United States v. State of Texas

Monitoring Team Report

Abilene State Supported Living Center

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Submitted By: Maria Laurence, MPA, Monitor

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

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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, Interdisciplinary Team (IDT) 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, since the Monitoring Team's last visit, there had been some notable areas of progress. In other areas, very importantly, leadership staff were able to identify next steps to address outstanding issues. However, there also were some areas where important changes that impacted individuals' health and safety simply had not occurred, and it was not clear there were plans to address these areas. At this point in the life of the Settlement Agreement, it is essential that these issues be addressed.

Of concern, as well, was the turnover rate of staff, particularly direct support professionals and nursing staff. These are key positions, and efforts were needed to identify the underlying causes and address them. Without stability in these areas, it likely will be difficult to ensure the necessary implementation of individuals' plans occurs.

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 sections of the Settlement Agreement:

<u>Restraints</u>

- The Monitoring Team found ABSSLC to be in substantial compliance with Section C.2 related to timely release from restraint. Areas of progress included:
  - Progress had been made in discontinuing long-term use of protective mechanical restraint for a number of people.
  - Revisions had been made to the monitoring tool that looked promising.
  - The Restraint Reduction Committee had good presentations of issues. However, more critical and creative thinking was needed regarding potential solutions.
- Some areas that needed improvement included:
  - The curriculum for Restraint Monitors needed to be adjusted to assure Restraint Monitors were not acting as both the restraint monitor and the person applying the restraint at the same time.
  - The communication issues around getting Restraint Monitors and Nurses notified that a restraint was in progress needed to be resolved.
  - Corrective action plans needed to be developed, particularly where there were systemic or cross-disciplinary issues related to restraint use.
  - Restraint documentation needed to capture good descriptions of the behavior that happened before the behavior that caused the restraint.
  - The Monitoring Team found inconsistencies in the quality of reviews completed when individuals experienced more than three restraints in a rolling 30-day period. Action plans were not always clearly developed to address events that led to restraint. Limited habilitation programs also impacted the individuals' access to an interesting and varied daily schedule designed to meet his/her specific needs

and interests. The Interdisciplinary Team (IDT) Review of Repeated Restraint, if completed as designed, offered a good guideline for thoughtful review and planning.

Abuse, Neglect, and Incident Management

- During this review, the Monitoring Team found the Facility to be in substantial compliance with 17 out of 22 provisions of Section D, as opposed to the 16 provisions that were in substantial compliance during the last review. Progress was noted in a number of areas. Highlights of progress included:
  - There was a good follow-up system for recommendations resulting from investigations that included a reminder letter from the Director or the Incident Management Coordinator to anyone responsible for follow-up and the collection of the evidence of that follow-up.
  - Work had been done to document in the annual Individual Support Plans (ISPs) that individuals and their LARs were informed about how to report abuse.
- Some of the areas in which improvements were necessary for the Facility to progress toward substantial compliance with the Settlement Agreement included the need to:
  - Work with DFPS to make sure they had considered prior history information, and that they make recommendations accordingly.
  - When there is clear evidence that staff have failed to report or to intervene in an abusive situation, consider disciplinary action not only for the perpetrator (which the Facility did), but also for those who were witnessing the abuse and not taking action.

Quality Assurance

- Although the Monitoring Team did not find the Facility to be in substantial compliance with any of the provision of Section E, the Facility had made progress with regard to Section E, including:
  - The QA Council meeting the Monitoring Team observed this time had improved from previous observations: there were data presentations, decisions on steps to resolve an issue, updates on a CAP with a decision on moving forward, and steps to follow-up on decisions. However, there were a number of missed opportunities to correct data, request further analysis of data, and formulate more meaningful action plans. On a positive note, the minutes of meetings captured more discussion and included important information from the QA presentations.
  - The Facility had Corrective Action Plans (CAPs) in the process of implementation, and while there were only six active CAPS, some had steps, time lines, and were being tracked.
  - PCMs had a good understanding of what was currently being monitored, how it was being done, and how the results were being shared.
  - The Facility had a QA Plan and matrix, and could produce the beginnings of a data inventory. While these documents needed some work to come into substantial compliance, there were definite improvements since the last monitoring visit.

- Some of the areas that will need to continue to improve for the Facility to progress toward substantial compliance with the Settlement Agreement included:
    - Not all of the monitoring on the QA Plan matrix was being done as listed. Either the matrix needed to be adjusted to reflect actual expectations of each section, or section leads needed to be encouraged to do what is required in the matrix.
    - Adjustments were needed to the QA Plan, including appending the data inventory and the matrix to the plan.
    - The Facility had amassed considerable data in many areas. That data needed further analysis and priorities needed to be established to address the results. The limited analysis that had been completed was generally insufficient to identify areas requiring attention.
    - The Facility needed to work on using the CAP process for more systemic and cross-disciplinary issues, as well as for discipline-specific issues that need the attention and oversight of the QA/QI Council.
    - The CAP tracking system needed some improvements to make it easier to use.
    - The Facility needed to develop key indicators of quality across the system and to measure progress through those indicators.

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

- Since the last review, a variety of training had been offered to ABSSLC staff on the ISP process, or specific components of it. For example, in October 2012, the ABSSLC Qualified Developmental Disabilities Professional (QDDP) Coordinator, Chief Nurse Executive, and Director of Habilitation Therapies provided training to team members on the ISP and Risk processes. In October 2012, DADS State Office consultants provided additional training to two teams on the ISP Preparation Meeting process and Preferences and Strengths Inventory (PSI), and in January 2013, DADS State Office provided training to teams on the Enhanced At-Risk process, including the revised Integrated Risk Rating (IRRF) form and Integrated Health Care Plan (IHCP) format. In April 2013, the State Office QDDP Discipline Coordinator provided more training to Facility staff on ISP development. At the time of the Monitoring Team's review, the Facility was still in the initial phases of implementing some of these forms and processes, and ABSSLC had not had the benefit of the more extensive training that two Facilities currently were undergoing. However, some improvements were noted.
- Generally, ISP meetings were being held annually, and individuals newly admitted to the Facility were having ISP meetings within 30 days of their admission. However, although efforts were underway to improve timely completion of ISPs, challenges remained in finalizing the ISP documents and having them available in the records for teams' use within 30 days of the meeting.
- 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. However, further refinement 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. Development of community skill acquisition goals was slow.
- 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." However, the need remained for the plans to more comprehensively address the identified needs, and for the methodologies to be strengthened, as well as measurable objectives/clinical indicators to be included in plans to provide teams with information to determine whether or not the supports and strategies were having the desired outcome (e.g., were they effective in improving the individual's health, or maintaining his/her current status).
- The Facility had adopted a new monthly report format. It was positive that QDDPs were now expected to complete these reports. However, because the ISP action plans did not include many of the healthcare and other clinical supports the individual was provided, the monthly reports focused mainly on skill acquisition programs, and did not provide information about individuals' progress or lack thereof on issues related to behavior, psychiatry, healthcare issues, and/or habilitation therapy.
- The Facility had made progress with regard to its quality assurance system related to the ISP process. The QA, QDDP, and Active Treatment Departments had continued to work together to revise the tool they used to monitor ISP meetings, as well as ISP documents. They were working on establishing inter-rater reliability, including modification of review tools and the related instructions. Efforts were in the very initial stages of analyzing the data, and determining if current action plans were sufficient or if additional ones needed development. However, all of these activities remained in the early stages of implementation and revision, and required additional work.

<u>Integrated Clinical Services</u>

- The challenge remained for the Facility to provide evidence of integrated clinical services. There had been collection of data related to attendance at the morning medical meetings and at ISPs, but the Facility presented little other evidence to show integrated clinical services. For example, the minutes of the morning medical meeting did not reflect integrated clinical discussions amongst various disciplines, even though at times it appeared they did occur. The Interdisciplinary Teams (IDTs) appeared not to develop Individual Support Plan Addenda (ISPAs) in response to hospitalizations, and Primary Care Providers' (PCPs') attendance rate at post-hospitalization ISPAs was not tracked. PCPs' attendance and guidance at these meetings was critical.

- The consult request form had been revised to include more space for pertinent history and questions, and the Settlement Agreement Compliance Physician tracked this to ensure completion. Although this was positive, problems remained with PCPs signing consultant reports to show they had reviewed them, indicating their agreement or not with recommendations in consultant reports, and following up with Integrated Progress Notes (IPNs) and/or ISPA meetings.

Minimum Common Elements of Clinical Care

- The Facility had a limited database related to the Medical Department. Tracking was possible of the timeliness of annual medical assessments and quarterly medical reviews. Little information was available regarding how the information from these limited databases were analyzed and at what frequency to provide guidance to the PCPs.
- The Facility continued to focus on the external general medical, and medical management audit indicators. Although these were an important start, they should lead to monitoring of all aspects of medical care. On a positive note, the Settlement Agreement Compliance Physician was developing a foundation for compliance with Section L, which also was having a positive effect on Section H. The PCPs had completed an in-service on the clinical guidelines the State Office developed. They also had been in-serviced on the general medical audit and medical management audit indicators to ensure the PCPs were changing their clinical practices. Other clinical indicators had been identified that focused not on the PCP quality care role, but on the outcome for the individual. However, these indicators had not been incorporated into a monitoring tool or data collection system at this time.
- It will be important for information management systems to be set up for this section to track many areas of clinical care (e.g., osteoporosis management, reasons for transfer to the ER, etc.). Measuring quality of care by quantifying the outcomes for individuals as well as the types of clinical supports and expertise provided for a diagnosis would reflect the requirement of this section – minimum common elements of clinical care. As more diagnoses are added to the database, documentation of services provided to the individual for specific diagnoses should reflect the minimum common elements required. The Facility remained noncompliant with this Section.

At-Risk Individuals

- Since the last review, the Facility reported that in September 2012, they had begun the implementation of the revised At-Risk Process using two teams from Residences 6500 and 6720. In November 2012, additional revisions to the process were implemented, and in January 2013, training regarding the Enhanced Risk Rating system was conducted. In April 2013, the SSLC Qualified Developmental Disability (QDDP) Discipline Coordinator provided additional training regarding the ISP Process.
- In addition, in January 2013, the Facility began using a revised Integrated Risk Rating Form (IRRF) that included sections addressing the History, Current Supports, Current Status, Proposed Recommendations, Team Deliberations, Final Recommendations, and the Risk Rating.

- Since the initiation of the At-Risk system, numerous changes had occurred, and as a result, the documentation submitted varied and continued to include many deficiencies. Specifically, the quality of the IRRFs varied, and the IHCPs generally were of poor quality. The overall lack of clear documentation included in the ISPs, the IHCPs, and the associated disciplines' assessments regarding specific actions that were taken in response to pertinent events or health issues, and the lack of supporting documentation addressing actions and completion of actions continued to negatively impact the supports that were planned for and provided to individuals, and made the Monitoring Team's review of the Enhanced At-Risk system difficult.
- Although from the ISP meetings the Monitoring Team observed during the onsite review, some positive changes were noted, there continued to be significant issues regarding the accuracy of the risk levels, the reflection in the IHCPs of the necessary clinical intensity to address designated risk levels, the identification of functional and/or measurable objectives, the inclusion of adequate preventative measures, and clear documentation of this process.

<u>Psychiatric Care and Services</u>

- At the time of the Monitoring Team's current review, based on the Facility's assessment of its psychiatric staffing needs, ABSSLC employed an adequate number of qualified psychiatrists.
- The data available indicated that there had been progress in completing the comprehensive psychiatric evaluations (CPEs). The Psychiatry Department had also developed a Psychiatric Treatment Plan (PTP), which was to serve as both an annual compilation of material for the individuals' ISPs and the annual update to the CPE. These 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 prescribed psychotropic medication.
- There continued to be incremental progress with the development of Desensitization Plans for dental procedures, but there was not any substantial advance with regard to the development of Desensitization Plans, or other strategies to reduce the need for sedation for medical procedures.
- In the Monitoring Team's prior reviews, the importance of making sure that the information required in Sections J.8, J.9, and J.10 also were represented in the ISP, had been stressed. The Facility had acted on these recommendations, which was reflected in the current reviews.
- Observation of the Psychiatric Clinics of the three current psychiatric providers 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 these Quarterly Psychiatric Reviews was detailed and fully completed for each individual.
- Progress in decreasing the rates of polypharmacy at ABSSLC continued. 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 considerable progress in assembling the necessary documentation to justify the efficacy of the psychotropic medications.

