was consistent with the Monitoring Team's findings. ▪ The Facility data identified areas of need/improvement. However, for these areas of need, the Facility Self-Assessment did not provide an 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.
	Summary of Monitor's Assessment: At the time of the review, the Facility had four full-time SLPs. In addition, there was a SLP intern. There was one SLP vacancy. The Facility documented appropriate qualifications for licensed SLPs. Four of four full-time SLP staff (100%) had completed continuing education relevant to communication and transferrable to the population served. An evaluation of individuals' SL comprehensive assessments revealed these assessments were missing some essential components. Observations by the Monitoring Team and the lead SLP of individuals with AAC systems noted an improvement in the presence of some of these individuals' AAC systems. In addition, some staff had been provided with individual-specific competency-based training and performance check-offs to demonstrate

	their competency in supporting individuals in the use of their AAC systems. Although the Facility's Communication Services policy included some important components, a number were missing. It did not include the following key elements: monitoring for the use of communication adaptive equipment in multiple environments (e.g., home, day program, work); the process for identification, training, and validation for monitors; the process of achieving inter-rater reliability; and a process for data trend analysis and utilization of findings to drive training and problem resolution (individual and systemic).

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R1	Commencing within six months of the Effective Date hereof and with full implementation within 30 months, the Facility shall provide an adequate number of speech language pathologists, or other professionals, with specialized training or experience demonstrating competence in augmentative and alternative communication, to conduct assessments, develop and implement programs, provide staff training, and monitor the implementation of programs.	**Samples for Section R:** ▪ **Sample R.1:** 10 individuals with a SLP Comprehensive Assessment completed in the last 12 months including: Individual #274, Individual #95, Individual #48, Individual #304, Individual #374, Individual #185, Individual #13, Individual #529, Individual #349 and Individual #5; ▪ **Sample R.2:** five individuals receiving direct speech services including: Individual #163, Individual #92, Individual #81, Individual #374, and Individual #274; ▪ **Sample R.3:** Eight individuals with a PBSP and communication deficits including: Individual #250, Individual #418, Individual #163, Individual #280, Individual #393, Individual #39, Individual #374, and Individual #150; and ▪ **Sample R.4:** 10 individuals with AAC systems including: Individual #479, Individual #390, Individual #287, Individual #109, Individual #250, Individual #418, Individual #429, Individual #393, Individual #480, and Individual #542; **Staffing** At the time of the review, the Facility had four full-time SLPs. In addition, there was a SLP intern. There was one SLP vacancy. Based on the documentation provided, the following chart represents the caseload of the Facility SLPs:	Noncompliance

Speech Language Pathologists	Current Caseload
SLP #1	Lead SLP and supported 163 individuals in Residences 5972 (24 individuals), 6330 (21), 6350 (18), 6360 (19), 6370 (22), 6450 (22), 6521 (22), and 6750 (15)
SLP #2	Supported 116 individuals in Residences 5962 (26 individuals), 6390 (six), 6400 (18), 6510 (24), 6720 (15), 6730 (15), and 6740 (13)
SLP #3	Supported 136 individuals in Residences 5961 (26 individuals), 5971 (24), 6480 (22), 6500 (23), 6690

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	(15), 6710 (14), 6760 (12)
Contract SLP #4	Did not carry a caseload, responsible for completing SLP assessments
SLP Intern #5	Began as an SLP intern on 7/2/12. She will be assigned a caseload upon completion of her training.

The Facility did not indicate what an adequate caseload for SLPs at Abilene would be to provide services and supports to individuals with communication needs. The Facility should complete an analysis, including consideration of the various requirements of the job, as well as the acuity of the individuals in relation to SLP needs.

Qualifications

The Facility had documentation to show appropriate qualifications for licensed SLPs.

- Four of four full-time SLP staff (100%) were licensed to practice in the state of Texas.
- Four of four full-time SLP staff (100%) had evidence of American Speech and Hearing Association certification.

Continuing Education

Documentation of continuing education courses completed by the SLPs was submitted. Based on documentation submitted, no State-sponsored webinars were offered in the past six months. The continuing education attended by the clinicians included the following topics:

- On 2/9/12, SLP #2 attended Autism: Evidence Based Practice – What does this Mean for Assistive Technology Implementation;
- On 4/17/12, SLP #2 attended Switch Access to iPad for Communication;
- On 5/2/12, SLP #3 attended Swallowing Issues in Individuals with Tracheostomy, Ventilator, and Respiratory Compromise;
- On 5/21/12, SLP #3 attended Cognitive Communication Strategies for Dementia;
- On 6/12/12, SLP #2 attended Promoting Active Communication Opportunities for Unique Learners;
- On 7/4/12, SLP #3 attended Practically Speaking: AAC Strategies for Beginning Communicators;
- On 8/1/12 and 8/2/12, SLP #1, SLP #2, SLP #3, SLP Intern, and SLP Assistant attended Evidence-based Practice for AAC Evaluations – From A & P to Rec: Building the Meaning Behind the Acronyms.

Based on a review of continuing education completed since the last review:

- Four of four full-time SLP staff (100%) had completed continuing education relevant to communication and transferrable to the population served.

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		Facility Policy In addition to the Facility's adherence to the State Communication Services policy, ABSSLC had a Specific Policy/Procedures for Speech Language Pathology, undated, which had not been revised since the last review. The Facility policy did not provide clear operationalized guidelines for the delivery of communication supports and services. The following components were included in this policy: ▪ Timelines for completion of new admission assessments (within 30 days of admission or readmission). The following components were not included in this policy: ▪ Roles and responsibilities of the SLPs (e.g., meeting attendance, staff training etc.); ▪ Outline of an assessment schedule; ▪ Frequency of assessments/updates; ▪ Timelines for completion of comprehensive assessments (within 30 days of identification via screening); ▪ Timelines for completion of Comprehensive Assessment/Assessment of Current Status for individuals with a change in health status potentially affecting communication (within five days of identification as indicated by the IDT); ▪ A process for effectiveness monitoring by the SLP; ▪ Criteria for providing an update (Assessment of Current Status) versus a Comprehensive Assessment; ▪ Methods of tracking progress and documentation standards related to intervention plans; and ▪ Monitoring of staff compliance with implementation of communication plans/programs, including frequency, data and trend analysis, as well as, problem resolution. The Facility should expand the local Communication Services policy to incorporate these essential components.	
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	**Assessment Plan** The Master SLP Evaluation Plan was based on the following priorities: ▪ Priority 1 - Individuals with high-risk behaviors who do not communicate verbally; ▪ Priority 2 - Individuals with high-risk behavior who communicate verbally; and ▪ Priority 3 – Everyone else who had not had a comprehensive evaluation since the Settlement Agreement was initiated. Based on information provided by the Facility, once individuals received a	Noncompliance

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	or augmentative communication systems, including systems involving behavioral supports or interventions.	comprehensive SLP assessment, individuals meeting certain criteria would move to an annual status for updates or rolling assessments. Updates (i.e., rolling assessments) would be maintained annually for the following individuals: school-aged individuals, individuals in therapy, individuals with AAC devices, individuals with input communication devices, individuals who were functionally verbal with a clarification device, and individuals with an electronic aid for daily living pertaining to communication. Individuals who were new admissions or experienced a change in status would be evaluated immediately. The ABSSLC Communication Master Plan SLP Evaluation Tracking included the following fields: name, case number, home, date of birth, administration date, update, priority number, ISP date, most recent evaluation, date issued to therapists, and name of therapist. The projected timeline for the completion of SLP assessments for individuals using the new State SLP assessment template was December 31, 2012. However, no data was presented to identify the Facility's progress toward this goal. The Facility should analyze the SLP assessment tracking system and present data in the Facility Self-Assessment. Such data should identify the number of individuals who require a SLP comprehensive assessment (N) and the number of individuals who have received an assessment (n). **New Admissions** Since the Monitoring Team's last review, the only individual that had been admitted to ABSSLC was admitted shortly before the Monitoring Team's onsite review. As a result, a 30-day assessment was not yet due. **Communication Assessment** A Speech Language comprehensive assessment should include the following essential components: ▪ Signature and date by the clinician upon completion of the written report; ▪ Date showing it was completed 10 working days prior to the annual ISP; ▪ Diagnoses and relevance of impact on communication; ▪ Individual preferences, strengths, and needs; ▪ Medical history and relevance to communication; ▪ Medications and side effects relevant to communication; ▪ Documentation of how the individual's communication abilities impact their risk levels; ▪ Description of verbal and nonverbal skills with examples of how the individual utilizes these skills in a functional manner throughout the day;	

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		▪ Evidence of observations by SLPs in the individual's natural environments (e.g., day program, home, work); ▪ Evidence of discussion of the use of a Communication Dictionary, as appropriate, as well as the effectiveness of the current version of the dictionary with necessary changes as required for individuals who do not communicate verbally; ▪ Discussion of the expansion of the individual's current abilities; ▪ Discussion of the individual's potential to develop new communication skills; ▪ Effectiveness of current supports, including monitoring findings; ▪ A description of the individual's AAC needs, including clear clinical justification and rationale as to whether the individual would benefit from an AAC device/system; ▪ Comparative analysis of health and functional status from the previous year; ▪ Comparative analysis of current communication function with previous assessments; ▪ Identification of the need for direct or indirect speech language services, as appropriate; ▪ Specific and individualized strategies to ensure consistency of implementation among various staff; ▪ Reassessment schedule; ▪ Monitoring schedule; ▪ Recommendations for direct interventions and/or skill acquisition programs, as appropriate, including the use of AAC as indicated for individuals with identified communication deficits; ▪ A recommendation regarding the individual's appropriateness for community placement; and ▪ Manner in which strategies, interventions, and programs should be utilized throughout the day. Ten individuals' Speech Language comprehensive assessments (i.e., Individual #274, Individual #95, Individual #48, Individual #304, Individual #374, Individual #185, Individual #13, Individual #529, Individual #349, and Individual #5) in Sample R.1 were evaluated for the presence of the following essential components: ▪ Six of 10 individuals' SL assessments (i.e., Individual #95, Individual #48, Individual #274, Individual #374, Individual #13, and Individual #304) (60%) were signed and dated by the clinician upon completion of the written report; ▪ One of seven individuals' SL assessments (i.e., Individual #95) (14%) were dated as completed 10 working days prior to the annual ISP. The SLP did not date the assessments for Individual #349, Individual #529, and Individual #5. Consequently, it could not be determined if the assessment was completed 10 working days prior to the ISP; ▪ Two of 10 individuals' SL assessments (i.e., Individual #13 and Individual #304)	

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		(20%) included diagnoses and relevance of impact on communication; ▪ Seven of 10 individuals' SL assessments (i.e., Individual #349, Individual #95, Individual #374, Individual #13, Individual #5, Individual #185, and Individual #304) (70%) included individual preferences, strengths, and needs; ▪ Four of 10 individuals' SL assessments (i.e., Individual #48, Individual #274, Individual #13, and Individual #304) (40%) included medical history and relevance to communication; ▪ Six of 10 individuals' SL assessments (i.e., Individual #349, Individual #95, Individual #529, Individual #5, Individual #185, and Individual #304) (60%) listed medications and discussed side effects relevant to communication; ▪ One of 10 individuals' SL assessments (i.e., Individual #304) (10%) provided documentation of how the individual's communication abilities impacted his/her risk levels; ▪ Three of 10 individuals' SL assessments (i.e., Individual #349, Individual #13, and Individual #304) (30%) incorporated a description of verbal and nonverbal skills with examples of how these skills were utilized in a functional manner throughout the day; ▪ Two of 10 individuals' SL assessments (i.e., Individual #304 and Individual #13) (20%) provided evidence of observations by the SLs in the individuals' natural environments (e.g., day program, home, work); ▪ None of seven individuals' SL assessments (0%) contained evidence of discussion of the use of a Communication Dictionary, as appropriate, as well as the effectiveness of the current version of the dictionary with necessary changes as required for individuals who did not communicate verbally. Individual #95, Individual #48, and Individual #304 communicated verbally; ▪ Five of 10 individuals' SL assessments (i.e., Individual #349, Individual #95, Individual #274, Individual #13, and Individual #304) (50%) included discussion of the expansion of the individuals' current abilities; ▪ Five of 10 individuals' SL assessments (i.e., Individual #349, Individual #95, Individual #274, Individual #13, and Individual #304) (50%) provided a discussion of the individuals' potential to develop new communication skills; ▪ None of 10 individuals' SL assessments (0%) included the effectiveness of current supports, including monitoring findings; ▪ Five of the 10 individuals' SL assessments (i.e., Individual #95, Individual #48, Individual #274, Individual #13, and Individual #304) (50%) assessed AAC needs, including clear clinical justification and rationale as to whether the individual would benefit from AAC; ▪ None of 10 individuals' SL assessments (0%) offered a comparative analysis of health and functional status from the previous year; ▪ Three of 10 individuals' SL assessments (i.e., Individual #349, Individual #95 and Individual #529) (30%) gave a comparative analysis of current	

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		communication function with previous assessments; ▪ Ten of 10 individuals' SL assessments (100%) identified the need for direct or indirect speech language services, or justified the rationale for not providing it; ▪ One of 10 individuals' SL assessment (i.e., Individual #349) (10%) had specific and individualized strategies outlined to ensure consistency of implementation among various staff; ▪ Six of 10 individuals' SL assessments (i.e., Individual #95, Individual #48, Individual #274, Individual #374, Individual #13, and Individual #304) (60%) had a reassessment schedule; ▪ None of the 10 individuals' SL assessments (0%) supplied a monitoring schedule; ▪ Ten of 10 individuals' SL assessments (100%) had recommendations for direct interventions and/or skill acquisition programs, including the use of AAC devices/systems, as indicated for individuals with identified communication deficits; ▪ Ten of 10 individuals' SL assessments (100%) made a recommendation about the appropriateness for community transition; and ▪ None of the 10 individuals' SL assessments (0%) defined the manner in which strategies, interventions, and programs should be utilized throughout the day. Although some of the assessments included some promising practices, these 10 individuals' SL comprehensive assessments were missing essential components and, consequently were not adequate comprehensive SL assessments. The SLPs should consider each of these essential components when completing assessments to ensure assessments are comprehensive as required by the Settlement Agreement. The Facility had developed an assessment audit tool, but the tool had not been implemented. The Facility should expand the assessment audit tool to incorporate the preceding essential components. **SLP and Psychology Collaboration** Based on review of eight individual's records in Sample #R.3 with Positive Behavior Support Plans (PBSPs) (i.e., Individual #250, Individual #418, Individual #163, Individual #280, Individual #393, Individual #39, Individual #374, and Individual #150), the following was noted: ▪ None of eight communication assessments and PBSPs reviewed (0%) addressed the connection between the PBSP and the recommendations contained in the communication assessment. ▪ None of eight communication assessments reviewed (0%) contained evidence of review of the PBSP by the SLP. The assessment should offer information on collaboration between the SLP and the psychologist related to functional communication and behavioral concerns. The SLP assessment and PBSP should	

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		discuss how related recommendations will be made to the team to improve and enhance functional communication skills. In order for the records to be considered compliant, collaboration between the SLP and psychologist/behavior analyst related to assessment findings, including an analysis of associated communication and behavioral concerns should have been documented. In addition, this discussion should have included the development and implementation of related direct and indirect supports (i.e. skill acquisition programs) as appropriate to improve and enhance communication skills. Although the SLP assessments for Individual #374 and Individual #150 indicated there was collaboration between the SLP and psychologist/behavior analyst, they did not show evidence of these activities. Based on review of the Positive Behavior Support Committee meeting attendance sheets from 2/8/12 to 7/2/12, participation by a SLP was noted in 17 of the 21 meetings (81%).	
R3	Commencing within six months of the Effective Date hereof and with full implementation within three years, for all individuals who would benefit from the use of alternative or augmentative communication systems, the Facility shall specify in the ISP how the individual communicates, and develop and implement assistive communication interventions that are functional and adaptable to a variety of settings.	**Integration of Communication in the ISP** Based on review of the ISPs for 11 individuals in Sample R.4 who had AAC devices (i.e. Individual #479, Individual #390, Individual #287, Individual #109, Individual #250, Individual #418, Individual #429, Individual #393, Individual #480, Individual #92, and Individual #542), the following was noted: ▪ In nine of 11 ISPs reviewed for individuals with communication needs (i.e., Individual #479, Individual #390, Individual #287, Individual #109, Individual #250, Individual #429, Individual #480, Individual #92, and Individual #542) (82%), a SLP attended the annual meeting. ▪ In seven of 11 ISPs reviewed (i.e., Individual #287, Individual #390, Individual #479, Individual #393, Individual #542, Individual #418, and Individual #92) (63%), the type of AAC device/system and/or communication supports (might include, but not be limited to, the Communication Dictionary and strategies for staff use) was identified. ▪ Communication Dictionaries for none of the 11 individuals (0%) were reviewed at least annually by the IDT as evidenced in the ISP. ▪ One of 11 ISPs reviewed (i.e., Individual #479) (9%) included a description of how the individual communicated, including the AAC system if they had one. ▪ None of 11 ISPs reviewed (0%) included how communication interventions were to be integrated into the individuals' daily routines. ▪ None of 10 ISPs reviewed (0%) contained skill acquisition programs to promote functional communication. The individuals' ISPs should include: attendance by a SLP for individuals with communication needs; the type of AAC device/system and/or communication supports provided and their effectiveness; review of the effectiveness of the current version of	Noncompliance

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		communication dictionary and description of necessary changes, as appropriate; a description of how the individual communicates including the AAC system, if they have one; and how communication interventions will be integrated into the individual's daily routine. **Individual-Specific AAC Systems** The Monitoring Team and the SLP Lead conducted observations in residences (i.e., 6400, 6380, and 6450) the OT/PT Center, a vocational area, day program, and the Senior Center for seven individuals identified by the Facility with AAC systems (i.e., Individual #480, Individual #92, Individual #287, Individual #390, Individual #382, Individual #280, and Individual #109). Observation findings included the following: ▪ AAC systems for five of the seven individuals (i.e. Individual #480, Individual #287, Individual #390, Individual #382, and Individual #280) (71%) were present. The presence of AAC systems for individuals was an improvement from observations conducted during previous reviews. ▪ AAC systems for none of seven individuals (0%) were noted to be in use. ▪ For five of seven individuals with AAC systems (i.e. Individual #480, Individual #287, Individual #390, Individual #382, and Individual #280) (71%), staff instructions/skill acquisition plans related to the AAC system were available. **General-Use AAC Devices** The Facility provided a List of General Common Area Devices that identified the location, type of device, and intent of device. The SLP Lead acknowledged that additional work needed to be completed to enhance the functionality of general-use AAC devices in residences and other environments. The Monitoring Team agrees the Facility should re-assess the functionality of general-use AAC devices in residences and other environments. **Direct Communication Interventions** At the time of the review, nine individuals received direct speech interventions. Direct communication-related intervention plans and supporting documentation (i.e., progress notes) for five individuals in Sample R.2 who received direct speech services (i.e., Individual #163, Individual #92, Individual #81, Individual #374, and Individual #274) were reviewed. Comprehensive progress notes related to communication interventions should include: ▪ Information regarding whether the individual showed progress with the stated goal. ▪ A description of the benefit of the device and/or goal to the individual. ▪ A report regarding the consistency of implementation. ▪ Recommendations/revisions to the communication intervention plan as	

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		indicated related to the individual's progress or lack of progress. For none of five individuals (0%), documentation of the SLP's review of communication interventions was comprehensive. The progress notes did not incorporate the essential components outlined above. **Indirect Communication Supports** Individuals with AAC devices did not have indirect communication supports/programs designed to assist the individuals and/or staff in using the AAC device or to enhance their skills in utilizing the AAC system. For such indirect supports, the SLPs monthly documentation should: ▪ Provide information regarding whether the individual showed progress with the stated goal(s); ▪ Describe the benefit of device and/or program for the individual(s); ▪ Identify whether or not implementation is consistent; and ▪ Identify recommendations/revisions to the program as indicated in reference to the individual's progress or lack of progress. The completion of monthly progress notes should provide effectiveness review/monitoring of the individual's progress with direct and/or indirect SL supports. **Competency-Based Training and Performance Check-offs:** The NEO curriculum for communication was not submitted. Core Communication Competencies, dated 6/19/12, presented the following rationale for communication: "We communicate all the time. Some of us just communicate differently because of who we are. We have to know the people we work with and honor those differences by helping them communicate as well as they can." In addition, this document presented the following information: ▪ Read the PNMP or Communication Dictionary in the Individual Notebook to find out how an individual communicates; ▪ Approach individuals from the front at eye level so they can see you; ▪ Tell them what is going on around them (i.e., parallel talk), using short, simple sentences; ▪ Individuals communicate with pictures (i.e., wall mounted communication pictures, communication books, computers, and other devices), gestures, sign language, objects or object cues, and writing or printing; ▪ Show interest and prompt individuals to use the ways they communicate best; and ▪ Pay attention and watch. The communication performance check-off, dated 6/19/12, required new employees to:	

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		▪ Define the rationale for why communication was important; ▪ Read an individual's PNMP communication section or Communication Dictionary and discuss the individual's communication skills; ▪ Demonstrates how to approach someone; ▪ Based on PNMP instructions, use the recommended strategies; and ▪ To test paying attention, the new employee was to watch the reviewer, interpret what is happening, and intervene. The development of communication core competencies was a positive step forward. However, the Facility should review the foundational communication training to assess if the following essential components were provided in the training provided to new employees and current staff: ▪ Methods to enhance communication; ▪ Implementation of programs; ▪ Benefits and use of AAC devices/systems; ▪ Identification of non-verbal means of communication; ▪ Opportunities for active participation and practice of the skills necessary for appropriate implementation of communication programs, AAC device/systems use, and strategies for effective communication partners; and ▪ Adequacy of skill performance check-offs. Two hundred fifty-eight new employees had completed Deaf Awareness. In the future, the Facility should provide the total number of current staff who required training (N) and the number of current staff who have completed foundational communication training (n) to yield a percent of training compliance. This data should be provided for new employees as well as current staff who have participated in training and performance check-offs. **Individual Specific Competency-Based Training** The Speech Alternative Augmentative Communication and Electronic Aids to Daily Living Equipment Spreadsheet identified 70 individuals with AAC devices, 48 individuals with input devices and 57, individuals with electronic aids to daily living (EADL). The Facility reported the staff for twenty-one individuals with AAC systems completed individual-specific competency-based training and performance check-offs. The data presented identified the number of staff per individual (N) and the number of staff trained (n). Four individuals' staff in Sample R.3 (i.e. Individual #479, Individual #390, Individual #287, and Individual #109) had completed individual-specific communication performance check-offs.	