- At the time of the Monitoring Team's prior review, a plan had been approved to have all of the individuals followed by both Psychiatry and Neurology reviewed in a distinct Neurology-Psychiatry Clinic, which would provide improved coordination of clinical care by both specialties. This did not occur, because the Facility had not been able to devise a mechanism to have the individuals who were followed by both disciplines, in a separate clinic. Coordination remained a challenge, using this or another viable alternative.
- In summary, the Facility had made significant progress in a number of areas. However, the impact of some of these positive initiatives was not fully reflected in the Monitoring Team's current review, due to the time lag before the new procedures were fully assimilated into the ongoing clinical processes and the documentation appearing in the individual records. This observation was particularly relevant to the inclusion of the materials related to Section J.8, Section J.9, and Section J.10 into the annual ISP documentation. If the Facility continues to focus on these areas, the full impact of these initiatives should be reflected in the next review cycle.

<u>Psychological Care and Services</u>

- The Facility continued to make good progress in supporting staff to obtain professional certification. The Department of Behavioral Services was now staffed with eight Board Certified Behavior Analysts (BCBAs), including the Director, Clinical Supervisor, and six Associate Psychologists. Support for training and supervision was ongoing.
- The Behavior Support Committee continued to meet weekly to review functional behavior assessments, behavior support plans, and crisis intervention plans. The Facility continued with efforts to ensure that these supports were prepared in time for the individual's annual meeting. The External Peer Review Committee and a newly formed Interdisciplinary Peer Review Committee each met monthly to review challenging cases. Due to time constraints, review was limited to one to three cases. Follow-up to recommendations made through the peer review process remained an area in which focused effort was needed.
- Monitoring of data collection and program implementation continued with recently initiated review of videotapes to help assess data reliability and treatment integrity. Training on plans was enhanced through the introduction of Behavior Support Checklists and the use of Behavior Coaches to provide supervision and support to staff. Further support was provided to staff with the introduction of a protocol for recruiting support during behavioral crises.
- Improvements were found in a review of functional assessments and behavior support plans. The staff were focusing more on descriptive assessment and in some cases were completing a structured, functional analysis. There was greater evidence of individualized reinforcement systems and expanded identification of replacement behavior. However, work was needed in a number of areas, including but not limited to ensuring BSPs included

operational definition of functionally equivalent replacement behavior, increased training opportunities for replacement behavior, and expanded prevention strategies.

Medical Care

- The Facility now had a dedicated position for Settlement Agreement Compliance Physician. With the staff member in this position working with the Medical Program Compliance Nurse, a number of progress steps had occurred in a short time span. It is important to note that the Compliance Physician did not have a caseload, and was able to concentrate efforts on development, implementation, and monitoring of new projects.
- The morning medical meeting had become a forum for critical thinking, in part due to the Compliance Physician's constant teaching of clinical problem-solving. All primary care practitioners (PCPs) had participated in this approach in regards to new hospital admissions and discharges, Infirmary admissions, and on-call concerns. Other disciplines also attended the morning meeting. However, as noted below, additional changes were needed.
- The annual medical assessments had been revised to incorporate updated plans of care for specific diagnoses, and included more details about the medication list, including indications and doses. The quarterly medical review template had been revised to focus on changes in the prior three months, and templates were available to assist the PCPs in reviewing the clinical care post-hospitalization. There had been in-services most weeks on clinical indicators and clinical pathways.
- As these changes had only been in place for the past three months, considerable challenges remained. The morning meeting needed to expand into a more managed system, with the group referring some concerns to the IDTs for review and ISPA development, reviewing consult reports at the meeting, and assigning follow-up items and open record reviews to members with timelines for completion. There should be a tracking system for closure of these many concerns.
- The mortality review process required monitoring to ensure recommendations had value, and they were tracked to completion. A Physical Nutritional Management Team (PNMT) member would add value to the Clinical Death Review Committee.
- The QA Department needed to review how it tracked the Medical Department's corrective action plans, and needed to present data in a user-friendly format.
- The Facility remained in noncompliance with Section L, but there was the potential for rapid progress, based on positive steps already implemented.

Nursing Care

- From September 2012 through April 2013, the Nursing Department had experienced significant staffing challenges that warranted the use of Agency nurses. Although at the time of the review, the Facility had hired a number of Licensed Vocational Nurses (LVNs), a majority of the new hires where recent nursing graduates with three months or less of nursing experience.
- Some of the Facility's positive steps forward included:

- The reliability of the Infection Control (IC) data continued to improve as reflected in data generated through comparisons of the Infection Control Reports and the Pharmacy reports for the utilization of antibiotics.
- Since the last review, the Facility had begun to aggregate and trend data generated from the Infection Control Real Time Audits.
- The outbreak timeline documentation the Facility provided indicated that since the last review, the IC Nurses provided a number of appropriate and timely in-service training sessions to staff in response to the outbreaks. In addition, the information was used to identify problematic issues that might have contributed to the spread to the infection resulting in some systematic changes in the Facility's procedures.
- The content of the minutes of the Infection Control Committee meetings continued to significantly improve regarding the information and issues discussed addressing the data generated from the IC Monitoring Tools, as well as including more detailed analyses of the acute infectious illnesses that had occurred and the development of corrective action plans.
- The Facility developed a new database to monitor the data regarding the Emergency Drills. The information could be aggregated by the items contained on the drill monitoring tool.
- The Facility had implemented procedures to track the excesses and shortages of medications being brought to the buildings in an attempt to reconcile these numbers and identify the issues related to large numbers of medications that were being returned to the Pharmacy without explanation.

- Although the Facility had made some positive steps forward in the areas noted above, at this juncture in the review process, the overall lack of progress 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 actual implementation of nursing protocols, and the problematic issues regarding the under-reporting of medication variances and excessive unexplained medications being returned to the pharmacy were very concerning.

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

- Many aspects of pharmacy services at ABSSLC represented a mature process. The new order system appeared to work well, and the internal audit process appeared to verify this. The QDRRs were done in a timely manner, were thorough, and offered practical recommendations, which were implemented in most cases. The drug utilization evaluations were timely, and follow-ups were numerous. The Pharmacy Department provided valuable information on the chemical restraint form in a consistent manner.
- Challenges included the consideration of refresher courses for adverse drug reaction identification. Although nursing staff appeared to be trained, it was less clear if that has occurred with other departments on campus. The Psychiatry Department needed to thoroughly conduct reviews of chemical restraints. The medication variances internal to Pharmacy Department remained problematic, and the new Pharmacy Director will be

challenged to resolve this quickly. There was a need for expanded collaboration with the Nursing Department in resolving the unexplained overages that were returned to the Pharmacy Department.

- The Pharmacy Department had made considerable, consistent progress. The Facility was found to be in substantial compliance with Sections N.1, N.2, N.4, N.5, and N.7.

Physical and Nutritional Supports

- The Facility's Physical and Nutritional Management Team (PNMT) had the required core members as outlined in the Settlement Agreement, and was meeting regularly. However, PNMT members were responsible for large individual caseloads beyond their PNMT caseload and responsibilities. These caseloads likely will present challenges as the PNMT members work to complete their respective roles and responsibilities.
- The Facility PNMT had a medical liaison. However, a review of PNMT documentation did not support routine participation by medical consultants.
- Based on interview, the Facility PNMT policy had been revised. The Monitoring Team requested copies of the Facility's physical and nutritional management (PNM) policies, but the only policy submitted was the State PNM policy. Consequently, the Facility PNM policies could not be reviewed to ascertain if necessary components were present.
- Some individuals who met the State Office policy's PNMT referral criteria had not been referred to the PNMT. A review of individuals' PNMT assessments, Integrated Health Care Plans, and individual PNMT discharge summaries identified multiple missing components.
- Progress had been made since the last review with individuals' Physical and Nutritional Management Plans (PNMPs) having more of the necessary components. The Facility had developed and implemented a PNMP audit tool, which included the necessary components.
- The Monitoring Team, members of the PNMT, and Facility therapists completed multiple direct observations of staff's implementation of individuals' PNMPs and dining plan strategies. These observations revealed that staff often did not follow prescribed PNMP strategies, which had the potential to place individuals at risk.
- The Facility had provided PNM foundational training to some new employees and veteran staff. However, additional work needed to be done to ensure all new employees and veteran staff successfully completed PNM foundational training. The Facility also needed to develop and implement training on individual PNMPs that included non-foundational components.
- The Facility had not yet developed or implemented a PNM monitoring policy that included the necessary components. Based on interviews with the HT Director and therapists, there was no confidence in the accuracy of the monitoring data and the Monitoring Team agreed with this assessment. The Facility had made revisions to the monitoring indicators on the forms for meals/snacks and positioning, which were positive additions. The HT Department planned to expand indicators for all the PNM monitoring areas.
- The Facility had not implemented an effectiveness monitoring system to assess individuals' progress in relation to their physical and nutritional management needs, or provide evidence that interventions were modified if an

individual was not making progress. More specifically, the implementation of individuals' IHCPs did not generate individual-specific clinical data to substantiate individuals' progress or to assess if the individual was better or worse. Monthly progress notes were not completed to report on the effectiveness of individuals' 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.

- The Facility maintained an updated list of individuals who received enteral nutrition. Individuals in the sample, who received enteral nutrition, were reviewed by their IDTs. However, the annual assessments did not include necessary components. Individuals who were transitioning to oral eating did not have formal plans.

Physical and Occupational Therapy

- With one exception, individuals newly admitted to the Facility received an Occupational (OT)/Physical Therapy (PT) assessment within 30 days. However, individuals who had experienced a change in status had not received an assessment update. Overall, individuals' OT/PT assessments were missing many of the components necessary to fully assess an individual's OT/PT functional status, provide an analysis of whether or not current supports and services were effective, and as appropriate, recommend new services or skill acquisition programs to improve the individual's functioning, health, and/or independence. The OT/PT assessment template and audit tool should be reviewed to ensure the essential components for OT/PT assessments are incorporated.
- Individuals receiving direct OT/PT interventions did not have plans. As a result these plans and/or programs were not integrated into individuals' ISPs. In addition, there were no monthly progress notes reviewing the effectiveness of programs/interventions and the individuals' progress with direct and/or indirect OT/PT supports.
- As discussed with regard to Section O.6 and O.7, the Facility did not have an adequate monitoring system for OT/PT services. The Facility did not have a policy to define the monitoring system.
- A database for Assistive Equipment Work Orders had been developed to track the completion of work orders. The development of this database was step in the right direction to assess the timeliness of work orders. However, the database results had not been analyzed to identify the total number of work orders and the number of work orders that had been completed by the due date, and/or identify and resolve problematic areas in the completion of adaptive equipment work orders.

Dental Services

- The Dental Department had continued to progress in many dental service areas. The Dental Policy and Procedure was extensive and well written. There appeared to be continued collaboration with the Psychology Department in the current program for improving compliance with dental services/desensitization. Documentation showed some progress. The Dental Department was available to provide an oral exam after the individual returned from the hospital for those at risk of aspiration, to determine whether oral health was a potentially contributing factor.

- Concerns included how to provide information and training to direct support professionals regarding the level of individuals' dental health, which might focus staff on ensuring the development of good tooth brushing skills, or the provision of necessary assistance to individuals in tooth brushing. There was no information concerning the competency-based training component for direct support professionals, or what training occurred at the dental office with both the individual and the direct support professionals.
- A quarterly review process was needed for the desensitization/improved dental compliance program, including review of data and analysis of trends. The role of psychology in reviewing this data also was not clear.

Communication

- The Facility had four Speech Language Pathologists (SLPs), but there was not a reasonable process to determine what an appropriate caseload would be for SLPs at ABSSLC.
- The Facility continued to make progress on improving individuals' communication assessments. Although further work was needed to include all of the necessary components, the assessments had begun to provide some important information to teams.
- ISPs generally provided some description of individuals' communication skills. However, more work was needed to include communication goals and objectives into ISPs, as appropriate, and/or integrate communication strategies into other goals and objectives. For individuals learning to use alternative or augmentative communication (AAC) devices or receiving direct therapy, goals or objectives also needed to be developed and included in ISPs to structure skill acquisition, and provide a mechanism to measure progress.
- Observations of individuals with AAC systems revealed the systems were not present and/or being used. Staff did not understand how to engage individuals with the systems. It could not be determined if individuals who received direct SL therapy interventions had their plans initiated in a timely manner. Progress notes did not include necessary components.
- Competency-based training and performance check-offs had not been developed and implemented for new employee orientation. Individual-specific training and performance check-offs had not been developed and implemented for individuals with AAC systems.
- The Facility did not have a policy for monitoring communication supports. Individuals with AAC systems had not been monitored using the Compliance Monitoring form. In addition, the Facility had identified that the monitoring data it was collecting was not reliable.