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R4	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall develop and implement a monitoring system to ensure that the communication provisions of the ISP for individuals who would benefit from alternative and/or augmentative communication systems address their communication needs in a manner that is functional and adaptable to a variety of settings and that such systems are readily available to them. The communication provisions of the ISP shall be reviewed and revised, as needed, but at least annually.	**Monitoring System** The local policy (i.e., ABSSLC Specific Policy/Procedures for Speech-Language Pathology that had been developed in addition to the DADS Communication policy), undated, defined monitoring of communication supports as follows: ▪ Equipment was monitored monthly for presence, condition, and function; ▪ Use of personal evaluation driven AAC devices to be monitored monthly during a 20-minute snapshot; ▪ Monitoring results were to be represented in a chart with a trend line noted. However, the Facility reported procedures were not in place to analyze monitoring results; and ▪ Monitoring results were to be shared with administration, Unit Directors and home supervisors. However, the policy did not address the following key elements: ▪ Monitoring for the use of communication adaptive equipment in multiple environments (i.e., home, day program, work); ▪ The process for identification, training, and validation for monitors; ▪ The process of inter-rater reliability; and ▪ A process for data trend analysis and utilization of findings to drive training and problem resolution (i.e., individual and systemic). The Facility should expand the local policy to include these essential components. Based on interview and documentation submitted, Habilitation Services Department staff's review of monitoring data confirmed that speech equipment was not being monitored at a frequency to ensure direct support professionals' consistent use of the equipment with individuals. As a result of this concern, the Director of Habilitation Services initiated the following: ▪ PNMP Coordinators were instructed to make monitoring of the use, condition, and function of speech equipment part of their routine monitoring for everyone who had a PNMP; and ▪ The Supervisor of Habilitation Therapy Technicians and Habilitation Therapy Technicians working in the homes across campus were instructed to model the use of speech books and equipment throughout the day. This initiative was to ensure equipment was operable and in good condition. These initiatives should be formalized in the Facility local policy. Based on documentation submitted, the Facility HT Department staff (i.e., SLPs, SLP Assistants, Habilitation Therapy Technicians, and PNMP Coordinators) implemented the	Noncompliance

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		Compliance Monitoring form to monitor individuals' communication equipment. The Facility reported the following information for each form: date monitoring form(s) use was initiated, presence of monitoring form instructions, staff positions responsible for monitoring, process used to confirm monitors' competency with the use of the forms, monitoring schedule, monitoring schedule for individuals at high risk, how monitoring forms were analyzed and by whom, and Facility protocols for the monitoring forms. This information further defined the Facility's protocols for the implementation of these forms. However, additional work was needed to establish inter-rater agreement between Habilitation Therapy Technicians and PNMP Coordinators and the therapists to establish Habilitation Therapy Technicians and PNMP Coordinators' competency in the completion of these forms. The Facility did not provide monitoring reports analyzing and trending results from the Compliance Monitoring Forms related to communication. These reports should address at a minimum the following indicators: ▪ Compliance with established monitoring frequency; ▪ Equipment presence; ▪ Equipment in working order; ▪ Equipment used in various environments; and ▪ In the case a problem was identified, there was evidence of resolution. Compliance Monitoring forms for the last six months for eleven individuals in Sample R.4 (i.e., Individual #479, Individual #390, Individual #287, Individual #109, Individual #250, Individual #418, Individual #429, Individual #393, Individual #480, Individual #92 and Individual #542) were reviewed and the following was found: ▪ None of 11 individuals (0%) were monitored at the recommended frequency; ▪ None of 11 individuals (0%) were monitored for the presence of their communication system; ▪ Monitoring for none of the 11 individuals (0%) included review of whether or not their communication system was in working order; and ▪ None of the 11 individuals (0%) were monitored for use in a variety of environments. The primary concern was these individuals' records did not provide completed Compliance Monitoring forms with the exception of Individual #92. One Compliance Monitoring form had been completed on 4/30/12 for Individual #92. This was problematic.	

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

1. The Facility should complete an analysis, including consideration of the various requirements of the job, as well as the acuity of the individuals in relation to SLP needs. (Section R.1)
2. The Facility should expand the local Communication Services policy to incorporate the following essential components:
    a. Roles and responsibilities of the SLPs (e.g., meeting attendance, staff training etc.);
    b. Outline of an assessment schedule;
    c. Frequency of assessments/updates;
    d. Timelines for completion of comprehensive assessments (within 30 days of identification via screening);
    e. Timelines for completion of Comprehensive Assessment/Assessment of Current Status for individuals with a change in health status potentially affecting communication (within five days of identification as indicated by the IDT);
    f. A process for effectiveness monitoring by the SLP;
    g. Criteria for providing an update (Assessment of Current Status) versus a Comprehensive Assessment;
    h. Methods of tracking progress and documentation standards related to intervention plans; and
    i. Monitoring of staff compliance with implementation of communication plans/programs, including frequency, data and trend analysis, as well as, problem resolution. (Section R.1)
3. The Facility should analyze the SLP assessment tracking system and present data in the Facility Self-Assessment to identify the number of individuals who require a SLP comprehensive assessment (N) and the number of individuals who have received an assessment (n). (Section R.2)
4. The Facility should review the revised SL assessment template and content guidelines to ensure the essential components for SL comprehensive assessments are addressed. The SLPs should consider each of these elements as they complete assessments to ensure assessments are comprehensive as required by the Settlement Agreement. In addition, the SL audit should include these elements. (Section R.2)
5. The Facility should ensure communication assessments and PBSPs address the connection between the PBSP and the recommendations contained in the communication assessment, as well as contain evidence of review of the PBSP by the SLP. (Section R.2)
6. Individuals' ISPs should include: attendance by a SLP for individuals with communication needs; the type of AAC device/system and/or communication supports provided and their effectiveness; review of the effectiveness of the current version of communication dictionary, and identification of necessary changes as appropriate; a description of how the individual communicates, including the AAC system, if they have one; and how communication interventions will be integrated into the individual's daily routine. (Section R.3)
7. The Facility should re-assess the functionality of general-use AAC devices in residences and other environments. (Section R.3)
8. The Facility should ensure comprehensive progress notes related to communication interventions for direct and indirect supports:
    a. Contain information regarding whether the individual showed progress with the stated goal;
    b. Describe the benefit of device and/or goal to the individual;
    c. Report on whether there is consistency in implementation; and
    d. Identify recommendations/revisions to the communication intervention plan, as indicated, related to the individual's progress or lack of progress. (Section R.3)
9. The Facility's monitoring policy for communication devices should include:
    a. Monitoring for the use of communication adaptive equipment in multiple environments (i.e., home, day program, work);
    b. The process for identification, training, and validation for monitors;
    c. The process to establish inter-rater reliability; and
    d. A process for data trend analysis and utilization of findings to drive training and problem resolution (i.e., individual and systemic). (Section R.4)
10. The Facility's monitoring reports should address, at a minimum, the following indicators:
    a. Compliance with established monitoring frequency;

b. Equipment presence;
c. Equipment in working order;
d. Equipment used in various environments; and
e. In the case a problem was identified, there was evidence of resolution. (Section R.4)

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 8/20/12; o Section S Presentation Book; o Section S Self-Assessment, updated 8/8/12; o Training materials: New ISP Facilitation, Preferences and Strengths Inventory, ISP Preparation, and Skill Acquisition Plan Process; o Training materials: Active Treatment/Skill Acquisition Training; o Annual Integrated Risk Rating Form (IRRF), dated 5/31/12; o Individual Support Plan Process Policy; o ISP Preparation Meeting outline; o Individual Support Plans for: Individual #87, Individual #267, Individual #517, Individual #540, Individual #65, Individual #61, Individual #95, Individual #216, Individual #518, Individual #307, Individual #156, Individual #81, Individual #120, Individual #455, Individual #48, Individual #315, Individual #49, Individual #89, Individual #201, Individual #355, Individual #135, Individual #231, Individual #533, Individual #461, Individual #320, Individual #252, Individual #397, Individual #525, Individual #148, and Individual #150; o Individual Support Plan Addenda for: Individual #87, Individual #517, Individual #540, Individual #120, Individual #48, Individual #315, Individual #89, Individual #231, Individual #533, Individual #461, Individual #320, and Individual #525; o Skill Acquisition Program (SAP) and accompanying data sheets for: Individual #305, Individual #61, Individual #534, Individual #509, Individual #29, Individual #156, Individual #546, Individual #502, Individual #442, Individual #462, Individual #3, Individual #241, Individual #34, Individual #150, and one individual for whom only the first name was provided; o Training Documentation Reports for: Individual #87, Individual #267, Individual #213, Individual #517, Individual #540, Individual #65, Individual #216, Individual #518, Individual #218, Individual #156, Individual #145, Individual #120, Individual #315, Individual #89, Individual #201, Individual #355, Individual #268, Individual #231, Individual #274, Individual #461, Individual #397, Individual #525, Individual #148, Individual #142, Individual #150, and Individual #152; o Skill Acquisition Programs for: Individual #95, Individual #48, and Individual #533; o Skill Acquisition Program In-service Dates – training provided by J. Borgerding, Active Treatment Coordinator; o Training Rosters of IDT members, ISP Process, provided by Ric Savage, consultant, 7/10/12 and 7/11/12; o Skill Acquisition Training Competency Checklist, dated 5/2/12;

	○ Skill Acquisition Training Monitoring (ABSSLC QDDP Monitoring Forms); ○ ABSSLC PLACheck Monitoring Form; ○ Instructions for Engagement and Active Treatment Monitoring; ○ Personal Focus Assessments (PFA) for: Individual #87, Individual #213, Individual #540, Individual #61, Individual #95, Individual #518, Individual #375, Individual #145, Individual #120, Individual #49, Individual #89, Individual #201, Individual #268, Individual #231, Individual #533, Individual #461, Individual #320, Individual #67, Individual #525, and Individual #148; ○ Functional Skills Assessments (FSA) for: Individual #517, Individual #540, Individual #65, Individual #61, Individual #151, Individual #95, Individual #307, Individual #375, Individual #218, Individual #156, Individual #120, Individual #48, Individual #315, Individual #89, Individual #318, Individual #355, Individual #274, Individual #533, Individual #461, Individual #46, Individual #252, Individual #397, Individual #525, and Individual #150; ○ Positive Assessment of Living Skills (PALS) for Individual #87; ○ Functional Skills Assessment Monitoring Tool ICF Plan of Correction (PoC); ○ Functional Skills Assessment Summary template, dated 7/12; ○ List of Vocational Assessments completed between 2/1/12 and 7/5/12; ○ Vocational Assessments for: Individual #418, Individual #424, Individual #375, Individual #460, Individual #355, Individual #107, Individual #287, Individual #189, Individual #397, Individual #225, Individual #133, and Individual #291; and ○ Vocational Assessment Report and related Employee Vocational Exploration documentation for: Individual #189 and Individual #170. ▪ **Interviews with**: ○ Candia Hallford, Vocational Services Director, on 8/21/12; and ○ Jeff Branch, Active Treatment Coordinator, and Ron Manns, Director of Behavioral Services, on 8/22/12. ▪ **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, Activity Center 6380, Activity Center 6460, and Activity Center 6700; ○ Senior Center; ○ Workshop 1, Workshop 2, and Workshop 3; ○ 5th Street Diner; ○ Re-admission meeting for Individual #94, on 8/20/12; ○ Center Incident Management Review Team meeting, on 8/20/12; ○ Daily Incident Monitoring meeting, Unit IV, on 8/22/12; and ○ Participation in Monitoring Team's review of Community Living Discharge Plan for

	Individual #272, on 8/22/12.
	Facility Self-Assessment: The Facility had developed a monitoring tool, along with guidelines for its use, to assess compliance with Section S of the Settlement Agreement. Below is a summary of the information gathered based on a review of the Facility Self-Assessment, the monitoring tool, the monitoring tool guidelines, and staff interview: ▪ The monitoring tool used to complete the self-assessment was divided into three sections. Section S.1 addressed "Adequate Habilitation Training Provided to Individuals." This included a review of the Individual Support Plan with particular focus on individual preferences and assessments used to guide programming; the content of the Skill Acquisition Programs, including observable and measurable behavioral objectives, clear instructions for teaching, specified schedules of training, and planning for maintenance and generalization of skills learned; indication that frequent refusals would trigger a review of the program; and finally, collection of inter-observer agreement measures. Section S.2 included five indicators, reviewing the Facility's use of assessments of living, working, and leisure skills to identify preferences, strengths, needs, barriers to successful community inclusion, and recommendations for habilitation services. Section S.3 focused on effective interventions provided in the most integrated setting possible, including the community. ▪ The monitoring tool was a good step in ensuring compliance with the Settlement Agreement. To identify additional indicators, such as inclusion of the Integrated Risk Rating Form in the ISP, the Facility is encouraged to review the Monitoring Team's reports. ▪ The Facility Self-Assessment identified a sample size of six individual records reviewed between 3/1/12 and 6/30/12. As the Facility served 411 individuals at the time of the visit, this sample size represented less than 1% of the population and was not considered adequate. As noted in the Self-Assessment, the designated QDDP and the Program Compliance Monitor assigned to Section S completed this audit. Measures of inter-rater reliability were not reported. ▪ The Facility Self-Assessment identified a review of engagement data from a pilot program introduced in one living unit between 6/3/12 and 7/21/12. The Self-Assessment did not identify the staff completing this audit and measures of inter-rater reliability were not reported. Graphs depicting engagement scores and measures of active treatment probes were included in the Presentation Book. ▪ The guidelines for the monitoring tool were not always specific enough to provide objective assessment of Facility compliance. For example, under S.1.6, teaching strategy was identified as chaining. Not all skills will consist of behavioral chains. Further the explanation of a backward chain was confusing, because staff were advised that the individual should start with the last step and work backward. This implied that the chain is not taught as a functional routine. Additionally, staff were told to review SAPs for a sufficient number of trials per training session and frequent refusals, yet neither "sufficient" nor "frequent" were identified in measurable terms. The guidelines for Section S.2 were vague, because recommendations for habilitation were identified as "whatever the assessment's recommendations are at the end of the assessment." The Facility should consider more specific guidelines for recommendations. For example, the Functional Skills Assessment the Facility employed included a section to summarize the individual's strengths and needs in each of 13 areas assessed. The needs identified could then be addressed in recommended

	habilitation goals. The guidelines could direct auditors to review these recommendations to ensure teams had considered them in their deliberations related to appropriate SAPs. In Section S.3, the guidelines were very brief, noting only that this section was addressed by the new PLACHECK engagement monitoring tool and the new Section F monitoring tool. It was unclear how a measure of engagement at the Facility would address the provision of effective services in the most integrated setting. ▪ The Facility did not present other relevant data or outcome measures to support its efforts to meet the requirements of the Settlement Agreement in Section S. ▪ The Facility presented aggregate data and did not outline data related to each identified indicator. In the future, it will be helpful to have data presented across each indicator, with ranges and averages noted. ▪ In addition, the quality of the items rated was not assessed. ▪ The Facility rated itself as out of compliance with all sub-sections of Section S. This was consistent with the findings of the Monitoring Team. ▪ The Facility identified broad areas of deficiency in sub-section S.2 and S.3.a, but did not identify potential causes or action plans to address these deficiencies.
	Summary of Monitor's Assessment: Since the Monitoring Team's last review, the Facility had taken a number of steps to improve its compliance with Section S of the Settlement Agreement. Positive actions included the following: ▪ Numerous staff had been trained in the Individual Support Plan process. ▪ The Functional Skills Assessment was increasingly being completed in full for the individual. Similarly, vocational services staff had completed comprehensive assessments for 36 individuals the Facility served. ▪ A pilot program had been completed in one of the residential units to assess the level of individual engagement. This same measure examined the availability of functional and age appropriate materials and the quality of the environment. The plan was to expand this monitoring system to other units, activity centers, and workshop areas. ▪ QDDP staff had just been trained to use a tool to monitor skill acquisition plans. This offered an introduction to competency-based training of all direct support professionals. Areas in which continued work was necessary included the following: ▪ Information gathered through assessment of functional skills and vocational interests and strengths did not consistently translate into the design of comprehensive habilitation services. ▪ Skill acquisition programs continued to be poorly written with limited opportunities for learning. ▪ Engagement remained limited, particularly in the residential units and the activity centers. In sum, much of the feedback the Monitoring Team has provided in the past remained relevant.

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S1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide individuals with adequate habilitation services, including but not limited to individualized training, education, and skill acquisition programs developed and implemented by IDTs to promote the growth, development, and independence of all individuals, to minimize regression and loss of skills, and to ensure reasonable safety, security, and freedom from undue use of restraint.	A total of 30 Individual Support Plans, all of which had been completed since the beginning of 2012 were reviewed. A summary of findings is provided below. ▪ All 30 plans (100%) included a review of the individual's preferences. ▪ Twenty-six of the 30 plans (87%) included strengths exhibited by the individual. The detail varied from plan to plan with three plans providing very limited information (i.e., Individual #201, Individual #355, and Individual #135) and one containing information that was difficult to interpret as a strength (i.e., Individual #231). ▪ Thirteen of the 30 ISPs (43%) included information regarding the integrated risk rating scale. The other plans referenced the rating of risk with directions to refer to the attached table. However, no table was attached. As noted in the last report, level of risk is an important consideration in both program planning and community inclusion. Therefore, a thorough review of the individual's current level of risk is an essential component of the ISP. ▪ Twenty-two of the 30 plans (73%) included training objectives ranging from one to eight in total. This computed to an average of 4.64 annual objectives per individual. The remaining eight plans either included no specific training objectives or simply noted: "Continue with training objectives." ▪ None of these plans (0%) described training objectives in observable and measurable terms. ▪ The implementation schedule for training was included in only 12 of the 22 plans (55%) in which training objectives were identified. The schedules ranged from daily to weekly training. Two plans suggested training was "ongoing," and another indicated it would occur "as needed." ▪ Six of the 22 plans (27%) in which objectives were identified included at least one objective in which training was to occur in the community. ▪ In only one plan (3%) was the date of the Functional Skills Assessment noted (i.e., Individual #461). However, it appeared that the assessment was not used to guide habilitation planning, because the determination was that there were "No recommendations to address." The Facility should provide a clear outline of the individual's preferences and strengths. The Integrated Risk Rating Form should be included and should be comprehensive in scope. Training objectives should be identified to meet the needs of the individual as determined by interdisciplinary assessment, should be written in observable and measurable terms, should be scheduled to ensure sufficient opportunities for learning to occur, and should take place in the most integrated setting possible, including the community. Prior to the ISP meeting, the Team was expected to complete the Personal Focus Assessment for the individual. Based on training the State Office consultants provided in July 2012, this was changing to the Preferences and Strengths Inventory (PSI). However,	Noncompliance