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:
  - The Facility had introduced a Pre-Individual Support Plan meeting during which necessary staff and required assessments were identified for the ISP meeting.
  - The new Skill Acquisition Plan (SAP) format included triggers to address frequent refusal to participate in training activities, and increasingly addressed maintenance and generalization of newly acquired skills.

    - The Facility had begun monitoring staff's understanding and implementation of Skill Acquisition Plans.
    - The Facility was monitoring active engagement of the individuals served.
    - Evidence of interdisciplinary efforts to improve habilitation services was evident in the introduction of discrete trial training for a small number of individuals in one of the activity centers.
- Areas in which continued work was necessary included the following:
    - Although the Preferences and Strengths Inventory (PSI) identified individual-specific qualities, the analysis used to guide future planning was often quite limited and shortsighted.
    - The Functional Skills Assessment Summary included information found in other documents (e.g., preferences and strengths), but did not focus on the primary purpose that was to review the individual's abilities across a broad array of skill domains, with corresponding recommendations for programming.
    - Training objectives remained limited in scope and schedules of training. Access to community-based training remained infrequent.
    - Engagement remained quite limited, particularly in the residential areas and activity centers.

<u>Most Integrated Setting</u>

- Most assessments prepared for annual ISP meetings now included the assessor's recommendation regarding transition to the community. In addition, individuals' ISPs generally included a recommendation from the Facility's team members' with regard to whether or not community placement was appropriate. This was positive. However, unfortunately, the assessments and/or ISP narratives often did not include sufficient justification for the teams' recommendations, including recommendations both for and against transition to the community.
- Although teams were identifying obstacles to community referral, the specific reasons for the obstacles were often missing. For example, when teams identified "medical issues" as the obstacle, little, if any, information was provided about the specific concerns that led the teams to believe the person could not be supported in the community due to their medical needs or a lack of medical supports. Similarly, when "LAR choice" was identified as the obstacle, little information was provided regarding the LAR's specific concerns. Without further detail, identifying potential solutions to the issues was difficult. Action plans to address obstacles were being developed, but they were poor in that they often did not address the underlying issue, and were not individualized. Similarly, the Facility continued to provide a number of educational opportunities to individuals and their families. However, an ongoing concern was the lack of individualization of action plans related to expanding individuals and their guardian's knowledge of supports in the community that could meet their needs.
- Teams had not yet begun to systematically identify obstacles to transition that individuals encountered after the referral was made. However, although still limited, the Facility had begun to analyze the aggregate data related to obstacles to referral. Although more work was needed with regard to completing a full analysis, the Facility's annual obstacles report had begun to include some information that could be helpful in addressing obstacles to

referral as well as transition, including integration of information the Facility had in relation to the community provider network(s) in the local area, and some initial analysis of the most frequent obstacles (i.e., LAR Choice and Individual Choice).

- Admissions and Placement Department staff had continued 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), and reviews were completed thoroughly. In addition, Facility staff were following up to ensure that necessary corrections were made or supports were provided to ensure individuals received the protections, supports, and services they needed. The Facility was found to be in substantial compliance with Section T.2.a.

<u>Consent</u>

- As previously reported, the State Office Guardianship Policy had been disseminated, but the policy on consent remained in the development phase. ABSSLC had adopted the State Office Guardianship policy and had begun to implement portions of the policy. The Facility also had individualized the policy some to reflect its internal processes.
- Teams continued to use the process for estimating an individual's priority need for guardianship discussed in the previous report, with some modifications to the prompts provided. It was anticipated that the Guardianship Committee would begin reviewing the teams' recommendations, but this process had not yet begun.
- 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 tools the Facility created in the absence of a State Office policy. Based on this list, a total of 74 out of the 393 individuals residing at ABSSLC (19%) were in need of guardians. However, Facility staff recognized that this likely underestimated the numbers of individuals requiring guardians or some other form of decision-making assistance.

- Since the last review, nine individuals identified as requiring a guardian had been appointed a guardian or successor guardian. According to information the Human Rights Officer had from individuals' families or attorneys, an additional nine individuals were in some stage of having a petition for guardianship filed.
- 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. The Facility also was continuing to make referrals as appropriate to a local nonprofit agency that offered guardianship services. Facility staff had developed a user-friendly brochure on guardianship. 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, Master Records, and Individual Notebooks.
- 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. The Facility was in the process of implementing some formal corrective action plans, as well as identifying less formal solutions to address some of the systemic issued identified. However, the Monitoring Team continued to find a number of missing documents in the records. It was unclear if these were related to filing issues or that the documents were not completed and/or submitted for filing.
- 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 had been finalized and implementation had begun. It identified 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/Development Department (CTD) had begun to track training, but the system to track training required modification to allow easy identification of staff who still needed to complete specific 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. A remaining challenge was establishing inter-rater reliability between the auditors.
- 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 behavior support plans and 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' behavior support plans and prescription of psychotropic medication.

Status of Compliance with the Settlement Agreement

SECTION C: Protection from Harm-Restraints	
Each Facility shall provide individuals with a safe and humane environment and ensure that they are protected from harm, consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o State Policy #001.1: Use of Restraint, dated 4/10/12; o ABSSLC Policy: Use of Restraints, dated 6/10, (revisions to match the revised DADS policy were in process per response to Document Request #1305.II.1); o ABSSLC Self-Assessment, dated 4/22/13; o ABSSLC Action Plan, dated 4/22/13; o Presentation Book for Section C; o Presentation for Section C at the entrance meeting on 5/6/13; o Section C Restraint Review, dated 3/22/12; o QA/QI Data Summaries, dated 11/9/12 and 1/11/13; o Crisis Intervention Restraint Checklist, dated February 2013; o Medical/Dental Restraint Checklist, dated February 2013; o Protective Mechanical Restraint for Self-Injurious Behavior checklist, dated February 2013; o Administration of Chemical Restraint: Consult and Review form, dated February 2013; o Post-Chemical Restraint Clinical Review form, dated February 2013. o Abilene State Supported Living Center: Restraint by Facility, from 10/1/12 through 3/31/13; o ABSSLC Restraints Trend Analysis Reports for February 2013; o Restraint Reduction Committee Minutes, dated 12/3/12, 1/24/13, 2/12/13, and 3/7/13; o Do Not Restrain/Modification of Restraint List, undated; o List of Restraint Monitors, undated; o Curriculum for Restraint Monitors, dated 5/31/12; o DADTX Course Due/Delinquent at ABSSLC, dated 3/29/13; o **Sample C1**: Chosen from list of Individuals Restrained Between 10/1/12 and 3/31/13 per II.7 of document request. The list included 87 incidents of restraint, none of which were classified as Protective Mechanical Restraint for Prevention of Self-Injurious Behavior, and involved 26 people. A sample of 13 (15%) of the restraint episodes, involving 10 people (38%) was drawn and documents requested included: ▪ The Restraint Checklist; ▪ The face-to-face/debriefing report; ▪ The crisis intervention plan, if applicable; ▪ Any/all reviews of the use of the restraint, including Unit Team, Incident Management Team (IMT), Restraint Reduction Committee; and ▪ Any addendums or changes to the individual's ISP or crisis intervention plan that resulted.

Note: the numbering used in the charts below is used in the text of this section when the Monitoring Team refers to specific restraint episodes within the samples. Sample #C.1 included:

#C.1 Sample	Name	Date and time	Notes
1.	Individual #318	1/3/13 at 10:17 a.m.	Included in sub-sample
2.	Individual #318	1/14/13 at 11:58 a.m.	
3.	Individual #95	1/22/13 at 2:50 p.m.	
4.	Individual #323	2/26/13 at 7:37 p.m.	Included in sub-sample
5.	Individual #252	2/4/13 at 12:26 p.m.	
6.	Individual #323	11/1/12 at 9:45 p.m.	
7.	Individual #323	3/25/13 at 5:00 p.m.	
8.	Individual #99	10/31/12 at 3:42 p.m.	Included in subsample
9.	Individual #430	3/18/13 at 9:55 a.m.	
10.	Individual #467	10/21/12 at 6:00 a.m.	Eliminated: this was a PMR-SIB that was reported on the wrong form and included in the list of crisis restraints.
11.	Individual #231	12/14/12 at 10:45 a.m.	
12.	Individual #233	11/24/12 at 7:00 a.m.	
13.	Individual #94	3/14/13 at 1:30 p.m.	

- **Sample #C.2** included 24 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;
  - The signed forms to show that each identified staff member had acknowledged his/her responsibility to report abuse/neglect;
  - Their start dates; and
  - The dates they were assigned to work with individuals;
- **Sample #C.3 - Medical Restraint Sample:** Chosen from the list provided in response to document request II.7 noted as II.7.b of 115 restraint reports involving 54 individuals. The sample of 18 (16%) of the restraint records was drawn and the following documents were requested:
  - The restraint checklist;
  - Documentation of the monitoring of the restraint;
  - Any reviews of the use of restraint;
  - Any desensitization plan or other plan to reduce the use of restraint;

- The doctor's order for the restraint, including the monitoring schedule to be used; and
- The medical restraint plan.

Sample #C.3 included:

Sample #C.3	Name	Date
1.	Individual #312	1/16/13 at 1:32 p.m.
2.	Individual #63	2/20/13 at 12:00 p.m.
3.	Individual #377	12/15/12 at 10:40 a.m.
4.	Individual #98	1/10/13 at 8:00 a.m.
5.	Individual #17	3/24/13 at 8:45 p.m.
6.	Individual #211	12/6/12 at 11 a.m.
7.	Individual #382	11/4/12 at 7:16 a.m.
8.	Individual #536	12/19/12 at 8:30 a.m.
9.	Individual #238	12/12/12 at 6:10 a.m.
10.	Individual #307	2/28/13 at 1:05 a.m.
11.	Individual #191	11/13/12 at 7:30 a.m.
12.	Individual #122	3/19/13 at 2:45 p.m.
13.	Individual #304	1/28/13 at 12:20 p.m.
14.	Individual #510	2/6/13 at 1:30 p.m.
15.	Individual #3	3/8/13 at 9:00 a.m.
16.	Individual #3	3/14/13 at 2:00 p.m.
17.	Individual #318	2/22/13 at 9:36 a.m.
18.	Individual #337	10/23/12 at 4:40 p.m.

- **Sample #C.4 - Chemical Restraints Sample**: Chosen from document request II.7a. The total number of restraints was 20. Sample size was four or 20%. Documents reviewed included:
  - The restraint checklist;
  - Face-to-face and debriefing reports;
  - Any reviews of the use of restraint;
  - Documentation of contact between the psychologist and physician prior to the use of the restraint; and
  - Any changes to the ISP or crisis intervention plan as a result of the restraint.

  Sample C.4 included:

Sample #C.4	Name	Date and Time
1.	Individual #99	11/7/12 at 12:50 p.m.
2.	Individual #525	12/20/12 at 1:45 p.m.
3.	Individual #318	1/14/13 at 11:58 a.m.
4.	Individual #397	3/4/13 at 11:40 a.m.

- Dental Desensitization Plans for Section C.4 for: Individual #440, Individual #507, Individual #469, Individual #144, and Individual #384;
- Dental Monthly Reports for Section C.4 for: Individual #440, Individual #507,

Individual #469, Individual #144, and Individual #384;

- **Sample #C.6**:
  - Behavior Support Plans for Section C.7 for: Individual #318, Individual #99, and Individual #323;
  - Individual Support Plans for Section C.7 for: Individual #318, Individual #99, and Individual #323;
  - Crisis Intervention Plans for Section C.7 for: Individual #318, Individual #99, and Individual #323;
  - Brief Behavioral Assessment for Section C.7 for Individual #318;
  - Restraint Checklists for Section C.7 for: Individual #318 (1/3/13 at 10:17 a.m., 1/3/13 at 11:15 a.m., 1/14/13 at 9:00 a.m., 1/14/13 at 11:27 a.m., 1/14/13 at 11:58 a.m., 1/20/13 at 9:38 a.m., 2/4/13 at 7:44 a.m., 2/13/13 at 9:07 a.m., 2/17/13 at 3:08 a.m., 2/18/13 at 10:45 a.m., 2/18/13 at 11:50 a.m., 2/19/13 at 1:02 p.m., 2/20/13 at 2:08 p.m., 2/20/13 at 3:19 p.m.), Individual #99 (10/31/12 at 1:23 p.m., 10/31/12 at 3:42 p.m., 10/31/12 at 5:25 p.m., 11/7/12 at 11:47 a.m., 11/7/12 at 12:50 p.m., 11/12/12 at 11:45 a.m., 11/12/12 at 12:50 p.m.), and Individual #323 (2/26/13 at 5:10 p.m., 2/26/13 at 7:37 p.m., 3/11/13 at 3:25 p.m., 3/19/13 at 4:35 p.m., 3/20/13 at 4:41 p.m., 3/20/13 at 4:58 p.m., 3/20/13 at 5:17 p.m., 3/25/13 at 5:00 p.m., 3/26/13 at 8:25 p.m.);
  - ISP/IDT Addenda for Section C.7 for: Individual #318 (1/4/13, 1/15/13, 1/21/13, 2/5/13, 2/12/13, 2/14/13, 2/19/13, and 2/20/13), Individual #99 (11/1/12, and 11/14/12), and Individual #323 (2/27/13, and 3/21/13);
  - IDT Review of Repeated Restraint for Section C.7 for: Individual #318 (2/12/13), Individual #99 (undated – reviewed restraints from 11/2/12 to 11/22/12), and Individual #323 (undated – reviewed restraints from 3/19/13 to 3/25/13);
- **Sample #C.7 - Protective Mechanical Restraints to Prevent Self-Injurious Behavior (PMR-SIB):** The following documentation was reviewed:
  - The Restraint Checklist;
  - The face-to-face/debriefing report;
  - The documentation of monitoring of the restraint;
  - The order for the restraint and any alternate schedule of monitoring;
  - The ISP confirming the use of the restraint;
  - Any and all reviews of the use of the restraint; and
  - List of Facility approved restraints with policy reference included.

  A total of seven mechanical restraints for SIB were reported involving two individuals. A sample of two was chosen. It was noted that all seven restraints appeared on the list as "type restraint: crisis intervention." The two in the sample are also part of the sample for crisis restraints (Sample C.1):

Sample #C.7	Name	Date and time
1.	Individual #467	10/21/12 at 6:00 a.m.

2.	Individual #233	11/24/12 at 7:00 a.m.

- Nursing Restraint documentation from the Restraint Checklists, Interdisciplinary Progress Notes (IPNs), and Client Injury Reports for the following individuals:
  - Individual #318 on 2/4/13 at 7:44 a.m., and 2/20/13 at 2:08 p.m.;
  - Individual #323 on 1/20/13 at 10:53 a.m., and 3/26/13 at 8:25 a.m.;
  - Individual #211 on 1/24/13 at 9:43 p.m., and 3/3/13 at 10:10 a.m.;
  - Individual #95 on 2/10/13 at 12:34 p.m., and 3/29/13 at 8:52 p.m.;
  - Individual #430 on 3/18/13 at 9:55 a.m.;
  - Individual #256 on 3/8/13 at 9:08 p.m.;
  - Individual #371 on 1/18/13 at 9:05 p.m.;
  - Individual #37 on 1/23/13 at 12:59 p.m.;
  - Individual #507 on 1/3/13 at 11:44 a.m.;
  - Individual #227 on 3/18/13 at 10:08 a.m.;
  - Individual #94 on 3/14/13 at 1:30 p.m.; and
- Psychologists' Restraint Documentation Checklist.

▪ **Interviews with**:
- Linda Hinshaw, Facility Director;
- Jolene Willis, Assistant Director of Programs;
- Pat Smith, Director for Quality Assurance;
- Ron Manns, Chief Psychologist;
- Dr. George Zukotynski, DADS Coordinator of Behavioral Services;
- Rene Kellum Program Compliance Monitor;
- Cathy Northrup, RN, MSN, CPN, Chief Nurse Executive (CNE); and
- Mary Willingham, RN, Program Compliance Nurse; and
- Various staff in residential units, including ten direct support professionals.

▪ **Observations of**:
- Quality Assurance/Quality Improvement (QA/QI) Council Meeting, on 5/6/13;
- Restraint Reduction Committee, on 5/9/13;
- Interdisciplinary Team Meeting for Individual #241, on 5/8/13;
- Unit IV Team Meeting, on 5/8/13;
- IMT meeting, on 5/8/13; and
- Residences #6690, #6710, #6730, #6740, #6521, #6400, #5971, and #5962.

Facility Self-Assessment: Based on a review of the Facility's Self-Assessment with regard to Section C of the Settlement Agreement, the Facility found that it was in substantial compliance with none of the eight provisions in Section C. This was not consistent with the Monitoring Team's findings, because the Monitoring Team found the Facility to be in substantial compliance with Section C.2.

To conduct its self-assessment, the Facility used a combination of data resulting from sampling of restraint documentation using a Quality Assurance Monitoring Tool, and review of tracking information for such indicators as length of restraint. The sampling totaled 55 out of 117 instances of restraint over the period

	from 11/1/12 to 3/31/13, or 47%. Overall ratings from checklists were not included. Instead the Facility chose specific elements related to the section to illustrate whether or not there was substantial compliance. For example in Section C.3, the Facility relied on two measures: whether staff who completed restraints had the appropriate training and whether checklists adequately documented use of an approved restraint. While both measures were found to be at 100%, the Facility determined noncompliance based on not having fully implemented its policies. In Section C.2, the Facility and the Monitoring Team used different approaches to determine compliance. The provision required that restraints be terminated as soon as the individual was no longer a danger to himself or others. The Monitoring Team relied on a sample and looked at whether individuals had been released as required. For Section C.1, the Monitoring Team found no evidence that anyone was restrained who was not in a crisis situation. The Facility examined the length of time individuals were restrained and determined that while it was short, information from their determinations in another section suggested that individuals might have been restrained unnecessarily, and, therefore, C.2 was out of compliance. In other words, the Facility had combined assessment of timely release from restraint with the appropriateness of the use of restraint. The Monitoring Team did not, and so, there was a discrepancy in the findings. For Section C.7, in conducting its self-assessment, the Facility: ▪ Used an abbreviated restraint audit tool entitled "the Psychologists Restraint Documentation Checklist;" ▪ This tool included adequate indicators to review the degree to which staff completed in full the restraint checklist and accompanying debriefing. This same tool was used to record whether the individual had been restrained in the past 30 days, whether he/she had been restrained more than three times in a rolling 30-day period, whether there was a Crisis Intervention Plan, and whether the IDT had met to review repeated restraint; ▪ The Self-Assessment indicated that the Director of Behavioral Service reviewed a minimum of 10 crisis intervention restraint checklists monthly. A total of 51 checklists were reviewed; ▪ Instructions for use of the monitoring tool were not provided to the Monitoring Team; ▪ Inter-rater reliability was reported between QA and the Director of Behavioral Services for all sub-sections of Section C.7. Reliability was assessed at 75% for sub-sections C.7.a through C.7.f. Reliability was assessed at 100% for sub-section C.7.g. The Facility noted a rating of noncompliance for Section C.7. This was consistent with the Monitoring Team's findings. To be a useful process, the Facility needs to monitor measures that will determine compliance, such as those used in the various metrics in this report. Other observations included: ▪ The data included in the self-assessment was graphed and displayed in helpful ways. ▪ Information on inter-rater reliability was included where it was important to understanding the data collection results. ▪ The new tool being used for monitoring should have some guidelines added to be useful in the self-assessment process.

	Summary of Monitor's Assessment: The Monitoring Team found ABSSLC to be in substantial compliance with Section C.2 related to timely release from restraint. Areas of progress included: ▪ Progress had been made in discontinuing long-term use of protective mechanical restraint for a number of people. ▪ Revisions had been made to the monitoring tool that looked promising. ▪ The Restraint Reduction Committee had good presentations of issues. However, more critical and creative thinking was needed regarding potential solutions. Some areas that needed improvement included: ▪ The curriculum for Restraint Monitors needed to be adjusted to assure Restraint Monitors were not acting as both the restraint monitor and the person applying the restraint at the same time. ▪ The communication issues around getting Restraint Monitors and Nurses notified that a restraint was in progress needed to be resolved. ▪ Corrective action plans needed to be developed, particularly where there were systemic or cross-disciplinary issues related to restraint use. ▪ Restraint documentation needed to capture good descriptions of the behavior that happened before the behavior that caused the restraint. ▪ The Monitoring Team found inconsistencies in the quality of reviews completed when individuals experienced more than three restraints in a rolling 30-day period. Action plans were not always clearly developed to address events that led to restraint. Limited habilitation programs also impacted the individuals' access to an interesting and varied daily schedule designed to meet his/her specific needs and interests. The Interdisciplinary Team Review of Repeated Restraint, if completed as designed, offered a good guideline for thoughtful review and planning.

#	Provision	Assessment of Status	Compliance
C1	Effective immediately, no Facility shall place any individual in prone restraint. Commencing immediately and with full implementation within one year, each Facility shall ensure that restraints may only be used: if the individual poses an immediate and serious risk of harm to him/herself or others; after a graduated range of less restrictive measures has been exhausted or considered in a clinically justifiable manner; for reasons other than as punishment, for convenience of staff, or in the absence of or as an alternative to	Data in the following chart was supplied by the Facility upon request.	Noncompliance

Type of Restraint	5/1/12-10/30/12 (6 months)	11/1/12-4/30/13 (6 months)
Personal restraints (physical holds) during a behavioral crisis	28	114
Chemical restraints during a behavioral crisis	14	22
Mechanical restraints during a behavioral crisis	40	13
TOTAL restraints used in behavioral crisis	82	149
TOTAL individuals restrained in behavioral crisis	31	25
Of the above individuals, those restrained pursuant to a Crisis Intervention Plan	5	27*

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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.

Medical/dental restraints	8 (dental) 115 (medical)	10 (dental) 79 (medical)
TOTAL individuals restrained for medical/dental reasons	Not available	Not available

*This number appeared to be in error since it exceeded the number of individuals restrained in behavioral crisis and there were individuals in Sample C.1 that did not have Crisis Intervention Plans.

<u>Prone Restraint</u>
a. Based on Facility policy review, prone restraint was prohibited.

b. Based on review of other documentation (trend reports and lists of restraints), prone restraint was not identified.

A sample, referred to as Sample #C.1, was selected. (A list is provided in the Documents Reviewed Section above.)

c. Based on a review of the 13 restraint records for individuals in Sample #C.1 involving 10 individuals, 0 (0%) showed use of prone restraint.

d. Based on questions asked in interview with 10 direct support professionals, 10 (100%) were aware of the prohibition on prone restraint.

<u>Other Restraint Requirements</u>
e. Based on document review, the Facility and State policies stated 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; and for reasons other than as punishment, for convenience of staff, or in the absence of or as an alternative to treatment.

Restraint records were reviewed for Sample #C.1 that included the restraint checklists, face-to-face assessment forms, and debriefing forms for 13 episodes of crisis intervention restraint. One record was eliminated (C.1.10) since it appeared to be a protective mechanical restraint (abdominal binder) for SIB, even though it was recorded as a crisis intervention on the tracking sheet from which the sample was drawn. The following are the results of this review:

- f. In 12 of the 12 records (100%), there was documentation showing that the individual posed an immediate and serious threat to self or others.