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		given the timing of this review and the limited number of PSI completed, only assessments utilizing the PFA form finalized on 9/7/11 were reviewed. This form was divided into three sections: personal preferences; personal goals regarding living environment, work activities, relationships, leisure, and other club/group activities; and summary. A review of 20 PFAs revealed the following: • Fifteen (75%) of the assessments noted the specific date the information was posted. • Twenty (100%) of the assessments provided information related to the individual's preferences. The directions indicated that this section was to be completed by direct support professionals and/or the person who knows the individual best through interview and observation of the individual. While some assessments provided more in-depth information (e.g., Individual #67 and Individual #525), other assessments provided more limited information regarding preferences (e.g., Individual #61 and Individual #120). • Seventeen (85%) provided information related to the individual's personal goals. In this section, the QDDP was expected to provide this information through interview and observation. Again, the quality of this information varied across assessments. For Individual #95, no answer was noted on 22 of 28 indicators. As a result, this was not helpful in guiding the ISP development for this individual. This section was blank for Individual #213 and Individual #201. • The summary section was completed in 14 (70%) individuals in the sample. Again, the assessments for Individual #67 and Individual #525 provided a good degree of information. This section was left blank for Individual #213 and Individual #201; there was no summary of the day-to-day preferences for Individual #120, Individual #320, and Individual #148; and information related to another individual was provided in the summary for Individual #231. The Monitoring Team requested the PFA for an additional four individuals whose ISP was held in 2012 (i.e., Individual #517, Individual #216, Individual #48, and Individual #315). The Facility's response to this request was that there was no PFA available. As noted in the past, the State has identified the Personal Focus Assessment as "… the cornerstone of the facility's person-centered process" (Personal Focus Assessment policy, dated 9/7/11), which was now being substituted with the PSI. Therefore, to ensure the utility of the 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. The Monitoring Team requested a total of 30 examples of newly developed Skill Acquisition Programs, with 10 representing programs designed for training in the	

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		community. The format of these programs was the same as described in the last report. Each program consisted of the specific target behavior, general instructions, prerequisite skills as necessary, materials, and a task analysis, where appropriate. Also provided were copies of the Skill Acquisition Program data sheet. The results of the Monitoring Team's review of the 30 SAPs is provided below: ▪ Although a specific target behavior was included in all of the SAPs (100%), this did not meet the criterion for a behavioral objective, because there was no indication of the criterion used to determine mastery. Absent were a level of independence or an identified period of time during which skilled performance had to be consistently demonstrated. ▪ Under general instructions, a method of teaching was identified. Thirteen of 30 programs (43%) utilized a backward chain, 12 of 30 programs (40%) utilized a forward chain, and the remaining five programs (17%) involved a total task methodology. Although chaining techniques were identified, instructions for teaching these programs remained unclear. In only two programs (i.e., Individual #156, street crossing, and Individual #241, purchasing a soda) was there the suggestion that the individual would learn the entire chain. These two SAPs specified that the trainer should assist the individual to complete all steps in the chain with the exception of the training step. All other programs suggested training only on identified steps of the chain. Chaining techniques allow one to learn complex skills as smooth routines, with each link in the chain serving as the discriminative stimulus for the next link in the chain. These chains should be taught in sequence with fading of prompts determined by the type of chaining technique chosen for instruction. As these SAPs were written, it was unclear how and when the steps in the sequence were to be taught. ▪ Where appropriate, a task analysis was provided in 25 of 26 SAPs (96%). The program designed to teach Individual #509 to trail the wall included steps one and four only. This again raised the need for input from an orientation and mobility specialist when working with individuals with visual impairment. Three other SAPs included a task analysis, but in each of these programs the individual was learning a range of skills rather than a behavioral chain (i.e., Individual #156 was learning different ways to interact socially, Individual #442 was learning to discriminate coins, and Individual #241 was learning to trace her first and last names). The SAP for Individual #546 in which he was to learn to respond to an alarm included only one step. ▪ Eight of the 30 SAPs (27%) indicated that training was to occur at a minimum of five times per week. One SAP (3%) included a training schedule of four days per week. ▪ Eighteen of the 30 SAPs (60%) identified the schedule of training as one time per week. Two other SAPs (7%) indicated training twice per week. As has been suggested in the past, such lean training schedules are unlikely to produce rapid	

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		learning of any skill. ▪ A specific schedule of training was not provided in the hand-washing program for Individual #442. Instead, staff were instructed to conduct the training "wherever and whenever" the need arose. ▪ Three of the 30 SAPs (10%) suggested that training was to occur more than once daily, either by specifying multiple trials or by indicating training during medication administration. ▪ Thirteen of the 30 SAPs (43%) identified praise as the reinforcer for correct responding. Sixteen of the remaining 17 programs identified praise and/or food, the item purchased, or money as the reinforcer. The last program identified access to his medication as the reinforcer for Individual #502 when he independently opened his blister pack. As noted previously, reinforcers used to teach new skills should be specific to the individual and are best identified through careful preference assessment. ▪ None of the SAPs (0%) included specific instructions regarding actions staff should take when the individual refused to participate, did not respond, or provided an incorrect response. Each plan listed either most to least or least to most prompting strategies, but this did not clearly describe staff response when the individual did not display the desired behavior. ▪ Although 10 community training programs were requested, only six of these 10 (60%) specified that training was to occur off campus. The remaining four suggested that training could occur either on campus or in the community. ▪ None of the programs (0%) included plans for the maintenance or generalization of newly acquired skills. ▪ Included on 26 of the 30 SAP data sheets (87%) were both the ISP date and the date of implementation. Three programs were initiated within one month's time of the ISP, 11 were implemented between one and two months after the ISP date, 10 were introduced between two and three months after the ISP date, and two programs were introduced over three months after the ISP date. It will be important to ensure that SAPs are developed and introduced in a timely manner to ensure ongoing access to habilitation services. As noted in past reports, SAPs should include the following: a) a behavioral objective; b) training guidelines that are clear and comprehensive; c) training schedules, including number of trials, that ensure sufficient opportunities for learning to occur; d) guidelines for the application of individually identified reinforcers following correct responding; e) guidelines for error correction; and f) plans to ensure maintenance and generalization of newly acquired skills. To assist in the appropriate design of SAPs, the State and Facility should work with individuals who have training and experience in the design and delivery of special education services. Three months of Training Documentation Reports were reviewed for 26 individuals. Of	

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		these individuals, one person (i.e., Individual #156) also had two Skill Acquisition Program data sheets reviewed and included in the analysis. With a total of one to eight training programs per person, this resulted in a review of 129 programs and 387 data sheets. A summary of findings is provided below: ▪ The IPP Review Date for nine of the 26 individuals (35%) had occurred over 12 months prior to the data record. This suggested that reviews, Individual Support Plan meetings, and/or updated data sheets were overdue. ▪ Data was recorded on the days identified at least 50% of the time in 328 of the 387 data sheets (85%) reviewed. ▪ In every case (100%) where data was recorded, there was a single data point, suggesting the program was implemented only once that day. As noted previously, the number of trials should be clearly identified. ▪ Refusal to participate in the training activity was noted in 50% or greater of the days on which data was recorded in 95 of the 387 data sheets (25%). Frequent or repeated refusal to participate in an activity should trigger a review with revisions to the program as appropriate. ▪ Programs were initiated at least 12 months earlier than the IPP review date in 19 of the 129 programs (15%) reviewed. In all but one of these 19 programs, progress appeared quite limited. If progress is not observed in a timely manner, programs should be revised or replaced as appropriate. ▪ Praise alone was the identified reinforcer in 101 of the 129 programs (78%). Seven programs (5%) identified access to food or drink as the reinforcer, eight programs (6%) identified the item purchased as the reinforcer, eight programs (6%) identified praise and some other form of social feedback as the reinforcer, and five programs (4%) did not specify the reinforcer. Reinforcers should be specific to the individual and should be assessed frequently for effectiveness. ▪ 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. Examples of problems with individual skill acquisition plans included the following: ▪ Individual #213 was learning to shave. The first step of the program required him to look at the razor, although it was noted that he had a severe visual impairment. ▪ Individual #267 repeatedly had refused to participate in four of her six programs. There was no indication that supervisory or active treatment staff had conferred with direct support professionals regarding program implementation difficulties and/or necessary revisions. ▪ Similarly, Individual #65 had an objective to learn to throw a ball. For three months, he had refused to even accept the ball from the staff member, yet there	

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		was no indication that a revision had been made to the program. ▪ A note was provided to the Monitoring Team that Skill Acquisition Programs were developed for Individual #95, but had not been put in his "chart" until 8/20/12. Implementation dates were noted as 8/17/12 for four programs and 7/12/12 for one program. His ISP meeting was held 5/25/12. A delay of almost three months in program implementation did not ensure adequate habilitation was provided. ▪ While the Training Documentation Reports were provided for Individual #216, there were often comments that the "skills [were] not in [his] book," or "skills [were] not updated." This resulted in an apparent absence of training. This problem with skill training and documentation should be corrected in a timely manner. ▪ Individual #216 had an objective in which he was told: "point to what you want to do," yet the instructions specified which picture he was to focus on. ▪ Individual #145 had completed training documentation reports reflecting the IPP review and date initiated as 10/28/12, which had not yet occurred. ▪ Four of the five objectives for Individual #120 indicated an initiation date almost four years earlier than the IPP review date. There was no indication that his slow progress on these objectives had been addressed through program review and revision, as appropriate. ▪ Data sheets were provided for Individual #48 and Individual #533, yet no data were recorded. ▪ Individual #231 had data sheets that contained identical program descriptions, yet contained different initiation dates. In each of six programs, the earlier data sheets reflected an initiation date prior to the IPP review date, while the most recent training documentation sheet reflected an initiation date approximately 11 months after the IPP review date. ▪ Individual #274 had two programs for which data sheets were provided with overlapping dates. In both cases, the step of the programs and the data codes differed. Two other programs offered no breakdown of steps, yet steps were identified in the box marked: "current objective." ▪ Individual #397 had a program to learn to tell time using his wristwatch. Seventy-five percent of the data points marked during one month indicated that the program was not implemented because he did not have a watch. On his money skills program, there were comments for five of nine data points that the program could not be implemented because there was no money. Materials necessary to implement training programs should be available and replaced in a timely manner. ▪ Individual #525 had a bathing program in which data was not collected for two days due to "no sponge yet." ▪ Individual #148 had a total of six programs for which training documentation	

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		sheets were provided. On each, the IPP review date was 2/16/12. Five of the programs had been initiated between 2003 and 2007. Three of these developed in 2004 had been revised in 2006 or 2007. There were no other documented changes to any of the programs since that time, yet this individual continued to demonstrate high refusal rates. ▪ At least two individuals (i.e., Individual #142 and Individual #150) had communication programs in which they were learning to sign. The identified reinforcer in both cases was praise. It would appear more motivating and more functional for the women to be given access to the item or activity that they requested through sign language. 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 lack thereof. When there is consistent refusal to participate 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 program to ensure that learning occurs. The Facility had developed a Skill Acquisition Training Competency Checklist to assist the active treatment staff in training the direct support professionals on individual skill acquisition plans. According to the Provision Action Information document included in the Section S Presentation Book, this checklist was developed on 5/2/12. A skill area was identified and the staff member was rated as competent or not on the following: a) identifies correct setting; b) identifies correct instruction/discriminative stimulus; c) demonstrates correct teaching strategy; d) demonstrates correct prompt sequence; e) demonstrates correct error correction procedure; and f) demonstrates correct documentation procedure. This was a good beginning for providing on-the-job competency-based training to staff. A few recommendations are offered. First, it would be helpful to ensure that the staff member has the necessary materials to carry out the training. There should also be a measure of the staff member's response to the individual's correct responding to determine whether reinforcement is provided as described in the SAP. While the form suggested that error correction procedures are outlined in the SAPs, the Monitoring Team found this information missing in the programs reviewed. There was an indication of the type of prompting sequence to employ, but this did not clearly describe the staff member's behavior when the individual did not respond or responded incorrectly. Lastly, the comments section should not be limited to additional instruction/coaching needed. The instructor's should ensure that positive feedback is provided when the staff member conducts the training or portions of the training with skill and competence. As first reviewed in the Monitoring Team's previous report, the Facility also had	

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		developed a Skill Acquisition Training Monitoring form that the QDDP staff had just been trained to use the week before the visit. This allowed the Facility's monitor to first interview a staff member about the contents of the SAP, and then observe him/her as instruction was provided to the individual. This form proved more comprehensive in scope and detail than the new form discussed above. A suggestion would be to add to the interview section a statement regarding the staff member's ability to identify what to do when the individual responded incorrectly, did not respond, or refused to participate. This should also be addressed in the observation section of the form. Under record review, the Facility's monitor was to check to ensure there was no missing data. The Facility's monitor was also to determine whether the data collected by staff during the observation was consistent with the other data recorded for the current month. This point was a bit concerning, because it suggested that no learning or change in performance was to be expected. Lastly, the Facility's monitor was expected to determine the level of agreement between his/her data and that recorded by the staff member. This introduction of inter-observer agreement measures was a commendable step. The back of the form provided space for comments regarding training provided to the staff. One suggestion would be to document any concerns or suggestions the staff member might have. This tool might prove very helpful in developing a competency-based training system. It is concerning however, that although first discussed six months prior, the tool had not yet been put into practice. Staff should ensure that those using the tool are fully trained in implementing the programs they are observing. <u>Engagement</u> As has been the case during previous visits, the Monitoring Team conducted periodic checks of engagement while visiting the Facility. Using a Planned Activity Check (PLACHECK), the levels of engagement of individuals in the residences, activity centers, and workshop areas were observed and measured. These are summarized below. ▪ A total of 24 PLACHECKS were conducted across the home environments. Engagement ranged from 0% to 100% with an average engagement score of 42.9%. Consistently, engagement was greater in homes with fewer individuals present and in homes where the individuals experienced greater independence. The exception to this was the home for the school-aged individuals in which engagement was poor even though the staff-to-individual ratios were quite rich (i.e., one-to-one). Positive engagement was noted in one home in particular during the evening meal, because individuals were encouraged to enjoy family style dining with the staff participation. ▪ A total of 17 PLACHECKS were collected across the activity centers. The range of engagement was 0% to 100% with an average score of 45.8%. Staff in the activity centers were often observed making efforts to engage individuals, and the activities presented offered greater variety than observed in the past. Two individuals were observed playing pool, four others were engaged in a game of	

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		cards, a small group of individuals were learning about birds and listening to their songs, and one group was playing a game of bingo. The difficulty often lay in adapting the activity so that there could be greater participation by the individuals. Here too, staff with training and experience in the provision of special education services might prove helpful. ▪ The workshop areas once again reflected the greatest levels of engagement. The average PLACHECK score was 90% with a range of engagement between 40% and 100%. Individuals were observed on their breaks or while working folding linens and shredding paper. There were several observations of individuals working cooperatively to fold larger laundry items such as blankets and sheets. It would be helpful to expand the vocational service options and to enroll more individuals in this program. As staff work to increase the variety of activities and individualized adaptations to activities to increase active engagement, it will be helpful to work with professionals who have training and experience in the provision of special education services. The Active Treatment Coordinator and the Director of Behavioral Services explained that a pilot project had been introduced in one residential unit at the Facility. According to a memo sent on 6/4/12 by the Settlement Agreement Coordinator, staff were to collect measures twice per week in their assigned home. Inter-observer agreement was to be assessed weekly. Using the ABSSLC PLACheck Monitoring Form, staff completed three consecutive observations of up to five individuals in the home setting. The Facility's monitors also conducted active treatment probes that addressed noise level, individual appearance, and aspects of the planned activity. The plan was to expand this activity to two additional units and the vocational areas and activity centers by the Fall. Based upon the review provided above, the Facility remained out of compliance with this provision of the Settlement Agreement.	
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.	The Facility continued to employ the Functional Skills Assessment to determine an individual's strengths and needs across 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 24 individuals. A summary of the findings from this review is provided below: ▪ The assessment date was included in 20 of the 24 documents (83%). It is important to indicate the date of completion to ensure that current information is used to guide treatment planning. ▪ The person or persons completing the assessment was identified in 20 or the 24 documents (83%).	Noncompliance

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		▪ The directions at the beginning of the assessment indicated that an explanation should be provided when the code "Other" is used. This was consistently evident in 11 of the 24 assessments (46%). ▪ A summary of the individual's strengths and needs was provided in seven of the 24 assessments (29%). The assessment is only useful if a summary of the person's skills and needs is provided to help guide treatment planning. ▪ A list of recommendations was provided in six of the 24 assessments (25%). Similarly, recommendations across all areas would be useful in guiding the team to develop comprehensive habilitation services at the annual meeting. Individual specific concerns included the following: ▪ Although an assessment was requested for Individual #87, the Monitoring Team was provided her incomplete Positive Assessment of Living Skills from the previous year. Even though her ISP was developed on 2/22/12, a note from the Facility indicated that an assessment had not been completed in 2012. This would suggest that her treatment planning was developed without comprehensive and current information regarding her strengths and needs. ▪ Although five recommendations were provided for skill development for Individual #517, he had been assessed to perform independently in four of these five areas. ▪ Similarly, five skills were recommended for Individual #48. The information provided within the assessment indicated that he could perform each of these skills independently. ▪ Although the strengths of Individual #355 were noted in four of 13 skill areas, the description was limited to "independent" or "can communicate effectively." His needs were addressed in only one of 13 skill areas. ▪ The reader was directed to refer to the summary for Individual #318, but this was not included with the assessment. Although the Active Treatment Coordinator had reviewed 60 FSAs completed for ISPs held in June and July of 2012, and had developed a template for summarizing the results of these assessments, there remained limited application in planning habilitation services. As noted previously, assessment of adaptive behavior or functional skills will only be useful if the information regarding the individual's strengths and needs is summarized with recommendations for future programming provided. The Facility continued to employ the expanded vocational assessment described in the Monitoring Team's last report. Information provided to the Monitoring Team indicated that 36 vocational assessments had been completed between 2/1/12 and 7/5/12. Twelve assessments were reviewed. As noted in the previous report, these continued to provide more comprehensive information regarding an individual's work history, skills, and preferences. Only seven of the 12 assessments (58%) included some	

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		recommendations for vocational exploration. All of the 12 assessment reports (100%) were dated and all (100%) identified the person completing the assessment. Only one report (8%) was signed. Staff should use the information gleaned from the assessment to develop an expanded vision for work opportunities for the individual. When recommendations are made, responsible staff and expected completion dates should be identified. Some specific concerns noted in individual assessments are reviewed below: ▪ Individual #418 was noted to use gestures, but then a comment was added indicating that he "…uses one to two words or short sentences to communicate." From these inconsistent statements, it was not possible to understand his communication abilities. ▪ Similarly, Individual #287 was identified as proficient in American Sign Language, but the added comments indicated that she "… uses some sign language, gestures, and single words." Pay, praise, and encouragement were noted to motivate this same individual. However, the comment indicated that money "… does not seem to motivate her enough," and her response to praise and encouragement is dependent upon her "mood." Such inconsistencies should be detected with information revised accordingly. ▪ Individual #189 was identified as a non-verbal communicator. However, rather than providing detail about his spontaneous and independent means of communicating, the evaluator noted that he will imitate a few words and signs. ▪ Concerns were noted for Individual #424 who was reported to exhibit behavior problems when at work. Later in the assessment, there was a statement that she "… is not motivated by anything to work." The recommendation was to discontinue her involvement in vocational services without any indication that different work activities or locations had been explored, or that efforts had been made to shape and reinforce better attendance and more appropriate work behavior. ▪ It was noted that Individual #375 should be informed of changes as he favors routine. Yet, in this same section of the assessment, a comment suggested that he does not "… mind changes in his trainer or task." Again, the information was contradictory, and therefore, the person's reliance on routine was not clear. ▪ Individual #397 had expressed an interest in learning to use computers, yet the recommendation for vocational exploration was to check on his involvement in shredding or his ability to join a janitorial crew. There was no indication that an attempt would be made to address this interest either through work or adult education. ▪ Individual #133 was identified as someone who did not like sedentary activities, yet his current work situation required him to remain at the same location stacking washcloths. Absent was a specific recommendation to explore alternative work opportunities that allowed for greater movement. ▪ Finally, the outlook for Individual #341 was very limited. The person	

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		completing the assessment noted that the individual might be bored working on laundry and should be given the opportunity to try shredding. There were no other alternatives suggested. Further, the assessment included the following statement: "I don't think (individual) will ever be able to maintain focus for 10 minutes." Unless more interesting and preferred work activities are explored and supports are put in place to encourage work persistence, it is difficult to know how focused this individual could become. The comprehensive vocational assessment afforded staff an opportunity to provide a clear profile of the person and his/her skills and interests. Staff should use this information to guide thoughtful exploration of work opportunities that will enhance the individual's skills and offer enjoyable and meaningful activity. The Vocational Training Coordinator explained that attempts were ongoing to ensure that assessments were completed for all individuals. Regrettably, the assessment for those individuals who were already engaged in some work activity remained overdue. As noted previously, the Facility should consider prioritizing individuals for vocational assessment based upon their expressed interest in working and their identified risk factors. Again, caution should be used to avoid generalized exclusion of individuals due to age and/or specific risk factors. Priority also should be given to those who have demonstrated a disinterest in the work that is offered on campus, but who continue to express an interest in gainful employment. When job exploration was recommended for those who were not employed, this typically resulted in tours of the workshop areas, as opposed to expanded opportunities for meaningful work in the community. Two Vocational Assessment Reports for individuals not employed at the time of the visit were reviewed. Both included a description of the individual's observed response during a visit to the workshop(s) and a recommendation to make a referral to vocational services. No timeline was identified for the referral. Although two to three individuals were working at the Second Edition or Diner on campus, the expansion of community based employment since the last Monitoring Team visit was evident for only one individual. Individual #355 had successfully held a community-based job during his summer vacation from school. Although his mother had obtained this job for him, his experience highlighted the possibilities that might exist for others to work outside of the Facility. The Facility is encouraged to continue to expand its efforts to identify more varied work across a range of environments. The Vocational Training Coordinator noted that inclusion of individuals who lived outside of the Facility in the workshop setting had been terminated. This resulted in reliance solely on individuals residing in the Facility to fulfill the laundry contracts completed in the workshop settings. Increased pressure was also experienced, because individuals with workshop history began to move into community-based settings. In an	

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		effort to better prepare others for work, the Vocational Services Coordinator had met with Active Treatment Coordinators to request their assistance in bridging the gap between home-based activities and employment activities. While an interdisciplinary approach is commendable, there are likely individuals who could make the transition from home to work if the right supports and training were provided. Based on the information reviewed above, the Facility remained out of compliance with this provision of the Settlement Agreement.	
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 previous reports prepared by the Monitoring Team is repeated here, because it remains relevant. As noted above in Sections S.1 and S.2, the assessment process remained flawed at the time of the visit. Individual preferences were not always addressed when designing habilitation plans. Although improvements in the completion of functional skills assessments was observed, the information gained from the assessment was not used to guide program planning. Habilitation programs remained quite limited in scope, were often the same across individuals regardless of skill or interest, and were poorly implemented. Teaching conditions were not adequately described, opportunities for instruction remained severely limited, reinforcement for correct responding was not individualized, and there were not plans for ensuring the maintenance and generalization of newly acquired skills. During the onsite review of the Facility, activities provided to individuals were often sedentary (e.g., watching television) or were designed for a large group with little regard for individual interests. These identified deficiencies will need to be corrected for the Facility to comply with the Settlement Agreement.	Noncompliance
	(b) Include to the degree practicable training opportunities in community settings.	The Facility had made an effort to increase training opportunities in the community. As noted in Section S.1 above, however, even when SAPs were identified as community-based training programs, the setting for training was occasionally either on campus or in the community. Many of the programs designed for community-based learning referenced making a purchase. Staff should pursue other activities that might be of interest to the individual. These could include job opportunities, trips to the library or	Noncompliance

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		post office, participation in local leisure or church-based groups, among others. Vocational services staff should make an effort to explore work opportunities outside the Facility. Community-based employment should not be restricted by the need to fulfill laundry contracts in the workshop areas. Attempts should be made to increase the schedule of community-based training activities so that these are not limited to one trial per week.	

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

1. As the 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/Preferences and Strengths Inventory 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 ISP. (Section S.1 and S.2)
2. The assessments used to guide the ISP process should be identified clearly with the date of completion included the individual's annual ISP. (Section S.1 and S.2)
3. Training objectives should be identified to meet the needs of the individual as determined by interdisciplinary assessment, should be written in observable and measurable terms, should be scheduled to ensure sufficient opportunities for learning to occur, and should take place in the most integrated setting possible, including the community. (Section S.1 and S.3)
4. 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, that will address his/her expressed interests and preferences, and that will enhance his/her overall quality of life. (Section S.1 and S.2)
5. 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)
6. Once training objectives are identified, programs should be written to include the following information:
    a. A behavioral objective that includes a description of the conditions under which the behavior is to occur, a description of the behavior in observable and measurable terms, and the criteria used to determine mastery;
    b. A schedule for training, including the number of trials to be provided, which 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, as appropriate;
    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).
7. The State and Facility should work with professionals who have training and experience in the design and delivery of special education services. This should include experience in adapting age-appropriate and preferred activities for those who present with physical and sensory difficulties. (Section S.1 and S.3)

8. Staff should be provided ongoing competency-based training to ensure their understanding and application of all training programs. This training should be provided by staff who are knowledgeable and skilled in implementing these same training programs. (Section S.1)
9. 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)
10. 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)
11. A plan should be developed to ensure inter-observer agreement measures are collected on skill acquisition programs. (Section S.1)
12. The Facility should expand its therapeutic services to include orientation and mobility services for those individuals who experience visual impairment. (Section S.1)
13. 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)
14. As recommended previously, staff should expand the variety of home, leisure, and vocational activities available to the individuals served. (Section S.1)
15. 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)
16. 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. (Facility Self-Assessment)

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

1. Every effort should be made to address improvements in individuals' personal hygiene, grooming, and dress. Again, staff should consider the core tenets of the principal of normalization and how this applies to these very basic rights. (Section S.3)
2. Consideration should be given to reducing the number of individuals residing together in a single residence, and increasing staffing ratios to allow increased opportunities for skill acquisition. (Section S)

SECTION T: Serving Institutionalized Persons in the Most Integrated Setting Appropriate to Their Needs	
	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 entitled: "Admissions, Alternate Placement, Transfers, and Discharges," dated 5/1/12; 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 and reason for no referral, 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 the Monitoring Team's last onsite review, undated; o List of individuals who have had a Community Living Discharge Plan (CLDP) developed since 2/17/12; o Discharge summary and related assessments for Individual #313; o List of individuals who have transferred to other SSLCs since the last onsite review, undated; o Response to request for list of alleged offenders: "There are no alleged offenders residing at AbSSLC," 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; 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: "There have been no post move deaths for any AbSSLC placed individuals since 7/1/2009"; o Community Placement Report, dated 7/17/12; 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," Information on Individuals Transitioned to the Community in the Past Year, undated; o Community Living Options Tour Attendance Sheets, from 2/12 through 7/12; o Self-Advocacy meeting flier, agenda, and attendance roster, for meeting on 5/8/12; o Provider Fair flier and attendance roster, for event on 4/21/12; o Maple Street Messenger, for March/April 2012 and May/June 2012; o Examples of brochures distributed at Provider Fair; o Training documentation for staff related to most integrated setting, various dates; 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 List of obstacles identified in ISP meetings during the months of April 2012 through June 2012; o QA/QI Council Third Quarter Obstacle Report March 2012 through May 2012, dated 6/11/12; o Individual Support Plans, Sign-in Sheets, Assessments, Individual Support Plan Addenda (ISPAs), Preferences and Strengths Inventory, Community Living Options Information Process (CLOIP) worksheet, skill acquisition and teaching programs, Rights Assessment, monthly reviews, and 90-day ISP planning meeting documentation for: Individual #403, Individual #371, and Individual #377; o CLDP, any associated assessments, and most recent ISPs for the following: Individual #272, Individual #43, Individual #375, Individual #319, Individual #133; and Individual #267; o State Office review of CLDP for Individual #375; o Since 1/6/12, a list of all post-move monitoring visits including the dates for each of the completed visits and due dates for upcoming visits; o Draft Living Options Guide, undated; o Pre- and Post-Move Monitoring Checklists for the following individuals: Individual #539, Individual #43, Individual #504, Individual #398, Individual #272; Individual #149; Individual #532, Individual #199, Individual #375, Individual #133, Individual #267, and Individual #319; and o Sample of Section T quality assurance monitoring tools the QA Department completed, and the Admissions/Placement Department completed, various dates. ▪ **Interviews with**: o Laura Wilford, former Admissions/Placement Coordinator and current Transition Specialist; o Kerry Loveland, former Post-Move Monitor and current Admissions/Placement Coordinator; o Kristin Wyrick, QDDP Coordinator;

	○ Heather Vivoda, Post-Move Monitor; ○ Diane Jackson, Transition Specialist; and ○ William Whitaker, Program Compliance Monitor. ▪ **Observations of**: ○ ISP Meeting for Individual #542, on 8/23/12.
	Facility Self-Assessment: Facility Self-Assessment: The Facility submitted a Self-Assessment for Section T, dated 8/8/12. In its Self-Assessment, for each sub-section, 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. For Section T in conducting its self-assessment, the Facility: ▪ Used monitoring/auditing tools. Based on a review of the Facility Self-Assessment, the monitoring/audit templates and instructions/guidelines, a sample of completed monitoring/auditing tools, inter-rater reliability data, as well as interviews with staff: ○ The monitoring/audit tools the Facility used to conduct its self-assessment included: 1) Section T – Serving Institutionalized Persons in the Most Integrated Setting Appropriate to Their Needs; Sub-Section 1 – Planning for Movement, Transition, and Discharge – Review of Living Options; 2) Section T – Serving Institutionalized Persons in the Most Integrated Setting Appropriate to Their Needs; Sub-Sections 1 and 4 – Planning for Movement, Transition, and Discharge and Alternate Discharges – Review of CLDP; and 3) Section T – Serving Institutionalized Persons in the Most Integrated Setting Appropriate to Their Needs; Sub-Section 2 – Serving Persons Who Have Moved from the Facility to More Integrated Settings Appropriate to Their Needs – Review of Post-Move Monitoring. ○ Although these monitoring/audit tools included indicators relevant to the Facility's compliance with the Settlement Agreement, modifications had been made to the State's systems that were not reflected in the tools. Two examples of this included: 1) changes had been made to the ISP Meeting Guide to structure the discussion about the types of obstacles teams discussed with regard to referrals and transition. This impacted the indicators included in the initial monitoring tool, but the tool had not been changed; and 2) similarly, the post-move monitoring tool had been significantly changed from what was in Appendix C of the Settlement Agreement, and likely changes should have been made with regard to the corresponding monitoring tool for Section T.2. As the Monitoring Team has discussed with the Facility and State, these monitoring tools were not designed for the Facilities to implement wholesale. The Facility is encouraged to make changes to the tools to make them more user-friendly. As this is done, the Facility is encouraged to review the Monitoring Team's report to identify indicators that are relevant to making compliance determinations. ○ The monitoring tools did not identify adequate methodologies, such as observations, interviews, and record reviews to ensure that all of the staff responsible for auditing used the same methodologies. ○ The Self-Assessment identified the sample(s) sizes. However, it did not include the number of individuals/records reviewed in comparison with the number of

	individuals/records in the overall population (i.e., n/N for percent sample size) to provide a sense of whether or not they were representative samples. o The monitoring/audit tools did not have adequate instructions/guidelines to ensure consistency in monitoring and the validity of the results. In the Monitoring Team's report on Austin SSLC, dated 7/7/11, the Monitoring Team provided some specific comments on how these could be improved upon. Now that the Admissions Placement Department was meeting monthly with the QA Department, the revision of the monitoring tools, including the development of adequate criteria and guidelines for the assessment process should be a priority. o Based on interview and documentation submitted, the following staff/positions were responsible for completing the audit tools: the assigned Program Compliance Monitor from the QA Department conducted reviews of CLDPs, and the post-move monitoring process. The Admissions Placement Coordinator also conducted reviews of a sample of post-move monitoring reviews, and the Post-Move Monitor conducted reviews of some CLDPs. The Program Compliance Monitor, and the QDDPs assigned to complete monitoring for Section F conducted reviews of the Living Options component of Section T. o The staff responsible for conducting the audits/monitoring had not been deemed competent in the use of the tools. Although all of the staff responsible had some experience with developing ISPs, completing transition plans, and/or conducting post-move monitoring, no formal methodology was in place to ensure they were programmatically competent in the relevant areas. o Adequate inter-rater reliability had not been established between the various Facility staff responsible for the completion of the tools. This is discussed in detail with regard to Section T.1.f. ▪ Used other relevant data sources and/or key indicators/outcome measures. For example, for Section T.1.b, which addresses education about community options, the Facility had included numbers of individuals that participated in community tours, numbers of individuals and families participating in the Provider Fair, etc. This was valuable information. However, in order for it to be meaningful, it needed to be put into the context of a measurable outcome indicator. This would need to be accomplished by identifying baselines, and then setting a goal for what would be considered an acceptable or desirable level of participation. ▪ The Facility did not consistently present data in a meaningful/useful way. Specifically: o Self-assessment activities did not consistently measure the quality as well as presence of items. For example, the quality of assessments used in developing CLDPs is essential to compliance with Section T.1.d, but the Facility did not appear to take quality into consideration, just presence and timeliness. o In addition, not all requirements of the Settlement Agreement had been reviewed. For example, nowhere in the Self-Assessment did it appear that the Facility had assessed the quality of the pre- or post-move required supports in the CLDPs. o At times, items that were being measured did not equate to compliance. For example, for Section T.1.b.3, the State Office requirement for assessment for appropriateness for placement required a number of steps as detailed in the Monitoring Team's report.

	However, the Self-Assessment did not address these steps, but rather repeated information about educational opportunities provided to individuals and their guardians. o The Facility Self-Assessment did not distinguish data collected by the QA Department versus the program/discipline. o On a positive note, the findings generally were presented based on specific, measurable indicators, as opposed to overall compliance scores. ▪ The Facility rated itself as being in compliance with the following sub-sections of Section T: T.1.c, which is an overarching provision encompassing a number of different provisions; T.1.c.1, which requires the Facility to specify in CLDPs the actions the SSLC needs to take as well as to coordinate the CLDP with provider staff; 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.e, which requires the development of a CLDP that includes adequate pre- and post-move required supports, and that the pre-move required supports are confirmed to be in place prior to the individual's transition; T.1.h, which requires the Facility to provide a Community Placement Report; and T.2.a, related to post-move monitoring. Not all of these findings were consistent with the Monitoring Team's findings. The Monitoring Team found the Facility in compliance with the following sub-sections: T.1.c.2, T.1.c.3, and T.1.h. While on site, the Monitoring Team and Facility staff discussed in some detail the potential reasons for the discrepancies between the findings. Largely, the issues related to the Monitoring Team assessing the quality as well as presence of items, and, in some instances, the Facility viewing certain Settlement Agreement requirements as falling into different subsections of Section T than the Monitoring Teams do. ▪ The Facility data identified areas of need/improvement. For these areas of need, the Facility Self-Assessment provided some limited but incomplete analysis of the information, identifying, for example, potential causes for the issues. The Facility had not connected 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.
	Summary of Monitor's Assessment: An increasing number of assessments prepared for annual ISP meetings had begun to include the assessor's recommendation regarding transition to the community. Based on review of ISPs using the new template, individuals' ISPs had begun to include a recommendation from the professional team members' with regard to whether or not community placement was appropriate. This was positive. However, unfortunately, the assessments and/or ISP narratives included statements showing disagreements amongst the team members regarding the individuals' appropriateness for community transition. The teams' recommendations were that the individuals remain at the Facility. However, it was not clear how the teams' disagreements about this had been resolved and/or the teams had not provided adequate justification for their decisions. ABSSLC had made some progress in identifying obstacles to community referral, but more work was needed. Teams had not yet begun to systematically identify obstacles to transition that individuals encountered after the referral was made. The quality of the action plans teams had developed to overcome obstacles remained inadequate, largely because they lacked individualization and often were not

	measurable. 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. This included providing training to teams and QDDPs, and working with the data analyst to develop user-friendly data entry tools. Admissions and Placement Department staff were clearly working hard with individuals' teams to expand the scope and definition of pre-move and post-move required supports in individuals' CLDPs. Additionally, 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. However, at the time of the current review, teams did not consistently identify all the pre-move and poste-move required supports that the individual needed to transition safely and successfully to the community. Although the measurability of supports was improving, this was an area that required attention, particularly as more complex supports were included in the plans. 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	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.	Noncompliance

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	individual or the individual's LAR, that the transfer is consistent with the individual's ISP, and the placement can be reasonably accommodated, taking into account the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities.	With regard to the availability for funding community transition of individuals from ABSSLC, funding availability was not cited as a barrier to individuals moving to the community. No one appeared to be on a waiting list, and transitions were occurring at a reasonable pace. In fact, the State's expectation was that once a referral was made, the transition to the community should occur within 180 days. Permission needed to be sought for any transitions that were anticipated to take longer than the 180-day timeframe. At the time of the review, a total of 16 individuals had been referred, and six individuals had exceeded the 180-day timeframe. One individual (i.e., Individual #328) that had been referred in June 2011 moved the week of the Monitoring Team's onsite review, reducing this number to five. Two others (i.e., Individual #152, and Individual #107) were anticipated to move in the next month or two. In discussing these individuals with the Admissions Placement Department staff, all had specific reasons that had caused the transitions to take longer than 180 days. In some cases, the individuals' medical conditions had required stabilization before they could move (e.g., Individual #152 and Individual #107). In some cases, finding the provider and specific home that could offer the necessary services and supports had taken longer than expected. In one instance, the individual had made multiple visits to homes in various areas of the state before making a decision. 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 teams had begun to identify obstacles to referral, these were limited in scope. Teams also need to identify and document obstacles to transition. It will be important for this information to be captured, analyzed, and submitted to State Office to allow work to be done to overcome such obstacles to the extent possible. 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. As noted in previous reports, one issue that appeared to delay individuals' referral to the community at times was a Local Authority (LA) representative not being at a meeting at which the team decided a referral should be made. Based on documentation the Facility provided (i.e., the Community Placement Report), one individual had not been referred to the community due to the LA not being present at their annual meeting (i.e., Individual	

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		#339). It was unclear whether or not a meeting had been held for this individual whose original meeting was held in September 2011. However, new rules had been put in place to resolve this issue. The rules were summarized in a document entitled: "Inclusion of the Designated Local Authority during Living Options Discussions." More specifically, the rules had been modified to allow a referral to be made without the LA present. The rules also set forth the parameters for ensuring LA representatives were invited to meetings, notifying the Admissions/ Placement Coordinator of referrals made during meetings, informing the LA of referrals made in their absence, and holding an additional meeting should the LA have any questions or concerns about the referral. It was positive that with these new rules, an LA representative's inability to attend a meeting would not delay a potential referral. As discussed with regard to Section F, a limited review was conducted of ISPs due to the use of a new format. The revised format specifically required professionals on the team to make an independent recommendation to the individual and his/her guardian. A total of three plans were reviewed including those for: Individual #403, Individual #371, and Individual #377. Based on this review, assessments prepared for annual ISP meetings increasingly included the assessor's recommendation regarding transition to the community. Of the three ISPs reviewed, all of the assessments for none of the individuals (0%) included the applicable statement/recommendation. However, for all three of individuals most of the assessments included such a statement. For these three individuals, two individuals' ISPs (67%) included an independent recommendation from the professionals on the team to the individual and LAR (i.e., Individual #403, and Individual #377). However, as is discussed in more detail with regard to Section T.1.b.3, for both of these individuals, the assessments and/or ISP narratives included statements showing disagreements amongst the team members regarding the individuals' appropriateness for community transition. The teams' recommendations were that the individuals remain at the Facility. However, based on documentation in the ISPs, it was not clear how the teams' disagreements about this had been resolved and/or the teams had not provided adequate justification for their decisions. In reviewing CLDPs and ISPs of those individuals that were referred, none of them had opposed transition to the community. The Facility remained out of compliance with this overarching provision of Section T of the Settlement Agreement.	
T1b	Commencing within six months of	As noted in the Monitoring Team's last report, the Facility had a policy entitled "Most	Noncompliance

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	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:	Integrated Setting Policies," dated 8/18/11. Since the Monitoring Team's previous review, the Facility had revised one of its policies related to Section T of the Settlement Agreement, entitled: "Admissions, Alternate Placement, Transfers, and Discharges." However, it was anticipated that the State Office was going to issue an updated policy related to Most Integrated Setting that likely would require modifications to be made to Facility policies. As noted in previous reports, the three Monitoring Teams had a number of concerns related to the DADS draft policy, and on 5/16/11, had submitted comments for the State's consideration. It was anticipated that the State would address the Monitoring Teams' concerns in the revised version of the policy. At parties' meetings in July 2012, the parties agreed that the Monitors would rate T.1.b as just the development of an adequate policy. The sections T.1.b.1 through T.1.b.3 would be considered stand-alone provisions that require implementation independent of T.1.b or any of the other cells under T.1.b. Due to the fact that the State and Facility had not yet finalized an adequate policy related to transition and discharge processes, the Facility remained out of compliance with this provision.	
	1. The IDT will identify in each individual's ISP the protections, services, and supports that need to be provided to ensure safety and the provision of adequate habilitation in the most integrated appropriate setting based on the individual's needs. The IDT will identify the major obstacles to the individual's movement to the most integrated setting consistent with the individual's needs and preferences at least annually, and shall identify, and implement, strategies intended to overcome such obstacles.	The specific requirements of this provision are discussed below, 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> The first sentence of this provision states: "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." Based on an agreement of the parties reached on September 7, 2012, substantial compliance with the first sentence of this provision equates to substantial compliance with the following provisions of Section F: Section F.1.d, which requires Facilities to 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; Section F.2.a.1, which requires ISPs to address, in a manner building on the individual's preferences and strengths, each individual's prioritized needs; and Section F.2.a.3, which requires ISPs to integrate all protections, services and supports, treatment plans, clinical care plans, and other interventions provided for the individual.	Noncompliance

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		As noted above with regard to Section F of the Settlement Agreement, although ABSSLC had continued to make efforts to improve ISPs, the Facility remained out of substantial compliance with Sections F.1.d, F.2.a.1, and F.2.a.3. Additional details are provided in the sections of this report that address these provisions. 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 pre-move required supports are identified and in place prior to an individual's move, and post-move required supports are provided in a timely and complete manner. <u>Identification of and Plans to Overcome Obstacles to Transition to Community</u> The revised ISP format included a section on obstacles identified by the IDT. It included the State Office's standardized list of obstacles to community referral to assist in the analysis of information collected from IDTs throughout the SSLC system. The State Office had developed a more detailed list of obstacles that teams would use should issues arise as they made efforts to transition individuals to the community. Since the Monitoring Team's last review, the Admissions Placement Department had taken the following steps with regard to obstacles and plans to overcome them: ▪ On 3/23/12, the Admissions Placement Coordinator provided training to QDDPs and other IDT members on "Essential/Non-Essential Support Identification, Obstacles to Referral/Obstacles to Community Transition, Community Transition Processes." During this training, a number of recommendations the Monitoring Team made in previous reports with regard to Section T were shared with the QDDPs and other IDT members. In addition, the list and rationale for reasons/obstacles to not make a community referral, as well as obstacles to transition were reviewed. The group also reviewed the community transition process, including the process, timeframes, and persons responsible for the various activities. The Admissions Placement Coordinator also reviewed	

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		a list of important items related to the referral and transition processes through to the post-move monitoring process. With regard to obstacles, it is important to note that this training covered some of the issues that the Monitoring Team continued to find as problematic during its review of the most recently developed ISPs. For example, the training clearly identified the need for teams to justify obstacles, such as a lack of medical or behavioral supports, if the individual was not referred. Similarly, the training addressed the need for action plans related to obstacles to be individualized. However, as noted below, both of these continued to be issues in the plans the Monitoring Team reviewed. ▪ The Facility also had developed an Excel Spreadsheet for tracking obstacles identified during team meetings. Instructions and training was provided to QDDPs. The QDDPs were responsible for entering this information into the spreadsheet within five days of the individual's annual ISP meeting. While the Monitoring Team was on site, staff provided a demonstration of the use of the spreadsheet. It was user-friendly, and appeared to be assisting with the collection of data related to obstacles. Of the three ISPs reviewed, three should have had obstacles to referral defined, because none of the individuals were referred to the community. Of these, none (0%) included an adequate list of obstacles. The problems associated with the remaining lists of obstacles included the following: ▪ Some were not adequately justified. For Individual #403 and Individual #377, the teams identified Medical Issues as one of the obstacles. As discussed in further detail with regard to Section T.1.b.3, the teams did not provide adequate justification for their determinations that medical supports were not available in the community to meet the individuals' needs. ▪ One was not correct/accurate. For Individual #371, the box for "LAR Choice" was checked, but Individual #371 did not have a guardian. Her sister was involved, but was not her guardian. This error not only had the potential to impact this individual, but also made the overall data the Facility collected inaccurate. On a positive note, the obstacles to referral teams selected now reflected the State Office's standardized list. This was an improvement over the last review. In addition, it appeared that teams were querying guardians and individuals more about the specific reasons for their reluctance to consider transition to the community. However, as the Facility staff pointed out, the list of reasons for guardian reluctance included on the State Office list was limited, and did not always adequately reflect the guardian's actual concerns.	