- g. For the 12 restraint records, a review of the descriptions of the events leading

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		to behavior that resulted in restraint found that 12 (100%) contained appropriate documentation that indicated that there was no evidence that restraints were being used for the convenience of staff or as punishment. ▪ h. In 10 of the 12 records (83%), there was evidence that restraint was used only after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner. While none of the records had a clear description on the order of application of less restrictive measures or specifics about the time involved, there was enough information between the restraint checklists, the face-to-face sheets and the Debriefing sheets to provide a sense of the time and order. The two that did not included: o Sample #C.1.7: there was no sense of the time involved or the order of events; and o Sample #C.1.12: there was no debriefing sheet to supplement the information in the restraint record, and the information in the restraint checklist was not sufficient to determine what measures were used. ▪ i. ABSSLC policy: Use of Restraint, dated June 2010, identified a list of approved restraints for medical restraint only, as well as a list for use in a behavioral crisis. The lists were not identical, but neither list included an abdominal tie as a restraint. The State Policy contained a list of prohibited restraints, which did not include an abdominal tie, and left open the potential use of other types of mechanical restraint, provided it was authorized by a physician. Since the Settlement Agreement specified "only restraint techniques approved in the Facilities' policies shall be used," the Facility policy that is under revision to match the most recent State policy will need to include a complete list of approved restraints. j. Based on the review of 12 restraints, involving nine individuals, all (100%) were approved restraints, listed in current ABSSLC policy. k. In ten of the 12 records (83%), there was documentation to show that restraint was not used in the absence of or as an alternative to treatment. Examples where this was not the case included: ▪ Sample #C.1.3: There was no face-to-face or debriefing document and the restraint checklist indicated the individual was trying to leave his room and staff were blocking him. There was no information about why he could not leave his room or what he was supposed to be doing in his room at 2:52 p.m. ▪ Sample #C.1.4: There was documentation in the debriefing that the individual needed to be kept busy and out of the house to avoid the behavior that precipitated the restraint. It appeared that he was not being provided with	

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		enough activity, which led to restraint use. l. Of the seven restraints that were the Facility considered to be PMR-SIB, the Monitoring Team reviewed two (Sample C.7). Of these, none (0%) completely followed State policy and/or the requirements of the Settlement Agreement regarding the use, management, and review of PMR. ▪ Sample #C.7.1 involved use of an abdominal binder to prevent pulling of a gastrostomy tube (G-tube). There was a physician's order, a restraint risk assessment, a Human Rights assessment, and a plan to fade the use of the restraint. The fading plan had been pursued and the restraint was discontinued in January 2013. On the date of the sampled restraint record, a restraint monitor and nurse had completed the necessary checks at the beginning of the day and a record of monitoring had been maintained throughout the day. While this was a successful use of PMR-SIB, it did not fully comply with the Settlement Agreement since an abdominal tie did not appear on a list of approved restraints. ▪ Sample #C.7.2 involved used of mittens to prevent the individual from putting his thumb in his throat, causing scratches, and inducing vomiting. The mittens did appear on the list of Facility-approved restraints in its 2010 restraint policy. However, the Facility used the Crisis Intervention Restraint Checklist rather than the checklist for Protective Mechanical Restraint for Self-Injurious Behavior. As a result, there was no morning check by the restraint monitor and nurse of the condition of the restraints and no monitoring record of checks made during the day. The record did contain his ISP, dated 11/20/12, with an approved rights restriction for use of mittens, and an action plan step for fading use of the mittens. There was evidence in the record that activities had been planned and implemented to engage him in ways that would distract his attention from his throat and otherwise engage his hands. For this review, the Facility was not in substantial compliance based on the three metrics that did not meet the substantial compliance criteria of 90%, as well as the need for Facility policy revisions to match the State restraint policy and the need for clarification about the mechanical restraints that are authorized for use. While the order and timing of graduated measures to avoid restraint could sometimes be inferred from information in the debriefing sheets, there should be clear descriptions of the steps taken and the time involved in avoiding restraints. Efforts should continue to ensure that restraint is not used in the absence of or as an alternative to treatment, and to ensure that the requirements related to PMR-SIB are followed. The Facility Self-Assessment found this provision to be noncompliant based on the need for clearer documentation.	
C2	Effective immediately, restraints shall be terminated as soon as the	The restraint records for the nine individuals in Sample #C.1 involved in 12 restraints were reviewed. Of the 12 restraints:	Substantial Compliance

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	individual is no longer a danger to him/herself or others.	▪ One chemical restraint and three restraints during which staff released the individuals because they were unable to maintain the restraint were removed. ▪ Of the remaining eight restraints, six were subject to crisis intervention plans (CIPs) at the time of the restraint. a. Of the six episodes of restraint involving individuals who had Crisis Intervention Plans, six (100%) included sufficient documentation to show that the individual was released from restraint according to the criteria set forth in the Crisis Intervention Plan. b. For two individuals who did not have Crisis Intervention Plans, two (100%) included sufficient documentation to show that the individual was released as soon as the individual was no longer a danger to him/herself. Based on this review, the Facility was in substantial compliance with this provision. The Facility's Self-Assessment did not find substantial compliance, based on deficits in documentation.	
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 of the Settlement Agreement. The Facility had not issued a local policy or procedures to implement the latest version of the State policy, but it appeared to have implemented use of the newer checklists. Since the Facility policy manual did not have the latest update, it made adherence to the latest State policy confusing. a. Review of the Facility's training curricula revealed that it included adequate training and competency-based measures in the following areas: ▪ Policies governing the use of restraint (the new state policy); ▪ 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. b. For staff in Sample #C.2, a review of training transcripts and the dates on which they were determined to be competent with regard to the required restraint-related topics, showed that: ▪ 24 of the 24 (100%) had current training in RES0105 Restraint Prevention and Rules. ▪ 19 of the 19 (100%) employees with current training who had been employed over one year had completed the RES0105 refresher training within 12 months of the previous training.	Noncompliance

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		▪ 24 of the 24 (100%) had completed PMAB training within the past 12 months. ▪ 19 of the 19 (100%) employees hired over a year ago completed PMAB refresher training within 12 months of previous restraint training. c. Based on responses to questions, 10 direct support professionals answered the following questions correctly: ▪ What policies govern the use of restraint? (100%); ▪ Describe two verbal or redirection techniques (100%); ▪ Describe two approved restraint techniques (100%); and ▪ How would you supervise an individual in restraint? (100%) d. In ten of the 12 records (83%), there was evidence that restraint was used only after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner. Based on this review, the Facility was not in substantial compliance. This was due to the Facility not meeting the substantial compliance criteria of 90% for metric C.2 d, and the need for the Facility policy to be amended to match the State policy. The Facility's finding in its Self-Assessments was the same.	
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.	a. Based on a review of 12 restraint records (Sample #C.1), in 12 (100%) there was evidence that documented that restraint was used as a crisis intervention. b. In review of 36 Behavior Support Plans for Section K.9 of this report, there was no evidence that restraint was being used for anything other than crisis intervention (i.e., there was no evidence in these records of the use of programmatic restraint). In addition, the Facility policy did not allow for the use of restraint for reasons other than crisis intervention. c. In addition, Facility policy did not allow for the use of crisis intervention restraint for reasons other than crisis intervention. d. In 12 of 12 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 maintained by the Facility. e. A subsample of Sample #C.1 was drawn including: #C.1.1, #C.1.4, and #C.1.8. In three of three restraint records reviewed (100%), there was evidence that the restraint used was not in contradiction to the individuals' medical orders according to a comparison of the Annual Medical Summary Active Problems list and the form used by the Facility to document restraint considerations/restrictions.	Noncompliance

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		f. In three of three restraint records reviewed (100%), there was evidence that the restraint used was not in contradiction to the individual's ISP, PBSP, or crisis intervention plan. Dental desensitization plans were reviewed for five individuals. These plans followed a similar format: a) the goal and objective were stated; b) baseline measures were noted; c) the plan was outlined (i.e., setting, schedule, materials needed, reinforcer, special considerations, and implementation steps); d) assessment and evaluation protocols were described; and e) the date and author of the plan were recorded. Each component of the plan is addressed below. ▪ Four of the plans noted initial implementation dates from 2011. Each of these plans was revised on 12/13/12. The fifth plan was introduced on 5/21/12. ▪ With a goal of increasing the individual's compliance or cooperation with dental exams, each objective indicated the individual was to participate with verbal prompts for one trial across a designated number of sessions. ▪ Baseline was reported as the current need for medical sedation with possible restraint (two plans), medical sedation with full body restraint (one plan), sedation (one plan), and refusal to participate (one plan). None of the plans reflected the collection of data to determine the individual's ability to complete activities outlined in the plan. This was problematic in that there was no objective measure against which to assess the individual's progress or lack thereof. ▪ Although structured data sheets were attached to every plan, the monthly Dental Desensitization Report provided greater information. Seven monthly reports, describing progress between 8/25/12 and 3/26/13, were reviewed for four individuals. For Individual #144, only three monthly reports were reviewed as his program was discontinued on 12/19/12 due to his successful completion of the program. The new plan was to conduct one or more primer sessions the week before regularly scheduled dental treatment. The Facility is commended for the efforts that had been undertaken to improve individual cooperation with and participation in dental care. ▪ For three of the five individuals (60%), training was limited to one trial per week. One person was scheduled to participate in training one to two times each week, and one person was scheduled for training three times per week. As noted previously, it is suggested that so few training opportunities will result in very slow and limited progress. ▪ Four of the plans identified praise and some preferred food as the reinforcer. One of these plans also identified access to a DVD player as a potential reinforcer. Although the fifth plan did not list edibles under reinforcers, delivery of a food item was noted in one of the steps of the program. This reflected a marked	

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		change in plans with less reliance on praise as an effective reinforcer and the introduction of potentially more preferred items. ▪ The four plans that had been revised in 12/12 described a shaping process in which the individual would allow increasingly intrusive procedures. The fifth plan was similar to those reviewed previously in which the majority of the steps described staff behavior. The Facility had clearly introduced activities to help reduce their use of sedation and restraint with dental procedures, but more work was needed. The Facility was using shaping to increase individuals' tolerance, but the limited trials each week will likely impede progress. The mock dental clinic continued to operate with a degree of success. The Departments of Behavioral Services and Dentistry are encouraged to develop an objective data collection system that would capture the noted improvement in individual behavior. Desensitization plans should be developed for all in need and training should occur more frequently. In addition, as discussed with regard to Section J.4 and 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 procedures. Although the Facility did not provide this information in a readily accessible format a review of the raw data related to the utilization of pre-treatment sedation for medical procedures (from 10/1/12 to 3/31/13) indicated that the vast majority of pre-treatment sedation at ABSSLC was utilized for medical appointments. 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. Given the lack of plans to eliminate to the extent possible sedation used for medical procedures, the Monitoring Team could not determine if: ▪ Appropriate treatments or strategies to minimize or eliminate the need for restraint had been developed; and/or ▪ Treatments or strategies developed to minimize or eliminate the need for restraint were implemented as scheduled. In the future, the following metrics will be reviewed to assess compliance with this provision: In reviewing ___ ISPs for individuals for whom restraint had been used for the completion of medical or dental work: ▪ g. ___ (___%) showed that there had been appropriate authorization (i.e., Human Rights Committee (HRC) approval and adequate consent);	

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		▪ h. ___ (____%) included appropriately developed treatments or strategies to minimize or eliminate the need for restraint; and ▪ i. ___ (____%) of the treatments or strategies developed to minimize or eliminate the need for restraint were implemented as scheduled Based on this review, the Facility remained in noncompliance with this subsection. Although progress had been made with dental desensitization, more work was needed, and desensitization or other strategies to reduce the need for restraint used for medical procedures was an area requiring significant work.	
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	a. Review of Facility training documentation showed that there was not an adequate training curriculum for restraint monitors on the application and assessment of restraint. Specifically, it did not make clear that restraint monitors were not to attempt to restrain an individual and to monitor that restraint at the same time. b. This training was competency-based. c. Based on review of training records, five staff at the Facility who performed the duties of a restraint monitor for Sample #C.1, three (60%) successfully completed the training to allow them to conduct face-to-face assessment of individuals in crisis intervention restraint. According to the list provided by the Facility, those who did not complete the training were the restraint monitors in the following records: Sample #C.1.6 and #C.1.11. The names of the monitors in both cases were difficult to read, and it is possible that had they been legible, the names would have been found on the list of trained restraint monitors. Based on a review of 12 restraint records (Sample #C.1), where a face-to-face assessment was required, it was conducted: ▪ d. In six out of 12 incidents of restraint (50%) by an adequately trained staff member. Records that did not contain documentation of this included: o Sample #C.1.2, #C.1.3, #C.1.4, and #C.1.12 where no face-to-face review was documented; and o Sample #C.1.6 and #C.1.11 where the person conducting the review did not appear on the list of restraint monitors. ▪ e. In eight out of 12 instances (67%), 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: Sample #C.1.2, #C.1.3, #C.1.4, and #C.1.12 where no face-to-face review was documented. ▪ f. In seven instances (58%), the documentation showed that an assessment was completed of the application of the restraint. Records that did not contain documentation of this included:	Noncompliance