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		However, the Facility was not yet consistently documenting obstacles to transition. Although QDDPs and teams had been offered training on the list State Office had issued, the system for capturing such obstacles during the transition process, in ISPAs or the CLDP documentation, and then entering such information into the spreadsheet had not yet been consistently operationalized. Anecdotally, some individuals had encountered obstacles to transition, including, for example, identifying a home in the Abilene area that was accessible for someone who is blind. The home also had to be for women, and this was described as currently challenging in the Abilene area. As individuals go through the transition process, it is essential for teams to identify and document any obstacles to transition the individual encounters, as well as the team's plans to overcome them. Action plans to overcome the obstacles identified generally were not adequate. Of the three ISPs, three (100%) included an action plan to overcome obstacles identified. Of these, none (0%) were adequate. The plans were not adequately individualized or measurable (e.g., many indicated that the individual would participate in community tours, but the number or tours, the types of programs that would be visited, or the specific timeframes in which this would occur were not stated), and a number only addressed the individual, when the obstacle related to a guardian's or family member's reluctance. As has been noted previously, when a guardian is reluctant, to the extent possible, the related action plans should address the specific issues about which the guardian is concerned. For example, if the guardian were concerned about the behavioral supports available in the community, then more education or research about the individual's options for being properly supported would be appropriate topics for an action plan. Sometimes, the action plans will involve staff action as opposed to guardian action. Based on interviews, Facility staff recognized that this was an area that continued to need improvement. The following additional detail is provided regarding the specific issues the Monitoring Team noted with the action plans related to overcoming obstacles: ▪ For Individual #403, the only plan to overcome obstacles was: "[Individual #403] and her LAR will continue to receive educational information about community living options and [Individual #403] will participate in at least one community living option tour in the next year." Although Individual #403's guardian had expressed some very specific concerns, these were not addressed through this action plan. The community tours were not individualized in any manner to address this individual's specific needs. In addition, given that the team had identified "Medical Issues" as an obstacle, no specific action plan was included to address this obstacle. For example, it was unclear if the team had specific knowledge about options that might be available for individuals with complex medical needs. If not, an action plan should have been included to	

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		conduct further research. ▪ For Individual #371, although a plan was developed to overcome the obstacles, it was not adequate. The family, although not the guardian, had some specific concerns. Many of these showed a lack of understanding of supports available in community settings. However, specific educational supports were not identified to address these specific issues. The only action step related to further education was for the Local Authority to send information about providers in a specific area. The other obstacle listed was "Individual Choice... Lack of understanding of community living options." The only action steps were: "will continue go on (sic) community tours," and the implementation of skill acquisition programs related to proper etiquette in community bathrooms and fastening a seat belt. Pre-requisites for community living such as teaching bathroom skills and fastening seat belts are inappropriate. Many individuals live in the community without these skills, and such skills can be taught in the community. These objectives might have been appropriate, but not under the heading of supports to facilitate the individual's movement to the most integrated setting. Although offering Individual #371 additional community tours was positive, the objective was not measurable, and it was not individualized. In addition, none of these objectives appeared to be specifically designed to assist the team in determining what Individual #371's preferences were, which appeared to be the real obstacle. For example, the objective related to community tours did not identify the frequency of the tours, who would attend with her, how her preference would be assessed, when the team would meet to review her reactions, etc. ▪ For Individual #377, the ISP identified as obstacles: 1) the individual's choice - lack of understanding of options; and 2) medical issues. The only action plan related to either of these obstacles was inadequate and not individualized. It read: "will go on a community options tour in the next year." No action plan was included to increase the team's knowledge of options for an individual with complex medical needs, or to address some of Individual #377's mother's specific concerns. The team's knowledge of community options was particularly important, given that the mother was not interested in becoming guardian, and the team had drawn the conclusion that Individual #377 could not make her own decisions. As a result, the team would need to make this decision on her behalf. ABSSLC had made some progress in identifying obstacles to community transition, but more work was needed. The quality of the plans teams had developed to overcome such obstacles remained inadequate, largely because they lack individualization and often were not measurable. These deficiencies, 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.	

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	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.	At the December 2011 parties' meeting, the Monitors and parties agreed upon a format/outline for assessing this section, which is reflected in this report. 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: ▪ **Annual provider fairs**: As noted in the previous report, 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. Since the last review, in response to the need for families to be able to attend a Provider Fair, the Facility offered a provider fair on Saturday, April 21, 2012. Similarly, the Admissions/Placement Department sent out a questionnaire ahead of time to assist individuals and staff in asking questions. Based on the sign-in sheets provided, approximately 94 individuals, two family members, 24 staff, and eight providers attended. As Facility staff indicated, the attendance at this Saturday provider fair did not show increases from previous fairs, particularly with regard to family involvement. However, for one family that attended, it was helpful in their efforts to identify an appropriate provider to support the individual's needs. Another provider fair was scheduled for September 14, 2012. ▪ **Education about community options:** Individuals and their guardians also were provided information through the Local Authority CLOIP process. Based on tracking sheets provided, it appeared that this occurred regularly as part of the individual planning process. However, it did not appear that outcomes/measures had been determined and/or data collected regarding the number of individuals and families/LARs who agree to take new or additional actions regarding exploring community options, or the number of individuals and families/LARs who refuse to participate in the CLOIP process. Collection and review of such data would allow the State to evaluate the effects of the process and make changes made to future educational activities. ▪ **Tours of community providers**: Visits to community group homes and day programs continued to occur. Based on documentation between 2/24/12 to 7/6/12, 18 such visits occurred. Approximately 44 individuals participated in the visits. This was an increase in the numbers of visits as well as the individuals involved when compared with the Monitoring Team's previous review. 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	Noncompliance

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		community. However, as discussed in further detail below, such action plans often were not individualized or measurable. In addition, it was unclear if data had been analyzed to ensure that: a) all individuals have the opportunity to go on a tour (except those individuals and/or their LARs who state that they do not want to participate in tours); b) places chosen to visit are based on individual's specific preferences, needs, etc.; and 3) the individual's response to the tour is assessed. It was positive to see that the form entitled "Community Living Options Tour Attendance Sheet" included space to document the individual's reaction. However, it was not clear how this information was utilized, or how the various factors that could impact an individual's reactions were assessed (e.g., time of day, staff accompanying the individual, etc.). ▪ **A plan for staff to learn more about community options**: Although ABSSLC had not provided a formal plan to address education on community living options to management staff, clinical staff, and direct support professionals, they had continued to take a number of steps to provide educational opportunities. However, this should be formalized in a plan. On the forms used to track individual's attendance on community tours, the Facility also was identifying the staff, including their titles that participated in the community tours, as well as the provider fair. It was not clear if data regarding staff training were being aggregated and analyzed. ▪ **Individuals and families have opportunities to learn about success stories:** Individuals, staff, and families had other opportunities for learning more about community options. For example, the March/April and May/June editions of the Maple Street Messenger included articles highlighting stories about individuals that had moved to the community. These were good articles that discussed some of the new opportunities the individuals had had since they moved. Staff were planning to contact the guardian of an individual with more complex medical needs that recently had transitioned to the community to discuss the possibility of an article that would show the types of supports available in the community to support a variety of needs. In addition, staff had come up with some creative ideas, such as having people email their questions about community transition, and including a question and answer forum in the Maple Street Messenger. However, the following were areas that the Facility had not yet addressed fully: o Providing opportunities for individuals to visit friends who live in community; o As appropriate, pairing families/LARs who have experienced a successful transition with families/LARs who are reluctant; and o If aggregate data showed that families and guardians had similar	

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		concerns, then using mechanisms to provide information on specific topics. For example, offering specific educational seminars might be useful. ▪ **Education may be provided at Self-Advocacy, house, and Family Association meetings, or other appropriate locations:** The Admissions Placement Department staff were offering education at Self-advocacy meetings. The Human Rights Officer had agreed invite them once every six months. The Admissions Placement Coordinator recently had presented at the Self-Advocates meeting on 5/8/12. As noted in the last report, on 10/1/11, the Admissions Placement Coordinator attended the ABSSLC Family Association Meeting, and presented some information about admissions and community placement. A forum for education that the Facility did yet provide evidence of included house meetings for the individuals. ▪ **Regular SSLC meeting with the Local Authority:** This was not an activity that the Monitoring Team discussed with specifically with Facility staff, and no documentation was provided regarding such interactions. Although the Facility appeared to have a good working relationship with the Local Authorities, more information about formal meetings will be requested during the next review. ▪ **Individualized Plans:** The most challenging area with regard to education of individuals and LARs/families is individualizing this process, and documenting that individuals and their guardians are making informed decisions. In reviewing three recently completed ISPs, three (100%) had a plan that addressed education about community options. However, none of these (0%) were adequate. The following concerns were noted: o None of the plans were individualized to address the individual and/or the LAR's particular needs or concerns. The action plans developed did not, for example, target specific types of providers for community tours, identify research that the team would do to answer the individuals or their guardians' questions, include visits to peers with similar needs that had moved to the community, etc. It is essential that teams individualize action plans using the information that the team is able to gather about the reasons for the individual, family member or LAR's reluctance. For example, if an LAR has questions about the specific supports available in the community, identifying providers with expertise in providing such supports and introducing the LAR or family member to such providers would be important. For some, talking to another guardian or family that has experienced a transition to the community might be helpful. At the time of the review, this had not yet occurred. Creative ideas and brainstorming within ABSSLC and with other SSLCs will be necessary to identify the best ways to provide effective educational opportunities. Some examples of concerns related	

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		to the individualization of action plans included: ▪ For Individual #403, the only plan to overcome obstacles was: "[Individual #403] and her LAR will continue to receive educational information about community living options and [Individual #403] will participate in at least one community living option tour in the next year." Although Individual #403's guardian had expressed some very specific concerns, these were not addressed through this action plan. The community tours were not individualized in any manner to address this individual's specific needs. ▪ For Individual #371, the family, although not the guardian, had some specific concerns. Many of these showed a lack of understanding of supports available in community settings. However, specific educational supports were not identified to address these specific issues. The only action step related to further education was for the Local Authority to send information about providers in a specific area. The other obstacle listed was "Individual Choice... Lack of understanding of community living options." The only related action steps was: "will continue go on (sic) community tours." Although offering Individual #371 additional community tours was positive, the objective was not individualized. o Most of the plans were not measurable, nor did they provide for the team's follow-up to determine the individual's reaction to the activities offered. Many of the plans involved participation in community tours, but did not say how many or when these would occur. No methodologies were included to ensure that the individual and/or guardian's questions were answered (e.g., helping them write a list of questions specific to them, or a staff person assisting with asking questions). No specific strategies were included to obtain the individual's reaction at the time or shortly after an educational opportunity. For example: ▪ For Individual #371, the action step: "will continue go on (sic) community tours" was not measurable, and did not provide an adequate description of the methodology. For example, the objective did not identify the frequency of the tours, who would attend with her, how her preference would be assessed, when the team would meet to review her reactions, etc. ▪ Similarly, although the action step related to education for Individual #377 was measurable, it did not describe an adequate methodology. It read: "will go on a community	

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		options tour in the next year." It also was unclear why it would take up to a year for this to occur. o None of the plans indicated whether or not there was a plan the previous year and/or if it was completed. Although the Facility was continuing to complete some of the basic activities related to education and some progress had been made in expanding these opportunities, minimal progress had been made since the last review in individualizing the process. Although more individuals had a plan in their ISP, the plans were not individualized or measurable. The individualization of this process is key to ensuring that individuals and their guardians are 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 an excerpt from State Office policy on Personal Support Plan Process related to Living Options Discussion, dated 7/30/10. The Facility had begun to implement the State Office's plan to have each professional member of the IDT document his/her recommendation regarding the individual's ability to transition to the community in the assessments completed prior to annual ISP meetings. In addition, at the ISP meeting, the professional members of the team needed to make a recommendation to the individual/guardian. As discussed with regard to Section F, the State asked the Monitoring Teams to review a smaller sample of ISPs, but provide more specific comments on them. This was because a new template/format was being used, and the State recognized that the former formats were not resulting in adequate ISPs. The new format included a section that more specifically addressed teams' recommendations regarding transition to the community. Below, the Monitoring Team has provided findings as well as a number of specific examples based on the review of three ISPs that used this new format (i.e., Individual #403, Individual #371, and Individual #377): ▪ Some professionals' assessments included the required statements/ recommendations, and others did not. However, this was an area in which improvement was seen. Of the three ISPs reviewed, for none (0%) did all of the assessments include the applicable statement/recommendation. However, for all three, most of the assessments provided included a statement/ recommendation. The following provides more specific information:	Noncompliance

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		o For Individual #403, many of the assessments included specific statements about whether or not the individual could be supported in a more integrated stetting. Those that did not included Recreation, OT/PT, and Dental. In addition, no formal recommendation was made formally from the QDDP, DSP or residential staff. This was the case for all of the individuals reviewed. o For Individual #371, many assessments were missing. Those that were present generally included a specific recommendation about the individual's appropriateness for a more integrated setting, with the exception of the dental assessment. o For Individual #377, the assessments that did not include the expected recommendation were dental, medical, and speech (i.e., outdated assessment). ▪ Of the three ISPs reviewed, none of the individuals had been referred for transition to the community. For these three individuals, two individuals' ISPs (67%) included an independent recommendation from the professionals on the team to the individual and LAR (i.e., Individual #403, and Individual #377). However, the following problems were noted: o For one individual (33%), no independent recommendation was found. Specifically: ▪ For Individual #371, there was no indication in the ISP that individual team members were polled regarding their opinions about whether or not Individual #371 could be supported in a more integrated setting. The sister, who was not the guardian, indicated that she would prefer for Individual #371 to remain at ABSSLC, but was open to receiving further information about options closer to where her family lives. The team concluded: "The IDT agreed that [Individual #371] can live in a less restrictive environment, but we are unable to gauge what she likes and dislikes. The IDT will set more SAPs in place to prepare [Individual #371] by training her in pedestrian safety, proper community etiquette, and personal hygiene. The Home Activity Specialist will take [Individual #371] over to the 2nd Edition store to allow [Individual #371] to pick up what she likes and better determine how to know what she likes and dislikes." In the Rights Assessment, the team had identified that the individual could not provide informed consent in any of the five areas identified. As a result, the team likely would need to make this decision for the individual. Although it would be important to try to determine her preference regarding community transition, it was unclear how the team intended to	

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		do this. Moreover, no independent recommendation of just the professionals on the team was included in the ISP document. o For two individuals (67%), the assessments and/or ISP narrative included statements showing disagreement amongst the team regarding the individual's appropriateness for community transition (i.e., Individual #403, and Individual #377). For both of these individuals, the professional team members' recommendation was that the individual remain at the Facility. However, it was not clear how the team disagreement about this had been resolved and/or the team had not provided adequate justification for its decision. For example: ▪ For Individual #403, according to the assessments and the ISP, everyone except for the physician indicated she could be served in a less restrictive setting. However, the ISP indicated that: "The **facility discipline members** (independent of the resident and LAR/family) determined that [Individual #403] would not benefit from moving to a less restrictive environment at this time. This determination is based on [Individual #403's] need for 24-hour medical care. The team also identified that [Individual #403] does not like change and has great relationships at AbSSLC." No information was provided regarding how the discrepancies between the physician and all of the other team members were reconciled, and why the other team members changed their minds. In addition, "24-hour medical care" was not defined. The ISP did not include integrated health care plans, and, therefore, no description was provided of the measurable health care supports the individual required. ▪ For Individual #377, most assessments indicated she could be served in a less restrictive environment. The only assessment that indicated she could not be was nursing. The ISP did not reconcile these differences in opinion. In one section of the ISP, the team indicated: "If everything that is currently provided at AbSSLC could be provided in the community, every represented department believes [Individual #377] could be served in a less restrictive environment." However, in the section in which the team's recommendation was documented, the team stated: "The facility discipline members (independent of the resident and LAR/family) determined that [Individual #377] would not benefit from moving to a less restrictive environment at this time. This determination is based on [Individual #377's] need for 24-hour medical care. The team also identified that	

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		[Individual #377] does not like change and has great relationships at the AbSSLC. The IDT is also respectful of [Individual #377's] primary correspondent's wishes for her not to move." The team did not define "24-hour medical care," nor did it describe any efforts to identify such supports in a more integrated setting. In one portion of the ISP, the team made the statement: "The IDT discussed that [Individual #377's] seizure activity is so great that supports are not available for community placement. The only placement with 24-hour nursing is a nursing home, and the team feels that is not an appropriate placement for [Individual #377]." Although the Monitoring Team agrees that a nursing home is not an appropriate placement, the team provided no information regarding how it reached the conclusion that nursing homes were the only settings in which 24-hour nursing was available, nor did the ISP include any health care plan(s) that described the specific roles that nurses needed to play on a 24-hour basis to maintain Individual #377's safety and health. If such supports were being provided, the ISP did a poor job of delineating them. As a result, the team's decision was not adequately justified. As noted in the last report, for some individuals (i.e., Individual #403 and Individual #377), team members 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." 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, and persons responsible. The Facility had made some progress in this area. Specifically, more assessments were including a statement/recommendation regarding whether or not the individual could be supported in a less restrictive environment. The new ISP format appeared to be assisting professional members to make a specific recommendation independent of the individual and his/her guardian. However, problems were noted with regard to teams	

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		documenting resolution of team member disagreements regarding individuals' appropriateness for community transition, as well as the justification for their decisions when most team members stated the individual could be served in a more integrated setting, but the team recommended that the individual not be referred. 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, some progress had been made with regard to teams' development of CLDPs. The CLDPs included a wider scope of pre-move and post-move required supports (it was agreed at the parties' meetings in July 2012 that the terminology "essential and nonessential supports" would be replaced with "pre-move and post-move required supports"), and the supports were often more detailed. However, team members needed to improve the assessments that contributed to the CLDPs, and ensure that a comprehensive set of protections, supports, and services were detailed in the CLDPs. Community Living Discharge Plans were reviewed for four of the eight individuals who had transitioned from the Facility to the community since the Monitoring Team's last onsite review, representing 50% of this group of individuals. The CLDPs reviewed were for Individual #272, Individual #43, Individual #267, and Individual #375. With regard to the timeliness of the Community Living Discharge Plans, three (75%) 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 pre- and post-move required supports. 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. The timing of the fourth plan (i.e., for Individual #375) appeared to be largely driven by the guardian. It was developed very quickly, and the individual moved approximately a week after the CLDP meeting. Although it was three months after the initial referral, the identification of the provider and the team meetings related to the CLDP appeared to mainly have occurred in the three weeks prior to the transition. It was unclear from the documentation whether the team was concerned about the limited time to plan this transition, and if so, if recommendations were made to the guardian to slow the process down. Given the individual's numerous previous failed community placements, it would be particularly important for an adequate transition process to occur. With regard to the timeliness of the development of CLDPs, the Facility had sustained its progress. However, as is detailed in further detail below, the Facility was not yet in compliance with developing and implementing adequate CLDPs.	Noncompliance

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	1. Specify the actions that need to be taken by the Facility, including requesting assistance as necessary to implement the community living discharge plan and coordinating the community living discharge plan with provider staff.	The Community Living Discharge Plans reviewed included a number of action steps related to the transition of the individuals to the community. 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: ▪ Many of the plans identified the need for training for community provider staff. This had been improved by providing more information about what would be included in the training. However, the pre-move required supports 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., didactic training, shadowing staff, demonstration of competence, etc.). In the few cases where competency-based training was identified for some aspects of the training (e.g., Individual #199), the evidence identified to confirm the provision of the training was not adequate. Requiring "sign-in sheets" as evidence for competency-based training was not adequate. The specific competency check-off forms should have been identified. In addition, 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. For some individuals, specific components of their ISPs should be targeted for more intensive training of community provider staff prior to the individual's transition (i.e., a pre-move required support), or, at a minimum, evidence that the community provider staff have the competencies necessary to safely support the individual (e.g., transfer techniques, or crisis intervention techniques, including physical holds, etc.). ▪ Missing from most of the plans was any requirement that collaboration occur between the Facility clinicians currently working with the individual and the community clinicians who would assume responsibility for supporting the individual (e.g., medical staff, nurses, therapists, psychologists, etc.). For many individuals, this would be necessary to ensure ongoing coordination of care. In a couple of the plans reviewed, action steps were included for the ABSSLC nurse to meet with the community provider nurse. This was positive, however, not necessarily well defined. However, for other clinicians, such as the psychologist/behavior analyst, psychiatrist, physician, habilitation therapists, etc., no such action steps were included. ▪ Similarly, no coordination was specified as needing to occur between current	Noncompliance

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		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). ▪ 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 pre- and post-move required 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 many additional pre- and post-move supports the individuals required. 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%) generally 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. However, in order to remain in substantial compliance, the Facility is cautioned to ensure that as the supports included in CLDPs expand that adequate timeframes and persons responsible are assigned. The Monitoring Team had begun to see some supports for which adequate timeframes and specific staff responsible had not been adequately detailed. Although only a couple of these situations were found (e.g., nursing care plans for Individual #375, as well as BSP implementation and monitoring of data for the same individual), this likely will become more of an issue going forward as more complex supports are included in	Substantial Compliance

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		the CLDPs. For example, implementation of plans, such as PNMPs, health care plans, and PBSPs, will require a start date, and then a frequency to be stated for a number of different aspects of plan implementation (e.g., daily implementation and documentation, monthly review by a clinician, at least annual review or as needed modifications to the plan, etc.). This will require a lot more detail regarding both timeframes and persons responsible.	
	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
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 ISP 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 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 included in previous reports was the use of a podiatrist to cut	Noncompliance

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		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 were not adequately justified. The following phrase was found in a number of assessments: "Discontinue recommendations from the ____ assessment as these were related to programming at this facility." It is unclear why therapeutic supports and/or other services provided at the Facility would not be relevant to the individual in the community. Numerous examples were seen of nursing care plans being discontinued, use of communication dictionaries, and for one individual, a behavior support plan and crisis intervention plan (i.e., Individual #43). None of these decisions were adequately justified. ▪ Most of the assessment formats were not designed to provide a summary of relevant facts related to individuals' stays at the Facility. Although it is understandable that an individual's full history cannot be included in a discharge summary, it is important that the Facility provide community providers with a summary of, for example, treatments or plans that have particularly successful or unsuccessful, and important milestones during the individual's stay at the Facility. ▪ 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.). Although occasionally, particularly some of the psychological assessments included recommendations about the need for ongoing involvement of a BCBA or psychologist (e.g., Individual #267). ▪ 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 any modifications that needed to be made to accommodate community settings that might not have nurses available at all times. Similarly, except to discontinue a BSP and crisis plan for Individual #43 and put in place a crisis plan that essentially involved calling the police, the 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	

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		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 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	The CLDPs reviewed included pre-move and post-move required supports. In the last report, the Monitoring Team noted that progress had been made, and since then, additional progress definitely was being made. Admissions and Placement Department staff were clearly working hard with individuals' teams to expand the scope and definition of pre-move and post-move required supports. Additionally, 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. However, as has been noted in previous reports, 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. However, at the time of the current review, teams did not consistently identify all the pre-move and poste-move required supports that the individual needed to transition safely and successfully to the community. Although the measurability of supports was improving, this was an area that required attention, particularly as more complex	Noncompliance

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	Facility before the individual's departure from the Facility.	supports were included in the plans. 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. During the onsite review, the Monitoring Team met with many of the discipline leads as well as staff from the Admissions Placement Department. The CLDP for Individual #272 was reviewed as an example. As was illustrated during this review, the team had not included a full array of pre-move and post-move required supports. The Monitoring Team encouraged the discipline leads to support their departments in providing adequate assessments for the CLDPs, as well as understanding the importance of including detailed and comprehensive pre-move and post-move protections, supports, and services in CLDPs. In none of the four plans reviewed (0%) was a comprehensive set of pre- and post-move required protections, services, and supports identified in measurable terms. The Monitoring Team has provided many examples of concerns in previous reports. The following summarizes the progress as well as the general concerns noted: ▪ As noted above, the scope of the protections, services, and supports included in CLDPs had improved. However, many supports were not included. As the Monitoring Team previously has recommended, teams should visualize the individual with no supports at all, and then identify each and every support that was needed to assist the individual to be successful in a particular community environment(s). 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. ▪ An area in which improvement was noted was in supports related to the clinical services (e.g., psychology/behavior, psychiatry, habilitation therapy, etc.) that were sometimes now referenced in the CLDPs. Often, the need for such supports was identified. However, the intensity of the supports generally was not identified, nor were the qualifications or the roles of clinicians clearly defined. Although not consistent across all relevant plans, the qualifications for psychologists had been identified, and some 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. For example, for an individual that had a number of nursing supports or habilitation therapy needs, work needed to be done with the community providers to determine how equivalent supports would be provided	

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		in community settings where nurses were not stationed in each home, and habilitation therapists generally were external vendors. ▪ 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, although teams had begun to reference nursing care/health management plans in CLDPs., little, if any, detail was provided about how they would be implemented in the community. For example, the role of nursing staff in the community versus direct support staff was not defined. It was not at all clear what level of nursing staff (i.e., RN or LVN, and/or the amount of time per day/week) was necessary. Likewise, individuals who were receiving habilitation therapies supports at ABSSLC did not have functionally equivalent supports identified in their CLDPs. Therapists at ABSSLC played a number of roles, including staff training, provision of direct therapy, monitoring of programs, monitoring of equipment, etc. Other than initial appointments with therapists in the community, it was unclear how these functions were being transitioned. ▪ 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 pre- and post-move required supports. ▪ 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. ▪ An area in which some improvements were noted was in the inclusion of various plans to be implemented (e.g., health management plans, PNMPs, diets, etc.). However, this was an area that required continued attention. For some individuals (e.g., Individual #199), some of the plans were identified as requiring implementation, but others were not. ▪ Many of the individuals reviewed had specific health care indicators that needed	

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		to be monitored and reported (e.g., constipation, input/output, seizures, weight, meal refusals, psychiatric symptoms, etc.). Although these sometimes were now included in the CLDPs, this was not consistently done. Even when they were included in the CLDPs it was not consistently clear which specific staff were responsible for monitoring such indicators, and when specific criteria were met, reporting these to health care staff. ▪ The only CLDP that identified a crisis intervention plan was for Individual #43, and it was inadequate. He had moved to his family's home, and the options in a crisis were for his guardian to call the provider agency or the police. No description or requirements were set forth for the provider agency's crisis intervention services, leaving open the likely possibility that the police would need to be involved. The BSP also had been discontinued without any support in the CLDP for a psychologist in the community to follow-up to determine if a BSP was necessary. For the remaining individuals, no crisis intervention plans were included in the CLDPs, and/or descriptions of 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 generally were 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.	

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		As noted above, the CLDPs continued to show some improvements. After each of the Monitoring Team's reviews, it was clear that efforts were made to better define pre- and post-move required supports. However, teams were still working from inadequate ISPs, and the CLDPs continued to be missing many necessary protections, services, and supports. As noted in previous reports, with regard to Monitoring by the MRA (i.e., now Local Authority) or other means to ensure pre-move required supports were in place prior to an individual's transition, the LA's review appeared to be a general safety assessment as opposed to an individualized assessment based on the pre-move required supports identified by the team. The only assurances that the LA staff completing the "Pre-Move Site Review Instrument for the Community Living Discharge Plan" had that the pre-move required 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 pre-move required 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 pre-move required supports were in place. However, the Post Move Monitor continued to conduct a pre-move site visit designed specifically to determine if the pre-move required supports were in place. A review was conducted of six individuals' pre-move site visit documentation (i.e., Individual #199, Individual #539, Individual #272, Individual #43, Individual #267, and Individual #375). For many of the supports listed, these reviews appeared thorough, and included each pre-move required 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 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. In addition, for Individual #43, a pre-move required support read: "Training on the Crisis Intervention Plan to guardian and… core staff." The ABSSLC nurse provided training to the provider core staff. This was not consistent with the pre-move support as written, but the Post-Move Monitor did not identify this as a concern. The same was true for the training on the use of adaptive	

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		equipment. The HT staff were supposed to provide the training, and did to the guardian, but the nurse provided it to the provider staff over the phone. 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 pre-move required supports are appropriately identified in individuals' CLDPs. Overall, a finding of noncompliance was made for this component of the Settlement Agreement. Although progress had been maintained with regard to confirmation of pre-move required supports, concerns were noted with the confirmation of training completion. In addition, progress continued to be made with the delineation of the pre- and post-move required supports in individuals' CLDPs. However, many protections, supports, and services continued to be missing. The Facility remained out of compliance with this provision.	
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 Monitoring Team's previous review, the Facility was using the monitoring tools that had been modified based on the Monitoring Teams' audit tools. At the time of this most recent review, the Facility continued to conduct audits using these tools. The QA Department conducted reviews of CLDPs, and the post-move monitoring process. The Admissions Placement Coordinator also conducted reviews of a sample of post-move monitoring reviews, and the Post-Move Monitor conducted reviews of some CLDPs. The QA Department, and the QDDPs assigned to complete monitoring for Section F conducted reviews of the Living Options component of Section T. ▪ The QA Department and staff from the Admissions Placement Department met monthly. Since the Monitoring Team's last review, the group had begun to maintain minutes. Based on review of minutes between April and July 2012, it appeared they had discussed some logistics of monitoring, as well as some criteria for monitoring a few specific indicators. Coordination with the group that monitors Section F also was discussed, and it was decided the Program Compliance Monitor for Section T would begin to attend the Section F meetings. ▪ The Facility had continued to incorporate the data from its monitoring process into its self-assessment. ▪ In order for an adequate quality assurance system to be in place with regard to Section T, outcome measures need to be available to measure individuals' successes as well as problems in the community. This is necessary to assist the Facility to determine if its planning and implementation of individuals' transition are adequate. The Monitoring Team had asked for some basic data in	Noncompliance

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		this regard, and for this review, the Facility provided a summary of the data it had collected. Specifically, the Facility provided a list of individuals who had transitioned to the community indicating whether or not since their transition, they had: 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, including a brief description of any action the Facility took with regard to any of these occurrences. As discussed below, the next step in this process will be analyzing this information, through thorough and critical reviews of the circumstances of such incidents/events, and determination of whether or not improvements are needed in the transition processes. Areas in which continued efforts needed to be made included: ▪ As noted in the previous report, 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. It was positive, however, that the QA Department and staff from the Admissions Placement Department met monthly with one goal being to attempt to resolve discrepancies in monitoring. However, based on a review of the minutes of these meetings from April through July as well as aggregate data included in the QA/QI data summaries for the second and third quarters, limited progress had been made in this regard. Areas with the greatest discrepancy had been noted, but no plan was presented to correct these differences. A standard inter-rater reliability methodology should be used statewide, and focus should be placed on ensuring that not only are the results of the monitoring similar, but also that they are 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	

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		ensure accuracy in monitoring as well. ▪ Based on interview with Facility staff, they had not yet begun to analyze the data mentioned above related to outcomes for individuals that had transitioned to the community, but recognized the need to do so. ▪ Similarly, analysis of the monitoring data, and development of appropriate corrective action plans had not yet occurred to the extent necessary. The QA/QI Data Summaries for the second and third quarters did not include the types of information needed to allow the QA/QI Council to identify specific areas requiring improvement, and to develop appropriate corrective action plans to address them. Data were reported as overall compliance scores. As the Monitoring Team has stated in the past, because the tools were not weighted, overall compliance scores were meaningless. Most importantly, they did not provide the reader of these reports with information about the specific issues that the monitoring had uncovered. 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 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. Since the Monitoring Team's last review, the Facility's progress in this area remained essentially unchanged. The Facility should continue to expand its monitoring activities for Section T, 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	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. As noted in the Monitoring Team's previous report, 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 annual	Noncompliance

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	such information to produce a comprehensive assessment of obstacles and provide this information to DADS and other appropriate agencies. Based on the Facility's comprehensive assessment, DADS will take appropriate steps to overcome or reduce identified obstacles to serving individuals in the most integrated setting appropriate to their needs, subject to the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities. To the extent that DADS determines it to be necessary, appropriate, and feasible, DADS will seek assistance from other agencies or the legislature.	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. ▪ 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. 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 noted in the Monitoring Team's last report with regard to Section T.1.b.1, the Admissions Placement Coordinator had begun to implement some creative options to address this issue. Since the Monitoring Team's last review, the Facility's teams had been provided additional training. 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	

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		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 from other state agencies (e.g., DARS). Since the Monitoring Team's last review, the Facility had continued to gather data related to obstacles. As discussed in detail with regard to Section T.1.b.1, concerns continued to exist with teams' accurate identification of obstacles. Based on review of individuals' ISPs, teams continued to struggle with understanding the potential obstacles, and selecting the appropriate ones, particularly the subcategories. As a result, the validity of the data was questionable. For example, in reviewing aggregate data included in the Third Quarter Obstacle Report for the quarters between March 2012 and May 2012, the report stated: "individual reluctance continues to be the second highest obstacle to referral. Teams continue to struggle with identifying an individual's preference for alternate living." Based on a review of a limited number of ISPs, it appeared that at times, teams identified this obstacle, even when for example, an individual's understanding of living options could not be and likely never could be assessed. Careful planning also would be necessary to allow teams to assess an individual's preferences for community transition, when the team had difficulty assessing the individual's preference for less complex choices. It is also important to note that the second and third quarter reports only identified obstacles to referral, but not obstacles to transition. As discussed with regard to Section T.1.b.1, as individuals go through the transition process, it is essential for teams to identify and document any obstacles to transition the individual encounters, as well as the team's plans to overcome them. In its second and third quarter obstacles reports, the Facility had included recommendations related to increasing the accuracy of obstacles and the quality of related action plans, as well as developing a better tracking system. Although these were necessary activities, the reports did not yet include any recommendations about ways to	

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		potentially address the trends that had been identified through the review of the aggregate data on a more systemic level. The Facility would soon be submitting its annual report to the State, which should include an analysis of data collected thus far. As discussed while the Monitoring Team was on site, it also will be important for the Facility to incorporate staff's knowledge of issues that potentially impede transition. Actions the Facility can take locally or with which Transition Specialists can assist, as well as those that fall more into the realm of DADS State Office should be incorporated into the report. 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	In response to a document request, the Facility submitted to the Monitoring Team a Community Placement Report. For the time period between 3/1/12 and 7/12/12, the report listed: ▪ Current Referrals: 19 individuals were included on this list. At the time of the review, four of these individuals had transitioned to the community, and one reportedly had rescinded the referral. ▪ Community Placements: three individuals were included on this list. ▪ Rescinded Referrals: three individuals were included on this list. The reasons for the referrals being rescinded were "LAR Choice," "IDT Decision: Behavior/Psychiatric," 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 9/1/11 and 7/12/12, the report listed: ▪ Individual Prefers Community, Not Referred – LAR Choice: This list included three individuals. ▪ Individual Prefers Community, Not Referred – Other Reasons: This list included five individuals. For three, 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	Substantial Compliance

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	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.	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. In the future, the Monitoring Team will be asking for "the Community Placement Report (inclusive of all five components) for the six-month period since the last one was produced and submitted to the Monitoring Team (i.e., the report should start with the day following the last day covered in the last report submitted)." This is to ensure that full information is provided, and one report can be compared with the last. The report the Facility submitted for this review did not cover a six-month period of time, and there was a lapse of information from the last one the Facility submitted, which covered the period from 9/1/11 and 1/12/12. This left an approximately six-week period of time uncovered. Although the Facility remained in compliance with this provision, the Monitoring Team would appreciate it if the Facility would provide information in the format described moving forward.	
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	<u>Timeliness of the Checklists</u> Post-move monitoring documentation was reviewed for seven of the eleven individuals (64%) for whom monitoring had been completed since the last review (i.e., Individual #199, Individual #504, Individual #539, Individual #272, Individual #43, Individual #267, and Individual #375). For these individuals during the time period reviewed, the ABSSLC Post-Move Monitor should have conducted 16 reviews. Of the 16 required visits, 16 (100%) had been documented as having been completed on time. <u>Visits to All Sites</u> 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>	Noncompliance

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	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.	All of the post-move monitoring reports used the updated format, which was consistent with the format the Settlement Agreement required. In fact, the new format included some additional items from those included on the sample tool provided in Appendix C of the Settlement Agreement. These additions enhanced the tool, and appeared to assist the Post-Move Monitor in reviewing important elements of the protections, supports, and services the community providers offered to individuals that had transitioned. Each of the items on the checklists reviewed had been addressed. Efforts continued to be made to add additional information regarding the interviews conducted, the documents reviewed, and the observations made. Often, this was stated briefly in the charts containing the listings of the pre- and post-move required supports, and was expanded upon in the "Additional Comments" section. To ease review of the reports, the Post-Move Monitor had begun to underline the topic of the pre- or post-move required support being discussed in the "Additional Comments" sections. This should facilitate the IDTs review of the often lengthy reports. The narrative sections also described the findings of the review. Generally, it appeared that thorough reviews had been completed, and the narrative helped significantly in justifying the Facility's findings. The checklists reviewed generally were completed thoroughly. To put this in context, because many additional supports were appropriately being added to the CLDPs, the post-move monitoring activities had become more complicated. Given this factor, it was positive that the reports were generally completed in a thorough manner. However, some concerns were noted with regard to ensuring and/or documenting that each pre- and post-move required 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 often did not adequately define 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, nor was it clear how many staff were supposed to receive the training (e.g., if day and residential staff were to be trained, a roster of staff was not provided, so it was not clear how the Post-Move Monitor determined that all staff had been trained). Only occasionally training was required to be competency-based (e.g., Individual #199). However, the documentation only consisted of sign-in sheets, and the competency-based column was not checked. It was unclear how the Post-Move Monitor confirmed that the competency-based training occurred. ▪ In some cases, the documentation did not support the Post-Move Monitor's thorough review of the support stated in the CLDP. For example: o For Individual #199, one of the post-move required supports was for an OT/PT assessment. It appeared she was seen by a PT, but not an OT,	

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		despite the provider having some questions about diet texture, which the Post-Move Monitor indicated could be addressed by an OT. No follow-up was found regarding the fact that she was only seen by a PT, not an OT. o For Individual #43, no mention was found in narrative about whether or not PCP addressed potential need to see neurologist as required per the post-move support. o For Individual #272, a pre-move support required continuation of certain nursing care plans. At the seven-day monitoring, the provider staff indicated the ABSSLC nursing care plans were in the records for staff's reference. However, no indication was provided that they were being implemented and/or necessary tracking completed. However, the PMM did not note this as a problem and rated the post-move required support as being in place. The same was true at the 45- and 90-day monitoring visits. In addition, it was not clear from the documentation whether or not the PMM was reviewing behavioral data at both the day program and residence. o Similarly, for Individual #267, the nursing care plans were not reviewed for implementation. The Post-Move Monitor just noted they were in the record and staff had been trained. The support read: "Continue Nursing Care Plans for Menstrual Cramps, Seizures, and Referred Otalgia - Oral Hygiene Deficit," but there was no indication that documentation was reviewed in relation to implementation of these plans. <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. As during the last monitoring review, in the sample of post-move monitoring reports reviewed, the Post-Move Monitor identified a fairly limited number of concerns. For one individual, no issues requiring further follow-up were noted (i.e., Individual #43). For two of the remaining six individuals (33%), issues were identified and addressed appropriately (i.e., Individual #539, Individual #375). However, for four individuals, 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, teams did not take timely and appropriate action to address issues the Post-Move Monitor brought to their attention. For example: o For Individual #199, despite a request from the Post-Move Monitor for the team to review the new BSP, which removed the tangible	

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		reinforcement program, after the 5/4/12 review, the team did not meet until 5/31/12, apparently in response to regression and Individual #199's request to return to ABSSLC. Even though Individual #199 was having behavioral issues, the team approved the changes to the BSP and made no further recommendations regarding appropriate actions for the provider to take. o For Individual #272, follow-up by the IDT was necessary after the 45-day post-move monitoring visit in relation to the community PCP's indication that Individual #272 did not need the services of a dietician. This did not occur. The same was true with regard to the PCP's indication that Individual #272 did not need to see a GI Specialist despite his repeated issues related to pica, and that ultrasounds could be substituted for KUBs. o For Individual #267, given that the police were called on 8/9/12 due to a behavioral incident, and the Post-Move Monitor's visit occurred on 8/10/12, it was unclear why the team was given until 8/29/12 to meet and determine if further action was needed. ▪ At times, appropriate team members were not involved in the follow-up activities. For example: o For Individual #272, three weeks after the 90-day post-move monitoring visit, the team met to discuss four issues raised in the reports. However, the appropriate team members were not present. One of the issues related to the use of the plate guard. Although the team's decision to discontinue it appeared to be reasonable, no input was obtained from the Habilitation Therapies Department. Likewise, the ABSSLC PCP was not present to review the other issues, all of which related to healthcare/medical care. The Dietician was not present to discuss discontinuation of the post-move required support for the individual to have review by a dietician in the community. ▪ At times, issues that the IDT should have reviewed were not flagged for their review. For example: o For Individual #199, it appeared from the documentation provided that a hospital bed was never obtained, because the community PT said she did not need one. Given that the ABSSLC PNMP required her head to be elevated, this should have been brought back to the ABSSLC team. Either an alternative needed to be identified, or the provider needed to obtain the required equipment. No documentation was submitted to show that either happened. ▪ At times, adequate action was not documented to show that either the community provider had taken steps to correct identified issues or if not, the Facility had taken adequate steps to ensure the supports were implemented.	