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	instance of a medical restraint, the physician shall specify the schedule and type of monitoring required.	o Sample #C.1.2, #C.1.3, #C.1.4, and #C.1.12 where no face-to-face review was documented; and o Sample #C.1.1 where the lack of documentation of the behavior prior to the restraint on the restraint checklist and the illegibility of the restraint checklist were not commented on by the restraint monitor on the face-to-face form. ▪ g. In seven instances (58%), the documentation showed that an assessment was completed of the consequences of the restraint. Records that did not contain documentation of this included: o Sample #C.1.2, #C.1.3, #C.1.4, and #C.1.12 where no face-to-face review was documented and o Sample #C.1.8 where no injuries were noted by the nurse on the restraint checklist and the box was checked "no injury" on the face-to-face, but a note was added to the face-to-face indicating a staff member had been injured. The inconsistency between the entries was not explained, and therefore, the assessment of the consequences of the restraint was incomplete. There were no records for which physicians had ordered alternative monitoring schedules. In future, if alternative monitoring schedules are ordered, they will be reviewed according to the following metrics. ▪ h. In ___ out of ___ (___%), the extraordinary circumstances necessitating the alternative monitoring were documented; and ▪ i. In ___ out of ___ (___%), the alternative monitoring schedules were followed. Based on a review of 15 restraint records for 11 individuals for restraints that occurred at the Facility (i.e., Individual #318, Individual #323, Individual #211, Individual #95, Individual #430, Individual #256, Individual #371, Individual #37, Individual #507, Individual #227, and Individual #94), there was documentation that a licensed health care professional: ▪ j. Initiated monitoring at least every 30 minutes from the initiation of the restraint in 12 (80%) of the instances of restraint. Records that did not contain documentation of this included: Individual #323 on 3/26/13 at 8:25 a.m.; Individual #256 on 3/18/13 at 9:08 p.m.; and Individual #227 on 3/18/13 at 10:08 a.m. ▪ k. Monitored and documented vital signs in 10 (67%) episodes. Records that did not contain appropriate documentation of this included: Individual #323 on 3/26/13 at 8:25 a.m.; Individual #95 on 2/10/13 at 12:34 p.m., and on 3/29/13 at 8:52 p.m.; Individual #227 on 3/18/13 at 10:08 a.m.; and Individual #94 on 3/14/13 at 1:30 p.m. Problematic issues that resulted in noncompliance included variations in the vital signs not retaken, vital signs not recorded, or	

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		marked as refused. As noted in previous reports, to obtain respirations, the individual's cooperation is not required. ▪ l. Monitored and documented mental status in 12 (80%) episodes. Records that did not contain appropriate documentation of this included: Individual #323 on 3/26/13 at 8:25 a.m.; Individual #371 on 1/18/13 at 9:05 p.m.; and Individual #227 on 3/18/13 at 10:08 a.m. Problematic issues that resulted in noncompliance included either the mental status was not recorded, or was generic such as "alert, and oriented" without a specific description of the behavior included to support the generic documentation. From discussions with the Chief Nurse Executive and Program Compliance Nurse, since the last review, the Facility's Nursing Department had not yet established a formal system to review and analyze these data or address the problematic issues found. The same was true for the data related to Section C.6 addressing the documentation of assessment by a licensed health care professional to determine whether there were any restraint-related injuries or other negative health effects. The following will be assessed in future reviews, as appropriate. Based on documentation provided by the Facility, ___ restraints had occurred off the grounds of the Facility in the last six months. A sample of __ was reviewed (Sample #C.5). A licensed health care professional: ▪ m. Conducted monitoring within 30 minutes of the individual's return to the Facility in __ out of ___ (__%). ▪ n. Monitored and documented vital signs in ___ (___%). ▪ o. Monitored and documented mental status in ___ (___%). Sample #C.3 was selected from the list of individuals who had medical restraint in the last six months. It represents 31% of the individuals for whom medical restraint was used. (Sample C.3 is defined above in the Documents Reviewed section.) For these individuals, the physicians' orders were reviewed, as well as documentation of monitoring. ▪ p. In three out of 18 (17%), the physician specified the schedule of monitoring required or specified Facility policy regarding this was to be followed (i.e., #C.3.1, #C.3.7, and #C.3.12 where the restraint was a brief hand hold and no schedule was needed). In interview with the Chief Psychologist, it was determined that there is no Facility policy regarding the schedule for monitoring medical restraint. ▪ q. In none out of 18 (0%), the physician specified the type of monitoring required if it was different than the Facility policy. Again, there was no Facility policy to provide guidance with regard to monitoring medical restraint. ▪ r. In two out of 18 of the medical restraints (11%), appropriate monitoring was completed either as required by the Settlement Agreement, Facility policy, or as	

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		the physician prescribed. The two cases where monitoring was completed correctly was Sample #C.3.1 where the doctor specified monitoring for 10 to 30 minutes, and #C.3.12 where hand-over-hand restraint was used and no monitoring was required. The Facility remained in noncompliance with this provision. The Facility's Self-Assessment included a finding of noncompliance as well. However, the Facility did not address all of the necessary components in its assessment, but relied primarily on the timeliness of reviews by nurses.	
C6	Effective immediately, every individual in restraint shall: be checked for restraint-related injury; and receive opportunities to exercise restrained limbs, to eat as near meal times as possible, to drink fluids, and to use a toilet or bed pan. Individuals subject to medical restraint shall receive enhanced supervision (i.e., the individual is assigned supervision by a specific staff person who is able to intervene in order to minimize the risk of designated high-risk behaviors, situations, or injuries) and other individuals in restraint shall be under continuous one-to-one supervision. In extraordinary circumstances, with clinical justification, the Facility Superintendent may authorize an alternate level of supervision. Every use of restraint shall be documented consistent with Appendix A.	A sample (Sample #C.1) of 12 Restraint Checklists for individuals in crisis intervention restraint was selected for review. The following compliance rates were identified for each of the required elements: ▪ a. In 12 (100%), continuous one-to-one supervision was provided; ▪ b. In 12 (100%), the date and time restraint was begun; ▪ c. In 12 (100%), the location of the restraint; ▪ d. In 10 (83%), information about what happened before, including what was happening prior to the change in the behavior that led to the use of restraint. For the two that did not: o In Sample #C.1.3: The individual was in his room in the middle of the afternoon, and there was no information about why he was there or why he had to stay there (i.e., staff blocked his exit from his room). o In Sample #C.1.12: There was no information about this on the restraint checklist, and no face-to-face sheet was provided. ▪ e. In two (17%), the actions staff took prior to the use of restraint to permit adequate review per C.8. Generally, records indicated what actions were taken by checking the boxes on the restraint checklist or by listing them in the debriefing. However, there was rarely an explanation of the order of the attempts or an indication of the time involved. In the two that were adequate: o Sample #C.1.6: There was an altercation between peers that necessitated immediate intervention to protect the peer who was attacked; and o Sample #C.1.13: The description of actions taken included reference to continuous attempts throughout the day to redirect the individual with restraint being used only when the attempts failed. ▪ f. In 12 (100%), the specific reasons for the use of the restraint were included; ▪ g. In 12 (100%), the method and type (e.g., medical, dental, crisis intervention) of restraint; ▪ h. In 10 (83%), the names of staff involved in the restraint episode. In two (Sample #C.1.2 and #C.1.3) the names of staff were illegible; ▪ Observations of the individual and actions taken by staff while the individual was in restraint, including:	Noncompliance

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		o i. In 11 of the 11 non-chemical restraints (100%), the observations documented every 15 minutes and at release. o j. None of those restraints lasted more than 15 minutes. If any had, then the following metric would have been assessed: In ___ (___%) of those restraints that lasted more than 15 minutes, the specific behaviors of the individual that required continuing restraint; and o k. None of those restraints lasted more than 30 minutes. If any had, then the following metric would have been assessed: In ___ (___%), the care provided by staff during restraint lasting more than 30 minutes, 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. ▪ l. In 12 (100%), the level of supervision provided during the restraint episode; and ▪ m. In 11 of 11 non-chemical restraints (100%), the date and time the individual was released from restraint; n. Based on a review of 15 restraint records for 11 individuals for restraints that occurred at the Facility (i.e., Individual #318, Individual #323, Individual #211, Individual #95, Individual #430, Individual #256, Individual #371, Individual #37, Individual #507, Individual #227, and Individual #94): ▪ In 10 (67%), 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 #323 on 1/20/13 at 10:53 p.m.; Individual #211 on 3/3/13 at 10:10 a.m.; Individual #95 on 2/10/13 at 12:34 p.m., and 3/29/13 at 8:52 p.m.; and Individual #371 on 1/18/13 at 9:05 p.m. Problematic issues that resulted in noncompliance included either the injury section being left blank, or the injuries were not appropriately documented in alignment with nursing standards on the Client Injury Reports regarding the specific description of the injuries (i.e., size, location, color). o. In a sample of 12 records (Sample #C.1), restraint debriefing forms had been completed for eight (67%). Those that did not have debriefing forms included: ▪ Samples #C.1.3, #C.1.7, #C.1.8, and #C.1.12. p. A sample of 18 medical restraints was reviewed (Sample #C.3), and in three (17%), there was evidence that the monitoring had been completed as required by the physician's order. This is discussed above with regard to Section C.5. Sample #C.4 was selected using the list the Facility provided of individuals who had had chemical restraint since the last on-site review. This sample of four individuals who were	

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		the subject of a chemical restraint was reviewed. q. In three (75%), there was documentation that prior to the administration of the chemical restraint, the licensed health care professional contacted the psychologist, who assessed whether less intrusive interventions were available and whether or not conditions for administration of a chemical restraint had been met. ▪ In record #C.4.2, there was no documentation of consultation. However, the Chief Psychologist had noted the missing documentation and sent a memo to the Chief Executive Nurse reminding her of the need to use the correct form and to include the consultation. Based on this review, the Facility was remained in noncompliance. For a number of metrics, the Facility had not met the substantial compliance thresholds. The Facility Self-Assessment also found noncompliance with this provision.	
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 Facility's report, dated 4/17/13, of all restraints from 10/1/12 to 3/31/13, a total of eight individuals were placed in restraint more than three times in any rolling 30-day period. However, it was unclear if this was correct, because the Restraint Reduction Committee meeting minutes from 1/24/13, noted that Individual #231 was in a total of nine restraints in 11/12. This was not reflected in the list of all restraints. A sample of three of these individuals was selected for review to determine if the requirements of Section C.7 of the Settlement Agreement were met. The following documents were reviewed: Behavior Support Plans (BSP), Individual Support Plan, Crisis Intervention Plans (CIP), Restraint Checklists, Personal Support Team (PST) Review of Repeated Restraints, and ISP/IDT Addenda. A Brief Behavioral Assessment was also reviewed for Individual #318. The results of this review are discussed below with regard to Sections C.7.a through C.7.g of the Settlement Agreement. For all of the individuals reviewed (100%), the individual's team met to discuss the restraints. The dates on all of the addenda documents indicated that the teams had met within 10 days. The PST Review of Restraints for Individual #318 also reflected compliance with this timeline. The PST Reviews of Repeated Restraint for Individual #99 and Individual #323 were not dated, and therefore, the timeliness of the team's response could not be determined. It should be noted that the PST Review of Repeated Restraints	Noncompliance

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		form was superior to the ISP Addenda, because it guided the team to address each of the factors noted in Section C.7.a through C.7.g. The quality of the review is important and staff should engage in thoughtful and comprehensive discussion about each of these matters. It will also be important for the Facility to date the PST Review of Repeated Restraints to document that the team met within 10 business days of the repeated restraints. Of the three individuals reviewed, three (100%) of individuals' teams (as reflected in ISPAs/PST Review of Repeated Restraints) discussed each individual's adaptive skills. The following are examples of individuals for whom this was done appropriately: ▪ The staff working with Individual #323 reviewed with him actions he could take when he became upset. He reported that he could listen to music or take a walk. Of these, there was evidence of an action plan or discussion/recommendations, identified in the ISPA, for modifying them to prevent the future probability of restraint in none of the cases (0%). The following are examples where teams failed to do this adequately: ▪ Although staff for Individual #323 identified ways he could help himself calm during stressful times, they did not review his current training objectives. A review of this individual's skills in his ISP suggested that he had many strengths, but his ISP contained only four training objectives (i.e., counting change, attending work for his entire shift, tooth brushing, and identifying one of his medications). Greater development of functional skills across multiple domains would be appropriate. ▪ Similarly, the ISP for Individual #99 reflected only three training objectives (i.e., dial a phone, make a purchase, and "keep up with daily totals of stacking/folding towels"). The ISP was dated 7/12/12, but appeared incomplete as several sections had lines drawn through the text. As it was over nine months since the date of her annual meeting, this plan should have been finalized. ▪ Finally, the ISP for Individual #318 included four training objectives (i.e., dial a phone, do his laundry, brush his teeth, and mix his medication fiber). This was a young man of 25 who did not work and had the option to visit the activity center. It is suggested that the development of enhanced and expanded adaptive behavior was not being adequately addressed for this individual. Of the three individuals reviewed, all (100%) of individuals' teams (as reflected in ISPAs/PST Review of Repeated Restraints) discussed each individual's biological, medical, and psychosocial factors. The following are examples of individuals for whom this was done appropriately:	

#	Provision	Assessment of Status	Compliance
		▪ The team for Individual #323 noted that when he complained of stomach pain, possibly due to his diagnosis of gastroesophageal reflux disease (GERD), he was directed to the nurse. He also was followed by psychiatry for support and medication management. Changes to his medications had been made during the period when he was experiencing repeated restraint. ▪ The team indicated that they had separated Individual #99 from a peer with whom she did not get along during meals. ▪ The team for Individual #318 repeatedly met to review his medication regimen. He was eventually transferred to Big Springs State Hospital for further evaluation. Of these, there was evidence of an action plan or discussion/recommendations, identified in the ISPA/PST Review of Repeated Restraints, for modifying them to prevent the future probability of restraint in one of the cases (33%) (i.e., Individual #323). The following are examples where teams failed to do this adequately: ▪ In the BSP for Individual #99, staff were advised to monitor her closely just before and during her menses. There was no indication that medication was given to alleviate any discomfort or pain symptoms. The PST Review of Repeated Restraints indicated there were no health concerns. ▪ Individual #318 required a restraint on 2/13/13 after becoming upset as he observed his housemates preparing for a trip to a local MacDonald's restaurant. He was not included in this outing due to his lack of funds. The team should review such incidents and put in place strategies to avoid similar events in the future. Perhaps this young man could have taken a trip to the chapel or some other preferred location on campus prior to the trip preparation. ▪ The PST Review of Repeated Restraint for Individual #318 revealed that no restraints were related to recent visits from family. However, this statement remained in his behavior support plan, revised after the review, thus perpetuating an idea that may not be supported by data.	
	(b) review possibly contributing environmental conditions;	Of the three individuals reviewed, all (100%) of individual's teams discussed the possibly contributing environmental conditions. The following are examples of individuals for whom this was done appropriately: ▪ Due to the hypothesis that peers tended to agitate Individual #323, he was moved to a home of his own. A fading plan was developed to re-integrate him with his peers in his original home. Although this may reduce his aggression and self-injury at the moment, caution is advised as this may prove reinforcing to the individual. Of these, there was evidence of an action plan for modifying them to prevent the future probability of restraint in none of the three applicable cases (0%). The following are	Noncompliance

#	Provision	Assessment of Status	Compliance
		examples where teams failed to do this adequately: ▪ The team for Individual #323 noted that times when individuals were on the home waiting for meals were often problematic. This individual was assigned "primary staff" during these times with the expectation that he would be engaged in activity. There were no specific recommendations made that described possible activities, including tasks that would take the individual away from the home or allow him to assist in the home. ▪ In the PST Review of Repeated Restraints for Individual #99, the team noted that lunch "…always involves a lot of noise." There were no strategies suggested to address this issue. ▪ On the morning of 2/4/13, Individual #318 was reported to have covered his breakfast with salt. His plate was replaced. He reportedly repeated this behavior. When staff took his plate to get him a new breakfast, he became aggressive and was placed in restraint. Strategies should be discussed to effectively limit the amount of salt he uses at meals.	
	(c) review or perform structural assessments of the behavior provoking restraints;	For all of the individuals reviewed, the team reviewed and/or completed structural and functional behavior assessments. (Although requested, copies of these assessments were not provided to the Monitoring Team.) However, due to the dramatic increases in problem behavior and related restraints, the assessment for all three individuals should have been updated, with particular emphasis on formal observation. As a result, none of the individuals had up-to-date assessments. The following offers examples where teams failed to update the assessment of behavioral function: ▪ The team reviewed the Abbreviated Behavioral Assessment that was completed for Individual #323 in 7/12. The team agreed that the function of his targeted problem behaviors remained to delay tasks, to escape negative peer interactions, and to receive staff attention and/or nursing care. While this review was appropriate, it would have been advisable to complete additional formal observations, at a minimum, to update the assessment. As noted in the PST Review of Repeated Restraints, his aggression and restraint had increased markedly in the last 12 and three months, respectively. Such a change in behavior should trigger a new or updated functional behavior assessment. ▪ The functional behavior assessment was referenced during the PST Review of Repeated Restraints for Individual #99, but there was no indication when this assessment was completed. Further discussion regarding methods used and need for update would have been appropriate.	Noncompliance
	(d) review or perform functional assessments of the behavior provoking restraints;	This is addressed above with regard to Section C.7.c above.	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 all of the individuals reviewed (100%), the individual had a BSP. The following was found: ▪ All of the BSPs (100%) were based on the individual's strengths; ▪ All of the BSPs (100%) identified the objectively defined behavior to be treated that led to the use of restraint; ▪ Two of three (67%) of PBSPs reviewed contained functional replacement behaviors (when practical and possible). The BSPs for Individual #318 and Individual #99 specified the alternative, positive adaptive behavior(s) to be taught to the individual to replace behavior that resulted in the use of restraint. The BSP for Individual #323 did not identify his replacement behaviors in observable and measurable terms; ▪ Adequate schedules of training for all identified replacement behaviors were not found in any of the plans (0%); ▪ Sufficient schedules of differential reinforcement were not identified in any of the plans (0%); and ▪ All of the BSPs (100%) specified, as appropriate, the use of consequences to reduce or eliminate the target behavior(s) leading to restraint. The Crisis Intervention Plans of the individuals in the sample were reviewed. The following represents the results. ▪ In three out of three (100%) of the CIPs reviewed, the type of restraint authorized was delineated; o The CIP for Individual #323 provided clear guidelines for implementing each type of approved hold. The CIP had also been revised according to recommendations reviewed and documented in the PST Review of Repeated Restraints. This included employing a third person when implementing a two-person horizontal restraint and guidelines for contacting the nurse regarding earlier administration of routine medications or administration of a chemical restraint. ▪ In three CIPs (100%), the maximum duration of restraint authorized was specified. Each indicated that a release from restraint must be attempted after 15 minutes of restraint. ▪ In three CIPs (100%), the designated approved restraint situation was specified; ▪ In three CIPs (100%), the criteria for terminating the use of restraint were specified. The CIP for Individual #323 noted he should be released from restraint as soon as he was no longer a danger to himself or others. The CIPs for Individual #318 and Individual #99 indicated release should occur when the individual stopped struggling or attempting aggression. ▪ In two of the three CIPs, the date of implementation was noted. Only one of the three CIPs was signed by the individual's psychologist.	Noncompliance

#	Provision	Assessment of Status	Compliance
	(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	The Facility had just begun assessing treatment integrity through staff interview and more importantly, review of incidents of behavioral difficulty. This latter was completed through review of video taped episodes of incidents. Based on review of the information submitted for these three individuals, there was insufficient evidence at this point in time to state that treatments and supports were implemented with a high degree of integrity. It should be noted, however, that teams for two individuals had initiated steps to improve treatment implementation. Behavior Coaches were assigned to work with Individual #323 and his staff to improve implementation of preventative strategies found in his BSP. A BSP checklist was also to be developed to help improve treatment implementation. Similarly, a BSP checklist was to be developed for Individual #318 to monitor and improve implementation of his plan.	Noncompliance
	(g) as necessary, assess and revise the PBSP.	For two of the three individuals, BSPs should have been revised. Of these, there was evidence of a revision to the PBSP in one of the cases (50%). In one of the records reviewed, there was documentation that the individual's BSP had been revised as appropriate. The following is an example of an individual for whom this was done appropriately: ▪ The BSP for Individual #318 was revised on 3/15/13 to include teaching him to wait using a Time Timer (a timer that provides a visual display of time elapsing). The psychologist had completed a brief assessment to test and assess the efficacy of this strategy. He then trained staff and included this in the BSP. The following provides an example where the team failed to do this adequately: ▪ The team had met on 11/1/12 to review repeated restraints applied to Individual #99. One of the recommendations was to revise her BSP to indicate that she should receive one-to-one staffing at the first sign of aggression and remain at this level of supervision for one hour following aggression. She also was to be allowed to choose an activity on days without aggression. Further, the PST Review of Repeated Restraints indicated that this individual would be provided an opportunity to use relaxation techniques once per hour. None of these strategies were included in the BSP that was provided to the Monitoring Team. In sum, the Facility remained out of compliance with this provision of the Settlement Agreement. Staff should provide a more thorough review of all indicators identified in Section C.7 whenever an individual is restrained more than three times in a rolling 30-day period. Use of the PST Review of Repeated Restraint is a useful tool in guiding this discussion and review. Strategies to address specific events that could have possibly been prevented should be identified and reviewed with all staff in a timely manner.	Noncompliance

#	Provision	Assessment of Status	Compliance
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.	A sub-sample of documentation related to 12 incidents of crisis intervention restraint was reviewed, including Sample #C.1.5, #C.1.7, #C.1.9, #C.1.11, and #C.1.13. Documents requested for this review included the Unit Team meeting notes, the IMT meeting minutes, Restraint Reduction Committee minutes, ISP addenda, and face-to-face and debriefing sheets. This documentation showed that: ▪ a. In five (100%), 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. ▪ b. In none (0%), the review by the IMT occurred within three business days of the restraint episode. ▪ c. In three (60%), the circumstances under which the restraint was used were determined and was documented on the Face-to-Face Assessment Debriefing form, including the signature of the staff responsible for the review. The two cases where this did not occur were: o Sample #C.1.5 where there was no debriefing sheet; and o Sample #C.1.7 where there was no debriefing sheet. ▪ d. In none (0%), the review conducted by the Unit IDT and the IMRT was sufficient in scope and depth to determine if the application of restraint was 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. Since the related minutes from the Unit Team and the IMT were not provided, although they were requested, there was no basis for determining sufficiency of scope and depth of the reviews. ▪ e. In none (0%), referrals were made to the team, as appropriate. ▪ f. Since no minutes were available to document referral to the IDT, whether appropriate changes were made to the individuals' ISPs and/or PBSPs as a result could not be determined. However, whether or not it was referred by the Unit IDT or the IMT, Sample #C.1.5 included a review by the IDT with changes discussed and incorporated. Based on this review, the Facility remained in noncompliance with this provision, since it did not achieve 90% compliance with several of the metrics.	Noncompliance

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

1. ABSSLC policy on restraints should be amended to coincide with the State Policy on Restraints, and the list of Facility-approved mechanical restraints should include abdominal ties, if they are considered appropriate forms of restraint. C.1)

2. Staff should clearly describe the events that lead to restraint application. (Section C.1).
3. 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)
4. Staff should revise Dental Desensitization Plans to include the following: increased opportunities for training, and an objective data collection system that captures the extent of progress observed by the dental staff. (Section C.4)
5. A focus should be placed on developing plans and/or strategies to eliminate to the extent possible the need for sedation for medical procedures. (Section C.4)
6. The Facility should ensure that trained 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. Restraint Monitors should be trained that they cannot serve as both the restraint monitor and the person applying the restraint. (Section C.5)
10. The Facility should ensure that a licensed health care professional timely and regularly monitors, and appropriately documents the vital signs, and the mental status of an individual in restraints at least every 30 minutes from the start of the restraint episode, except for a medical restraint pursuant to a physician's order. (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 or that Facility policy should be followed, and indicate the time the monitoring may stop. These schedules should then be followed as written. (Sections C.5 and C.6)
13. The Facility should ensure that nursing assesses and appropriately documents any restraint-related injury. (Section C.6)
14. Staff should ensure that the PST Review of Repeated Restraint form is completed whenever the individual experiences more than three restraints in a rolling 30-day period. Additionally, staff should ensure that the date of review is documented. (Section C.7)
15. Staff should consistently review teaching of adaptive skills to individuals who experience frequent restraint. This should include a review of the breadth of habilitation services identified in the Individual Support Plan. (Section C.7.a)
16. Staff should consistently review the biological, medical, and psychosocial factors related to individuals who experience frequent restraint, and implement timely and complete action based on this review. (Section C.7.a)
17. Staff should consistently review environmental conditions for individuals who experience frequent restraint. (Section C.7.b)
18. 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)
19. Ongoing improvement to competency-based training should occur to ensure high rates of treatment integrity. (Section C.7.f)
20. 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)
21. Staff should ensure timely follow-up to all recommendations made by the individual's interdisciplinary team. (Section C.7)
22. 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)
23. With regard to the Facility's self-assessment processes, if the latest tool is going to continue to be used, guidelines should be considered to facilitate inter-rater reliability.