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		For example: o For Individual #504, for both the 45-day and 90-day reviews, the PMM appropriately referred items to the IDT, and the IDT met and documented the results of its discussion. The team appeared to make appropriate recommendations and requested follow-up by the community provider. The PMM emailed the provider, including copies of the ISPAs. However, after the 90-day review, no documentation was found showing that two significant issues had been rectified, including: 1) evaluation of the individual by a community OT and PT; and 2) completion of monthly weights. Individual #504 was significantly overweight, but the community provider had not yet identified a mechanism for obtaining an accurate weight, due to the fact that she used a wheelchair. In addition, she had multiple OT and PT needs, and already had experienced some skin breakdown since transitioning to the community. Although the PMM's email to the provider requesting response to these issues was included in the documentation, no follow-up information from the community provider was included. Given the significance of these issues, if the community provider did not send a response, further follow-up should have occurred. Although progress continued to be made with regard to the post-move monitoring process, follow-up to the monitoring visits remained the biggest challenge for the Facility. This will require the efforts of individuals' IDTs, as well as the Admissions and Placement Office. The Facility remained out of 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, one post-move monitoring visit was scheduled. However, due the distance from the Facility, a member of the Monitoring Team was not able to attend. As a result, this provision could not be rated. The Monitoring Team looks forward to accompanying the Post-Move Monitor on visits during future reviews.	Not Rated

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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 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	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 last review, one individual had transferred to another SSLC (i.e., Individual #313). This was the only individual that met the definition of an alternate discharge. The Monitoring Team recognizes that this discharge was completed due to findings related to a regulatory review. Based on interview with staff, this occurred over a very short period of time, making thorough discharge planning a challenge. Based on a review of the discharge summary completed for Individual #313, it contained the categories consistent with the Centers for Medicare and Medicaid Services (CMS) requirements. They included a summary of the individual's developmental, behavioral, social, health, and nutritional status. However, in some cases, this summary did not "accurately describe the individual, including his/her strengths, needs, required services, social relationships and preferences" as required by the CMS guidelines [42 Code of Federal Regulations (CFR) §483.440(b)(5)(i), and W203]. In addition, the discharge plan did not appear to meet the CMS requirement [42 CFR §483.440(b)(5)(ii), and W205] to	Noncompliance

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	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.	provide a discharge plan "sufficient to allow the receiving facility to provide the services and supports needed by the individual in order to adjust to the new placement." 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 one out of one records reviewed (100%), good cause was identified in the discharge summaries (i.e., inability of ABSSLC to provide locked environment and/or a peer group that was appropriate to support her needs, as well as impact of her behavior on other individuals in the residence). ▪ The Facility provided a reasonable time to prepare the individual and her parents or guardian for the transfer or discharge (except in emergencies): It appeared for this individual, a short period of time was available, given the recommendations of the regulatory agency. In this sense, it likely would be considered an "emergency" transfer. Based on the narrative in the discharge summary, her guardian and other parent were in agreement with the transfer. ▪ 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. Much of the information appeared to be cut and pasted from the most recent assessments. o Incomplete historical and current status information was provided (e.g., very little information related to medical/nursing and psychiatric information). o Generally, little information was provided about the supports the individual was receiving, and little analysis was provided regarding what supports had assisted the individual versus those that had not been effective to assist the receiving facility to develop an appropriate treatment plan. o The individual had significant psychiatric issues. However, the summary did not provide adequate information about her the effectiveness of her current treatments, or history with successful or unsuccessful treatment. Although previous medications were listed, no analysis was provided. ▪ With the consent of the individual, parents (if the individual is a minor) or legal guardian, provides a copy to authorized persons and agencies: For none of the one individual (0%), ABSSLC provided documentation to show that a copy of the discharge summary and related assessments had been provided to the receiving	

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		Facility. ▪ 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 one individual (0%) adequately described the key supports that the individuals would need in their new settings. In some cases, the information appeared to be cut and pasted from the recommendation sections of assessments. Some of this information was extraneous, and confused any description of supports the individual required in the new setting (e.g., recommendations regarding community transition). For other supports (e.g., psychiatry), a heading was included, but no specific information was provided about the services needed in the new setting. For other supports, no mention was made of them at all (e.g., nursing, medical, or dental). 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. As some teams had begun to do, 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 demonstrate competence in the identification of obstacles to referral as well as obstacles to transition of individuals to the most integrated setting appropriate to their needs and preferences. (Section T.1.b.1)
4. Obstacles 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)
5. 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. Facility staff should work with the State Office to expand the list of possible reasons for guardian or individual reluctance to ensure that accurate data is collected. (Section T.1.b.1)

6. As teams begin to better define obstacles to referral and transition, and begin to talk in greater depth about the options available in community settings to meet individuals' specific needs in comparison with services and supports available at the Facility, 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)
7. As individuals go through the transition process, it is essential for teams to identify and document any obstacles to transition the individual encounters, as well as teams' plans to overcome them. (Section T.1.b.1)
8. Teams should demonstrate competence in the development of action plans/strategies to overcome identified barriers. (Section T.1.b.1)
9. 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)
10. 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)
11. In making recommendations to individuals and guardians regarding the individuals' appropriateness for transition to the most integrated setting, professionals on the teams should ensure that the disagreements or differences in the recommendations various team members include in their assessments are reconciled, and the justification for the team's final recommendation is clearly documented in the ISP. (Section T.1.a and T.1.b.3)
12. Similarly, when teams identify "Medical Issues" or "Behavioral Issues" as the obstacle(s) for transition to the community, as part of its justification for not referring the individual to the community, the team should identify clearly in the ISP the supports and services the individual requires that the team believes cannot be provided in the community. This should be much more specific than phrases such as "24-hour nursing/medical." (Section T.1.a and T.1.b.3)
13. When citing an individual's lack of understanding or inability to express his/her preference with regard to community transition as the justification for not making a referral to the community, teams should take into consideration other information in assessments and the ISP to determine whether or not the individual is able to gain such an understanding and/or express such a preference. When these are relevant factors, then teams should develop very clear action plans for increasing the individual's understanding and/or expressing a preference. (Sections T.1.b.3 and T.1.b.1)
14. 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 occurs expeditiously, an action plan should be developed with specific action steps and associated timeframes, and persons responsible. (Section T.1.b.3)
15. 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)
16. Pre-move and post-move required 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 is 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 ISPs should be targeted for more intensive training of community provider staff prior to the individual's transition (i.e., pre-move required 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 pre- or post-move required supports;

h. As appropriate, teams should identify as pre- or post-move required 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 pre- or post-move required 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 a pre- post-move required 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)

17. 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)
18. 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)
19. 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 outcome measures/key indicators, 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)
20. 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.1.f)

21. Whenever appropriate, IDTs should identify actions necessary to resolve issues related to the pre- or post-move required 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)
22. ABSSLC should review the transition/discharge summary process that it is using for individuals who undergo "alternate discharges" to ensure that the requirements set forth by CMS are met, including a process that:
    a. "[A]ccurately describes the individual, including his/her strengths, needs, required services, social relationships and preferences" [42 Code of Federal Regulations (CFR) §483.440(b)(5)(i), and W203]; and
    b. Provides a discharge plan "sufficient to allow the receiving facility to provide the services and supports needed by the individual in order to adjust to the new placement" [42 CFR §483.440(b)(5)(ii), and W205]. (Section 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 DADS Policy Number 019 on Guardianship, effective 3/7/12; o ABSSLC Policy Number 019 on Guardianship, with exhibits, effective 3/7/12; o Rights Assessment Instruction Sheet, revised January 2007, and ABSSLC Rights Assessment template, revised June 2007; o Guardianship Priority Discussion template, undated; o Guardianship Policy and Restrictive Practice Write-ups training, including handouts and sign-in sheets, dated 3/23/12, and related emails from various dates; o Client Assignment and Registration System (CARE) blank form, revised 1/10; o Priority I and Priority II lists of individuals needing guardians, updated 5/1/12, and 5/11/12, respectively; o List of individuals who obtained a guardian and/or advocate since last review, and guardianships in process with an attorney, undated; o Maple Street Messenger, dated March/April 2012; o Emails and other documentation showing possible leads for people who need a guardian, but do not have any family/correspondents interested in obtaining guardianship, various dates; o Examples of individuals referred to Guardianship Committee for prioritization with the related ISPA, including Individual #454 and Individual #267; o Description of process for sending family members and primary correspondents letters regarding applied income and Guardianship Assistance Program (GAP) funding options, including sample letters; o Guardianship Assistance Committee meeting minutes, dated 5/16/12; o Spreadsheet entitled "Guardianship Assistance Program/Committee/Applied Income Information," undated; 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, contact logs, and committee meeting minutes. 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: At the time of the review, the State Office Guardianship Policy had been disseminated, but the policy on consent remained in the development phase. ABSSLC had adopted the State Office policy and had begun to implement portions of the policy. In March 2012, the Human Rights Officer provided a training session to QDDPs on the process for completing the Guardianship Priority Discussion form that they were to submit after each ISP meeting with input from the team. This form included the factors for prioritization from the DADS State Office policy, which were consistent with those in the Settlement Agreement. However, the definition of terms or criteria with which teams were to make decisions were not clear. This likely will result in teams using different criteria and recommendations regarding prioritization being inconsistent. At the time of the review, teams had just begun to implement the process, and, appropriately, were conducting the reviews as part of individuals' ISP meetings. As a threshold issue, prioritizing an individual's need for guardianship cannot be done adequately until a process is in place to screen for an individual's need for a guardian. 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 maintained its prioritized list of individuals in need of guardians, which was based on the previous tool the Facility had created in the absence of a State Office policy. Based on this list, a total of 81 out of 411 (20%) 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, one individual had obtained a guardian, and another individual had a successor guardian appointed. For an additional eight individuals, some steps reportedly had been taken to initiate guardianship proceedings. Facility staff were continuing to attempt to identify family members or other involved individuals that might be interested in pursuing guardianship for individuals that teams believed needed such support. Information was provided to such individuals about funding sources. Since the last review, more information had been obtained about a local nonprofit agency that offered guardianship services. This appeared to be a promising possibility. In addition, a newsletter article provided contact information for people interested in becoming a guardian. Although these were positive efforts, given the number of individuals the Facility estimated needed guardians, ongoing collaboration was needed with State Office to identify additional viable guardianship resources.

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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.	Since the Monitoring Team's last review, DADS State Office had issued Policy Number 019: Guardianship, dated 3/7/12. Based on interview with Facility staff and document review, ABSSLC had adopted the State Office policy and had begun to implement portions of the policy. The Facility had not individualized the policy to reflect the local procedures that had been decided upon to implement the policy. For example, as discussed in further detail below, the Facility had developed a form and process for identifying an individual's priority level for guardianship and notifying the Human Rights Officer. However, this process and/or form were not reflected in the Facility's policy. A second policy on consent reportedly was in development. Since the last review, because ABSSLC was awaiting further guidance through State Office policy, it had continued its efforts to develop a prioritized list of individuals requiring guardians, and to identify guardians and pursue guardianship for individuals. However, as discussed while the Monitoring Team was on site, an important first step was missing. Specifically, the Facility continued to use the Rights Assessment to determine individuals' ability to make informed decisions. This tool with its related instructions was inadequate to determine an individual's functional capacity to make decisions. For example, the Rights Assessment Instruction Sheet, revised January 2007, provided the following instructions related to the team's decision-making regarding the individual's ability to give or withdraw informed consent: "If the Team feels the person is unable to give informed consent, check all appropriate lines." This did not provide an objective methodology for making this important determination. Therefore, it remained unclear if everyone that needed a guardian was on the list, and/or if those on the list, actually needed a guardian or if they could make some or all decisions with other less restrictive supports. The State is encouraged to finalize the consent policy, because it should assist the Facilities in	Noncompliance

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		moving forward with regard to the implementation of the Section U Settlement Agreement requirements. The Human Rights Officer reported that in September 2012, the Human Rights Officers from all of the Facilities were planning to meet, and the additional policy on consent was expected to be a topic they would discuss. As noted in the Monitoring Team's previous reports, implementation of such a policy 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. 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. The Human Rights Officer recognized that this was an area that required further development. Efforts should be made to identify supports that might assist individuals to make decisions. These include, but are not limited to assisting individuals to identify advocates; 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.). As noted above, ABSSLC had begun to implement portions of DADS Policy Number 019 on Guardianship. On 3/23/12, the Human Rights Officer provided a training session to QDDPs on the process and written document that they were to submit to the Human Rights Officer after each ISP meeting. The Guardianship Priority Discussion form replaced the Guardianship Priority forms that QDDPs previously completed with input from the team. The Guardianship Priority Discussion form included the factors for	

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		prioritization from the DADS State Office policy, which were consistent with those in the Settlement Agreement. The Facility had chosen to implement this process as ISP annual meetings occurred throughout the year. This appeared to be a reasonable approach. Although the Facility recognized that it would take a year for all individuals to complete the process, it was positive that it was viewed as a discussion in which all team members attending the annual ISP meeting should participate, and one to which teams should give thoughtful consideration. According to the Human Rights Officer, although the initial training occurred in March 2012, the process had a slow start. In May 2012 and again in June 2012, the Human Rights Officer sent a reminder about the new process due to the fact that QDDPs had not been submitting the new forms. At the time of the Monitoring Team's review, the Human Rights Officer had received and reviewed a number of new forms with the corresponding Rights Assessments, and had added about 10 individuals to the list of individuals requiring guardians. It was anticipated that the Guardianship Committee, which was the same as the Guardianship Assistance Committee discussed in previous reports, would review the documentation for these individuals and make final decisions about their priority on the guardianship list. Based on review of documentation provided, a number of problems were noted with regard to the implementation of the process: ▪ As noted above, a missing component from this process was the adequate screening and/or assessment of individuals "functional capacity to render a decision regarding the individual's health or welfare." The first factor the team was to consider if an individual did not have a guardian read: "This person has been determined to be least able to express their own wishes or make determinations regarding their won health or welfare." However, no tool was provided to assist teams in making this determination. Without some further guidance, teams likely will use inconsistent criteria to make their decisions. It is the Monitoring Team's understanding that the State Office policy on Consent will provide further guidance. However, until that time, teams' ability to assess individuals' functional capacity is limited. ▪ During the interview with staff as well as in reviewing the sample ISP addenda, it was noted that without providing teams with some criteria with which to make decisions, it was unlikely that teams would be consistent in their determinations about the various factors included in the prioritization process. For example, one of the factors was: "This person has a frequent need for decisions requiring consent," but "frequent" was not defined. Another factor was: "This person has restrictive programming, such as those receiving psychotropic medications,	

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		restrictive practices, etc.," but this was not further defined. The final factor was: "The individual has potential guardianship resources." It was unclear if this meant, for example, funds to pay for guardianship, or involved family or primary correspondent. The Facility provided two samples of individuals' ISPAs during which teams discussed the priority levels for guardianship (i.e., for Individual #454 and Individual #267). In neither instance did the teams provide any detail with regard to their decision-making. The teams merely repeated the factors identified above without providing any individual details about, for example, the types or numbers of decisions that had to be made, or the specific restrictive practices the individuals required. The Human Rights Officer explained that the Guardianship Committee would be responsible to review the information submitted, and ask relevant questions. As this process progresses, it is recommended that the Facility in concert with the Guardianship Committee develop criteria to better define and standardize the factors teams are using in their prioritization discussions. Based on the Monitoring Team's review of ISPs, although teams often identified that individuals did not have guardians and had difficulty with decision-making, the discussion appeared limited. In the ISPs reviewed, teams made no delineation of an individual's priority need for a surrogate decision-maker, and little planning appeared to occur in relation to alternatives to guardianship or identifying potential guardians. It will be important for the Facility's monitoring and self-assessment activities to evaluate the quality of teams' activities related to assessment of individuals' functional capacity, identification of viable options to assist individuals with decision-making, and prioritization of individuals' needs for guardianship. Prior to the March 2012 issuance of the DADS policy on guardianship, ABSSLC had maintained a prioritized list of individuals needing guardians based on teams' completion of the "Guardianship Priority" form. The process for the completion of these forms was discussed in the Monitoring Team's previous reports. Although teams had stopped using this form and had initiated the new process described above, the Facility was maintaining the lists the previous process had generated. 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 34 individuals had been identified as Priority I, and approximately 47 individuals had been identified as Priority II. The Facility recognized that this might not include all individuals who were in need of assistance with making decisions and/or advocacy supports, and that this might change based on the more formalized screening and assessment	

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		processes contemplated by the draft State policy. However, based on these initial projections, approximately 81 out of the 411 individuals residing at ABSSLC (20%) were in need of guardians. The Facility had made some progress in beginning to implement the new DADS State Office policy on Guardianship, including the initiation of a team process to prioritize individuals' needs for guardianship and identification of the Guardianship Assistance Committee as the Guardianship Committee required by the policy. However, it remained out of compliance with this component of the Settlement Agreement. An adequate standardized process for determining individuals' functional capacity to render informed decisions still was not being used. 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, one individual identified as requiring a guardian had been appointed a guardian, and one other individual had a successor guardian appointed. According to individuals' families or attorneys, an additional eight individuals were in some stage of having a petition for guardianship filed. 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. ▪ As part of its implementation of the Guardianship policy, the Facility also had sent a number of letters to family members or primary correspondents explaining the importance of guardianship, and notifying them of potential funding sources, including applied income (i.e., as discussed in more detail in the previous report), if the individual qualified, or Guardianship Assistance Program 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. ▪ The March/April 2012 edition of the Facility's newsletter included a description of the need for volunteer to act as guardians. Although this had not generated any immediate calls, as was discussed, it might plant the seed for volunteers down the road. ▪ The Facility had continued to develop a relationship with a nonprofit agency that provided guardianship services. The agency had been appointed as guardian for one individual. Through conversation with agency staff, the Facility had discovered that the agency had the potential to act as guardian for other individuals at no cost to the individuals. The funding came through the applied	Noncompliance

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		income funding that also could be used to fund legal and other fees associated with guardianship. This agency used a model where the agency was the guardian, but a case manager was assigned to spend time getting to know the individual, attending team meetings, etc. Based on the limited experience of the one individual for whom the agency had been appointed as guardian, staff reported that the case manager had been on campus regularly to see the individual and had attended relevant meetings. As discussed with the Facility staff, as other SSLCs were doing, it might be beneficial to discuss with this agency or other nonprofit social service agencies opportunities for grant writing to further develop the guardianship supports they might be able to offer to individuals residing at ABSSLC. As discussed in previous reports, the Texas Guardianship Statute identified a number of pieces of information that the court may consider in making its decision regarding the need for guardianship and, if needed, the type of guardianship that would be ordered (i.e., full or limited guardianship). 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 for individuals with interested families or other interested persons, but not necessarily based on prioritized need. In addition, although the Facility was trying to identify guardianship resources for individuals without involved family, given that the Facility estimated that many additional individuals required guardians, these efforts were not adequate. As has been discussed in previous reports, identifying guardianship resources likely will need to involve collaboration between DADS State Office and the State Supported Living Centers.	

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 policy on consent, and implement it as soon as possible. In doing so, it should consider including 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.); and

c. 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 policy is finalized, the State should provide key Facility staff with training on its 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, and individualize the policies to the extent necessary to reflect local procedures. (Section U.1)
4. 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)
5. Efforts should be made to identify other supports that might assist individuals to make decisions. These include, but are not limited to identifying advocates for individuals, as appropriate; 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)
6. In concert with the Guardianship Committee, the Facility should develop criteria to better define and standardize the factors teams are using in their prioritization discussions. (Section U.1)
7. ABSSLC staff should collaborate with staff from DADS State Office and other SSLCs to identify and implement potential initiatives and resources for identifying guardians. (Section U.2)
8. 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)
9. 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 Procedures, dated 7/9/10; o DADS Policy Number 020.1: Recordkeeping Practices; o List of persons responsible for management of records and for auditing records, including names and titles, revised 7/6/12; o State Office Core Active Record and Guidelines, revised 2/4/11; o ABSSLC Active Record Order and Maintenance Guidelines, revised 6/14/12; o Individual Notebook and Guidelines for Filing and Purging, revised 6/28/12; o Individual Notebook Guidelines, dated 7/3/12; o Instructions for Monthly Purging and ISP Folders, dated 4/5/12; o ABSSLC Policy for Routing Reports/Documents, dated 6/5/11; o Master Folder Table of Contents, dated 2/24/12; o Procedure for Random Monitoring Sample Selection, revised 7/9/12, with notation "Currently Being Revised;" o Completed review tools for last 10 records reviewed, various dates; 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, various dates; o List of SSLC Policies, dated 7/10/12; o ABSSLC Policies and Procedures Implemented or Revised since last CM [Compliance Monitoring] visit in February 2012, as of 6/28/12; o Dissemination, Training, and Implementation of New/Revised Policies and Procedures, with notation "Currently Being Revised;" o Documentation of training on Guardianship Policy and Restrictive Practices Write-ups, dated 3/23/12; o Description of electronic records, dated 7/9/12; o Clerk In-service Training on Individual Notebook Changes, dated 5/21/12; o Campus In-service training documentation on Individual Notebook changes and documentation requirements, dated 5/24/12. 5/25/12, and5/29/12; o QA/QI Data Summaries for Section V, dated 2/13/12 and 5/9/12; o Monthly meeting notes for meetings with QA Department and Records Department staff, dated 5/31/12 and 7/26/12; o Standard outline for ABSSLC policies, undated; o Policy Tracking Form, undated; and

	○ Presentation Book for Section V. ▪ **Interviews with**: ○ Kalana Allen, Records Coordinator; ○ Vickie Allmand, Unified Records Coordinator; and ○ Jeremy Akin, Program Compliance Monitor.
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section V, dated 8/8/12. In its Self-Assessment, for each sub-section, 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. For Section V, in conducting its self-assessment, the Facility: ▪ Used monitoring/auditing tools. Based on a review of the Facility Self-Assessment, the monitoring/audit templates and instructions/guidelines, a sample of completed monitoring/auditing tools, inter-rater reliability data, as well as interviews with staff: ○ The monitoring/audit tools the Facility used to conduct its self-assessment included: the Settlement Agreement Section V – Recordkeeping and General Plan Implementation review tool, the Individual Notebook Maintenance Guidelines Review, the Master Folder Table of Contents review tool, the Document (Tracking) Monitoring Tool, and the Section V.4 monitoring tool. ○ As discussed with Facility staff during the Monitoring Team's onsite review, these monitoring/audit tools did not yet include adequate indicators to allow the Facility to determine compliance with the Settlement Agreement. Facility staff indicated that some conversations had occurred with State Office staff about revising the tools to allow better measurement of specific indicators. Criteria needed to be determined to measure factors such as "legible" and "missing signatures." For example, the level of deviation from these standards to determine when a record was not compliant needed to be established. The Records Department staff are encouraged to work with the Quality Assurance Department and the Settlement Agreement Coordinator to make necessary changes to the monitoring tools. ○ The monitoring tools did not yet include adequate methodologies. Although some methodologies had been identified, such as record reviews, and staff interview for Section V.4, as discussed with regard to Section V.4, additional methodologies, such as observations of meetings and review of data collected in relation to skill acquisition programs, PBSPs, etc. needed to be added. ○ The Self-Assessment identified the sample(s) sizes. However, it did not include the number of individuals/records reviewed in comparison with the number of individuals/records in the overall population (i.e., n/N for percent sample size). However, based on the Monitoring Team's knowledge of the overall population, the sample sizes were adequate to consider them representative samples. ○ The monitoring/audit tools did not have adequate instructions/guidelines to ensure consistency in monitoring and the validity of the results. As discussed above, it will be important as criteria for monitoring are developed and methodologies finalized that these

	be memorialized in the form of formal instructions/guidelines. o The following staff/positions were responsible for completing the audit tools: the two Unified Records Coordinators completed a total of 10 audits a month. In addition, the Program Compliance Monitor assigned from the Quality Assurance Department, and the Records Coordinator conducted a review of a subsample of these records. o The staff responsible for conducting the audits/monitoring had not been deemed competent in the use of the tools. Although all of the staff responsible had varying levels of experience with records management, no formal methodology was in place to ensure they were programmatically competent in the relevant areas. o Adequate inter-rater reliability had not been established between the various Facility staff responsible for the completion of the tools. However, the Facility recognized this was an issue, and the staff involved in conducting the audits were actively working to improve inter-rater reliability. ▪ Used to a limited extent other relevant data sources. For example, with regard to Section V.2, the Facility reported the numbers of new or revised policies issued. The Facility also recognized the need to track training of staff on new or revised policies. This would be an area where key indicators/outcome measures could be developed to measure compliance. In addition, it was positive that the Facility had begun to discuss monthly meetings with the QA Department with regard to compliance with Section V.3. However, in the future, it will be important to discuss analyses of the data, corrective action plans developed, and their impact on improvements to the system. ▪ The Facility presented some, but not all of the data in a meaningful/useful way. Specifically: o Although the Facility presented some findings based on specific, measurable indicators, some overall scores continued to be included. For example, although for Sections V.3 and V.4, the Facility provided helpful data related to specific indicators, for Section V.1, overall compliance scores were provided for the entire audit tool. As indicated previously, these scores are not helpful in identifying areas of strength and weakness, and are misleading because the indicators on the tools are not weighted. o Due to the lack of instructions/guidelines for the tools, it was unclear whether or not the audits were measuring the quality as well as presence of items, as appropriate. o The Self-Assessment, did not distinguish data collected by the QA Department versus the program/discipline. It appeared that the data included in the Self-Assessment was that the Unified Records Coordinators had collected, but it was unclear what role the data the QA Department staff completed played in the Facility's Self-Assessment. ▪ The Facility rated itself as being in substantial compliance with none of the sub-sections of Section V. This was consistent with the Monitoring Team's findings. ▪ In the Facility Self-Assessment, some areas in need of improvement were identified. To a limited extent, the Facility identified or referenced action plans it had put in place or planned to develop to address the negative findings. This is discussed in further detail 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. Since the last review, the Facility also had developed and implemented

	Individual Notebooks for all individuals. This was a significant undertaking. Staff appeared to find them helpful, particularly with regard to documenting essential data. 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 conduct more in-depth analyses of the systemic issues identified, and develop and implement corrective actions to address them. The Facility was continuing to develop and revise policies to address the requirements of the Settlement Agreement. The policy related to policy development and dissemination was in the process of being reviewed 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 with the assistance of the Competency Training and Development Department had designed a system to track training. 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, and progress had been made in using some of this data to identify actions needed to make improvements. However, an area in which further work was needed was in the conduct of more in-depth analyses of this data. Such analysis should result in the identification of more specific areas or departments in need of attention, the development and implementation of action plans to address the underlying causes, and follow-up to determine if the desired outcomes are achieved. The Facility had continued to implement the policy designed to improve the timeliness of filing items in the records. The Facility was monitoring a sample of documents each month to determine if the five-day timeline for filing was met. Since the Monitoring Team's last review, initial data over approximately four months showed a 40 percent compliance rate, but in June and July 2012, this increased to 80 percent. Based on observations of team meetings, improvements were noted particularly with regard to teams using more data in making decisions regarding risk ratings. However, additional work was needed in this area as well as with the use of data to make other decisions, such as in relation to skill acquisition programs. In addition, issues related to the maintenance of complete and accurate data had the potential to impact negatively on teams' decision-making ability, such as in relation to individuals' PBSPs and prescription of psychotropic medication.

#	Provision	Assessment of Status	Compliance
V1	Commencing within six months of the Effective Date hereof and with full implementation within four	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:	Noncompliance

#	Provision	Assessment of Status	Compliance
	years, each Facility shall establish and maintain a unified record for each individual consistent with the guidelines in Appendix D.	▪ According to staff, all of the individuals at ABSSLC had Active Records and Master Records. ▪ At the time of the Monitoring Team's last review, the Facility did not have Individual Notebooks. However, based on input from an interdisciplinary group, the contents of the Individual Notebooks had been determined. Since then, Individual Notebooks were set up for each individual. They included a combination of information (e.g., DNR orders, level of supervision information, PBSP, Crisis Intervention Plan, PNMP, etc.), and data collection forms (e.g., PNMP check sheet, behavioral data sheets, skills acquisition plan data sheets, and observation notes). This was a significant undertaking. Guidelines also had been revised on 7/3/12. They included directions for maintenance of the Individual Notebooks, as well as when and how they should go with the individuals, which had been revised slightly since the last review with input from the Records Committee. The changes appeared reasonable. In-Service training had been provided in May 2012 to Clerks, as well as direct support professionals, and other staff that would access or be responsible for updating the Individual Notebooks. Based on conversations with some direct support professionals while the Monitoring Team was on site, it appeared that staff generally found the Individual Notebooks helpful. The Individual Notebooks appeared to be in use and with the individuals, as appropriate. ▪ 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 and continued to meet regularly. 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 five meetings between March and May 2012 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-Assessment, based on a review of 30 individuals' records between 3/1/12 and 5/31/12, the following was a list of some of the indicators that fell below 70% (which was a fairly lenient standard): o Legibility was at 39%; o Accuracy was at 53%; o Current was at 56%; o Complete was at 44%; and o No evidence of inaccurate recordkeeping procedures was at 36%. Some of the challenges with this data, including clear criteria for auditing are	

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		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, more in-depth analyses of systemic issues, and identification of potential solutions for resolving them were needed. The Facility Self-Assessment referenced the need "to identify specific staff or groups of staff who consistently fail to meet indicators and in-services and or classes will we done specifically for those groups." This would be a good example of how more in-depth analyses could be helpful in targeting more specific solutions to the systemic issues the Facility's data was revealing. ▪ Based on data the Facility was maintaining, during March through May, reviews showed that 40 percent of a sample of records was filed in five days or less. In June and July 2012, this rate increased to 80 percent. Although this was a positive trend, it was too early to tell if it could be sustained. One initiative that had been put in place was a Clerk Buddy system. For each Clerk, a Buddy was identified, so that if one Clerk was out, the other could cover. The issue of timely filing required continued scrutiny. If current processes were not adequate, then more discussion should occur between the Records Department, Unit Directors, and Facility Administration. 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. 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 this Agreement.	As is discussed throughout this report, policies and procedures necessary to implement the Settlement Agreement were in various stages of development. This included policies that DADS State Office was developing, as well as those being developed or revised at the Facility level. 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: ▪ The Facility had initiated revisions to the policy on Dissemination, Training, and Implementation of New/Revised Policies and Procedures. During the week of the Monitoring Team's review, the Policy Review Committee was scheduled to review the changes. As described in the Monitoring Team's previous report, this policy set forth a reasonable process for review and approval of policies. In response to the Monitoring Team's comments that further definition was needed of how determinations would be made of which staff required training on which	Noncompliance

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		policies and the level of training required, as well as timeframes for completing the training, the Facility had drafted revisions to the policy, including a process for the policy's author to include such information in the policy shell. As a result, this information would go through the same approval process as the rest of the policy. The policy also set forth a process for tracking the training completed, including completion of a policy tracking form. The Unified Records Coordinators as well as the Competency Training and Development Department were involved in tracking the training. The revisions also include a mechanism to communicate the issuance of new policies and training requirements to relevant staff. ▪ A list was provided of nine policies that had been developed/revised and approved since the last review. Some of these related to requirements of the Settlement Agreement and others did not directly relate. Areas in which efforts are needed in order to achieve compliance, included: ▪ The Facility provided a list of SSLC Policies, dated 7/10/12. 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 Assistant Commissioner's 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. ▪ The Facility recognized that it was at the beginning stages of tracking training related to policies. The Unified Records Coordinators had set up a system in their office to track training documentation, and send reminders, when necessary. Hopefully, during the next review, the Facility will be able to demonstrate that it has a tracking system to ensure all staff who require training on new or revised policies and/or procedures successfully complete the training, and it is able to identify clearly those staff who have not completed the training, or have not mastered the competency-requirements. As noted in other sections	

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		of this report, it will be important to present findings related to training in terms of the number of staff that have successfully completed the training (n) over the number of staff that require the training (N) to show the percent compliance with completion of the training (n/N). Although the Facility continued to make progress in updating and/or developing policies to address the various requirements of the Settlement Agreement, it was not yet in compliance with this provision.	
V3	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall implement additional quality assurance procedures to ensure a unified record for each individual consistent with the guidelines in Appendix D. The quality assurance procedures shall include random review of the unified record of at least 5 individuals every month; and the Facility shall monitor all deficiencies identified in each review to ensure that adequate corrective action is taken to limit possible reoccurrence.	Progress had been made and/or sustained with this provision of the Settlement Agreement. Positive developments included: ▪ 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 documentation provided for reviews conducted in the months prior to the onsite review, changes had been made with regard to the auditing tools used. The Facility was no longer using the Active Record Order Guideline. The tools used included: the Settlement Agreement Section V – Recordkeeping and General Plan Implementation review tool, the Individual Notebook Maintenance Guidelines Review, the Master Folder Table of Contents review tool, the Document (Tracking) Monitoring Tool, and the Section V.4 monitoring tool. Based on review of completed audit tools, they appeared to be completed thoroughly. ▪ It was positive that the Facility had added a review of the new Individual Notebooks. In addition to questions about the completeness of the Individual Notebooks, the tool also collected data related to their availability and helpfulness in the data collection process. ▪ 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. ▪ As during the Monitoring Team's last couple of reviews, 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 Monitoring Team's review of documentation continued to show effective and strong follow-up to ensure deficiencies were corrected.	Noncompliance

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		▪ 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. On 5/21/12, specific training had been provided to the Clerks, including review of some of the systemic issues identified. On 5/24/12, 5/25/12, and 5/29/12, as part of the rollout of the Individual Notebooks, the Records Department had incorporated reminders about some of the problematic issues into the training provided to all staff. In addition, the Records Department had purchased flexi-frames that would hang near the records in each residence. Staff had developed catchy reminders about some of the persistent issues related to the records. These could be changed periodically. This was a creative way to try to obtain staff's compliance with specific components of records management. Emails and a memorandum also had been sent related to legibility and documentation concerns, such as incomplete signatures and titles. 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 discussion between the Monitors and the parties during a December 2012 parties' meeting, the State Office likely will provide additional guidance. ▪ Facility staff had been taking some steps to establish inter-rater reliability. Based on interview and documentation, since the last review, each month between March and July 2012, those staff auditing the records had conducted reviews of the same record within a short period of time. Noticeable differences between the auditors' ratings were identified, particularly for some indicators. Facility staff were beginning to look at these areas in more depth. As discussed with regard to the Facility Self-Assessment, it will be important for necessary changes to be made to the monitoring tools, clear criteria to be established, and methodologies for review standardized. These criteria and methodologies should be memorialized in instructions/guidelines for the audit/monitoring tools.	

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		▪ The Facility continued to show progress in using information gained from internal audits to develop and implement corrective actions. The QA/QI Council had approved some corrective action plans related to inter-rater reliability between the auditors, guidelines to be used during monitoring, and some of the systemic issues such as legibility, accuracy, signatures, etc. However, the action plans were general, and did not necessarily even reflect some of the specific steps the Facility had taken, including training, reminders hung near the records, etc. It will be important to continue to analyze data to identify potential systemic issues, and to develop and implement specific 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. ▪ Review of minutes of meetings between the Records Department and Quality Assurance Department from March through July 2012 showed that recent meetings had focused on inter-rater reliability. Some past meetings minutes indicated discussion about systemic issues, but limited information was provided in the minutes, particularly regarding the specific issues discussed and recommendations related to actions needed. ▪ Similarly, review of QA/QI data summaries for Fiscal Year 2012 – Quarters 1 and 2 identified indicators that had scored under 70%, but provided no analyses of the information, and/or recommendations for specific corrective actions. The recommendations mainly addressed ongoing work between the Quality Assurance Department and the Records Department staff to increase inter-rater reliability and work on improving the monitoring tools. Although these were important activities, more in-depth data analysis (e.g., were particular residences/disciplines responsible for larger percentages of the problem, was particular documentation consistently missing or inaccurate, etc.), and development of specific action plans had not yet been completed. Although progress continued to be made with regard to this provision of the Settlement Agreement, issues remained with regard to the reliability and validity of the monitoring data, as well as the comprehensiveness of the monitoring efforts for Section V.4. In addition, as efforts continue to analyze aggregated results of monitoring data, and to develop, and implement actions necessary to correct systemic deficiencies, efforts also should be made to assess the effectiveness of the actions taken, and modify them, as necessary.	
V4	Commencing within six months of the Effective Date hereof and with full implementation within four	As discussed in the last report, 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. The Facility's Self-Assessment did not yet reflect evaluation of all of these	Noncompliance

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	years, each Facility shall routinely utilize such records in making care, medical treatment and training decisions.	actions, but did include some relevant information. The items are presented below along with the Monitoring Team's findings: ▪ **Records are accessible to staff, clinicians, and others**: Although ABSSLC was not yet self-assessing this, the Monitoring Team 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. Some additional medical documents also were maintained in electronic format with access given to team members. These included items such as annual evaluations, consultations, diagnoses, tests, procedures, and surgeries. 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. 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. However, some issues continued to exist with the timely filing of documents, but the lag time had been reduced. In its Self-Assessment, the Facility reported the results of audits that had been completed of 30 documents to determine if they were in the records within the five-day timeframe. It was positive that the Facility had initiated these audits. Based on the information gained, though, for the time period between 3/1/12 and 5/31/12, 12 of the 30 documents (40%) were filed in the Active Record within five days or less. However, the Facility's data for June and July showed this had improved to 80 percent. o Generally, it appeared that records were available in the residences, and, as needed, for example, at clinic appointments ▪ **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	

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		discussed with regard to Section K.4, observations during the onsite review indicated that staff were completing data sheets hours after they should have, and/or significant amounts of data was missing. o In the Facility's Self-Assessment, it reported that based on reviews conducted between 3/1/12 and 5/31/12, record audits reveled that the "Active record is current 56% of the time and is complete 43% of the time." ▪ **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 Section V.4. As noted in past reports, review of completed forms generally showed that staff were able to articulate how they used the records. Sometimes, team members included recommendations to improve the records. ▪ **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 ISP meeting observed during the week of the Monitoring Team's review, 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 this had improved, more work was needed to ensure full data was used in making decisions about risks, and data generally was not incorporated into decisions about skill acquisition programs. Although progress was being made, the Facility remained out of compliance with this provision. Teams were not consistently using data to make decisions, and the quality of data and information in the records often was not adequate to allow teams to make well-informed decisions.	

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

1. The State 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)
2. As the Facility presents findings related to training, it should do so in terms of the number of staff that have successfully completed the training (n) over the number of staff that require the training (N) to show the percent compliance with completion of the training (n/N). (Section V.2)
3. The Records Department staff should work with the Quality Assurance Department and the Settlement Agreement Coordinator to make necessary changes to the monitoring tools. (Section V.3 and Facility Self-Assessment)
4. As criteria for monitoring are developed and methodologies finalized, they should be memorialized in the form of formal instructions/guidelines. (Section V.3 and Facility Self-Assessment)
5. Monitoring efforts for Section V.4 should be expanded to include a number of different methodologies, including, for example, observing meetings in which information from the records needs to be utilized (e.g., psychiatric reviews, 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. (Section V.3 and Facility Self-Assessment)
6. Inter-rater reliability should be established between the various staff monitoring the records. (Section V.3 and Facility Self-Assessment)
7. 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 and Facility Self-Assessment)
8. As is specified in other sections of this report, improvements should be made with regard to the quality of the data and other information that is entered into individuals' records. (Section V.4)

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
BMP	Basic Metabolic Panel
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
FDA	Federal Drug Administration
FTE	Full-time Equivalent
FY	Fiscal Year
GAP	Guardianship Assistance Program
GERD	Gastroesophageal Reflux Disease
G/J-tube	Gastrostomy/Jejunostomy feeding tubes
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
IDD	Intellectual and Developmental Disabilities
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
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
MPAC	Medical Provider Audit Committee
MR	Mental Retardation
MRA	Mental Retardation Authority
MRI	Magnetic Resonance Imaging
MRSA	Methicillin-resistant Staphylococcus aureus
NCM	Nurse Case Manager
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
PoC	Plan of Correction
POI	Plan of Improvement
PPD	Purified Protein Derivative
PPMTP	Physician Psychotropic Medication Treatment Plan
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