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 #002.4: Incident Management Policy, dated 11/20/12; o ABSSLC Policy #021.2: Abuse/Neglect/Exploitation (A/N/E) Policy, dated 12/4/12; o Self-Assessment, updated 4/22/13; o ABSSLC Action Plans, updated 4/22/13; o ABSSLC Provision Action Information, dated 4/22/13; o Presentation Book for Section D; o Abuse/Neglect/Exploitation Investigations between 10/1/12 and 3/22/13, undated; o Investigations Conducted Solely by Facility between 10/5/12 and 3/23/13; o ABSSLC Abuse Neglect and Exploitation –Trending Report, from 12/1/12 to 2/28/13; o Abuse/Neglect Trend Analysis Report, dated 10/1/12, 12/17/12, and 3/11/13; o ABSSLC Unusual Incidents – Trending, from 12/1/12 to 2/28/13; o Unusual Incident Trend Analysis Reports, dated 10/1/12, 12/17/12, 3/11/13; o Injury Trend Analysis Report FY12 for Q4 FY12; o ABSSLC Staff Status Tracking – by Date, undated; o List of one individual who was on chronic caller list, undated; o Course Delinquency List for ABU0100, Abuse and Neglect, dated 4/19/13; o Course Delinquency List for UNU0100, Unusual Incidents, dated 4/19/13; o Individual Support Plan Meeting documentation for Individual #241, on 5/8/13; o ABSSLC Annual Employee Registry Check and Fingerprint Criminal History Submission, dated 9/6/12; o List of ABSSLC Volunteers with corresponding date on which background check was completed, dated 4/11/13; o Centers for Medicare and Medicaid (CMS) Intermediate Care Facility for Persons with Developmental Disabilities (ICF/DD) reports of 8/8/12 and 7/17/12; o ABSSLC Procedure: Injury Audits; o Semi-Annual Audit (of non-serious injuries from 3/1/12 to 9/30/12), undated; o Semi-Annual Audit of Significant Injuries Reported for Investigation, 8/1/12 to 2/28/13, undated; o **Sample #D.1**: included a sample of 26 DFPS investigations of abuse, neglect, and/or exploitation with the corresponding Facility investigation reports drawn from the report of all DFPS allegations from 10/1/12 to 3/22/13. Investigation records included the following records, which will be referred to in this report by the Sample Identification number:

Sample #D.1 Identification	DFPS #	Facility #	Date
1	42491326	583	10/2/12
2	42498631	590	10/6/12
3	42507597	600	10/13/12
4	42508970	607	10/13/12
5	42522175	615	10/22/12
6	42525747	621	10/24/12
7	42532102	629	10/30/12
8	42540733	635	11/7/12
9	42544642	641	11/10/12
10	42560748	647	11/27/12
11	42565068	655	12/3/12
12	43578000	665	12/12/12
13	42583061	670	12/14/12
14	42586120	678	12/17/12
15	42602943	686	12/29/12
16	42609754	691	1/4/13
17	42616259	696	1/11/13
18	42628233	703	1/19/13
19	42631122	710	1/22/13
20	42635250	715	1/26/13
21	42635897	721	1/27/13
22	42642981	728	2/3/13
23	42650737	734	2/9/13
24	42676976	743	3/6/13
25	42680093	749	3/10/13
26	42687803	756	3/20/13

- **Sample #D.2**: included a sample of eight investigation reports completed by the Facility only that were selected from the list provided in response to Document Request #III.21. Investigation records included the following, which will be referred to in this report by the Sample identification number:

Sample D.2 Identification	Facility Incident #	Date
1	609	10/16/12
2	623	10/27/12
3	636	11/7/12
4	656	12/4/12
5	671	12/15/12

6	698	1/14/13
7	726	2/2/13
8	735	2/20/13

- **Sample #D.3**: additional incident reports were not selected for review;
- **Sample #D.4**: included four Individual Support Plans for Individual #577, Individual #127, Individual #40, and Individual #120;
- **Sample #D.5**: included six of the DFPS investigations from Sample #D.1 where abuse or neglect was confirmed:

Sample #D.5 Identification	DFPS #	Facility #	Date
2	42498631	590	10/6/12
5	42522175	615	10/22/12
8	42540733	635	11/7/12
16	42609754	691	1/4/13
22	42642981	728	2/3/13
24	42676976	743	3/6/13

and two of the Facility investigation from Sample #D.2, including the following investigations:

Sample #D.5 Identification	Facility Incident #	Date
1	609	10/16/12
6	698	1/14/13

- **Sample #D.6**: sample of audit reports: not included; and
- **Sample #D.7**: sample of action plans developed as a result of trend analysis, none found.

- **Interviews with**:
  - Linda Hinshaw, Facility Director;
  - Jolene Willis, Assistant Director of Programs;
  - Pat Smith, Director for Quality Assurance;
  - Luee McCreary, Incident Management Coordinator (IMC);
  - Rene Kellum, Program Compliance Monitor (PCM);
  - Ten staff members from various residential locations; and
  - Ten individuals in various residential and day/vocational locations.
- **Observations of**:
  - QA/QI Council Meeting, on 5/6/13;
  - Interdisciplinary Team Meeting for Individual #241, on 5/8/13;
  - Unit IV Team Meeting, on 5/8/13;
  - IMT meeting, on 5/8/13; and
  - Residences #6690, #6710, #6730, #6740, #6521, #6400, #5971, and #5962.

Facility Self-Assessment: The ABSSLC Self-Assessment indicated the Facility was in substantial compliance with 18 of the 22 provisions in Section D of the Settlement Agreement as opposed to 16 in the last self-assessment. The Monitoring Team found the Facility to be in compliance with 17 of the 22.

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: 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.
  - The monitoring tool included methodologies, such as observations and record reviews.
  - The Self-Assessment identified the sample size as 88 records out of 185 (48%) unusual incident reports, which included abuse/neglect/exploitation for the period 9/1/12 through 2/28/13. The 88 records were reviewed by the Incident Management Department, and the QA Program Compliance Monitor also reviewed 35 of the 88 records.
  - 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.
  - 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.
- The Facility 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.2.a	Noncompliance	Substantial Compliance	The Facility based its finding of noncompliance on the lack of a tracking log for calls to the Director. The Monitoring Team found sufficient evidence that calls were made to find

			compliance.
D.2.e	Noncompliance	Substantial Compliance	The Facility did not find substantial compliance based on its monitoring of a sample. In its smaller sample, the Monitoring Team did find compliance.
D.2.i	Substantial Compliance	Noncompliance	To address the requirements of this section, a new State policy/procedure was to be implemented, but the Facility had not had time to adjust its practice to that policy and its practice remained insufficient.
D.3.e	Compliance	Noncompliance	Necessary recommendations for corrective action were not included in some DFPS reports.
D.3.g	Noncompliance	Noncompliance	Supervisory notes for DFPS investigations were not present, some DFPS investigations were not of sufficient quality, and there was not sufficient review of the DFPS reports by the Facility to identify issues in those reports.
D.3.i	Noncompliance	Noncompliance	Measurement of the results of programmatic changes and disciplinary actions made to prevent recurrence were not documented.
D.4	Substantial Compliance	Noncompliance	Based on its finding that the tracking and trending of incidents was stable and on-going, the Facility found compliance. Based on the lack of trending of most categories over a yearlong period and inadequate follow-up, the Monitoring Team found noncompliance.

- 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 substantial compliance with 17 out of 22 provisions of Section D, as opposed to the 16 provisions that were in substantial compliance during the last review. Progress was noted in a number of areas. Highlights of progress included: ▪ There was a good follow-up system for recommendations resulting from investigations that included a reminder letter from the Director or the Incident Management Coordinator to anyone responsible for follow-up and the collection of the evidence of that follow-up. ▪ Work had been done to document in the annual ISPs that individuals and their LARs were informed about how to report abuse. Some of the areas in which improvements were necessary for the Facility to progress toward substantial compliance with the Settlement Agreement included the need to: ▪ Work with DFPS to make sure they had considered prior history information, and that they make recommendations accordingly. ▪ When there is clear evidence that staff have failed to report or to intervene in an abusive situation, consider disciplinary action not only for the perpetrator (which the Facility did), but also for those who were witnessing the abuse and not taking action.

#	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 an 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 substantial 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	Although in the paragraphs that follow, the Monitoring Team has provided some figures	Substantial

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>serious incidents, including but not limited to death, abuse, neglect, exploitation, and serious injury, as follows: 1) for deaths, abuse, neglect, and exploitation to the Facility Superintendent (or that official's designee) and such other officials and agencies as warranted, consistent with Texas law; and 2) for serious injuries and other serious incidents, to the Facility Superintendent (or that official's designee). Staff shall report these and all other unusual incidents, using standardized reporting.</td><td>with regard to allegations and incidents, it is essential to note that reviewing pure numbers provides very little meaningful information. For each of these categories, the Facility would need to conduct analyses to determine causes, and to review carefully whether for incidents that were preventable, adequate action had been taken to prevent their recurrence. Determining the reasons or potential reasons for increases or decreases in numbers also is essential. Although the ultimate goal is to reduce the overall numbers of preventable incidents, care needs to be taken to ensure that the result of such efforts is not the underreporting of incidents. For an incident management system to work properly, full reporting of incidents is paramount, so that they can be reviewed, and appropriate actions taken. The Facility's progress in analyzing data collected, and addressing issues identified is discussed in further detail with regard to Section D.4 of the Settlement Agreement.

According to data the Facility provided in response to Document Request TX-AB-1305-TR.7, the numbers of abuse/neglect/exploitation allegations for the past two six-month periods were:

<table><tr><th></th><th>5/1/12 to 10/31/12 (Six months)</th><th>11/1/12 to 4/30/13 (Six months)</th></tr><tr><td>Total abuse allegations</td><td>146</td><td>138</td></tr><tr><td>Abuse substantiated</td><td>18</td><td>11</td></tr><tr><td>Total neglect allegations</td><td>121</td><td>87</td></tr><tr><td>Neglect substantiated</td><td>11</td><td>16</td></tr><tr><td>Total exploitation allegations</td><td>1</td><td>5</td></tr><tr><td>Exploitation substantiated</td><td>0</td><td>0</td></tr></table>
According to Facility data provided in response to Document Request TX-AB-1305-TR.7, the numbers of Unusual Incidents investigated over the past two six-month periods included:

<table><tr><th></th><th>5/1/12 to 10/31/12 (Six months)</th><th>11/1/12 to 4/30/13 (Six months)</th></tr><tr><td>Deaths</td><td>4</td><td>7</td></tr><tr><td>Serious Injuries</td><td>31</td><td>20</td></tr><tr><td>Sexual Incidents</td><td>12</td><td>4</td></tr><tr><td>Suicide Threat (credible)</td><td>2</td><td>1</td></tr><tr><td>Unauthorized Departure</td><td>4</td><td>3</td></tr><tr><td>Choking</td><td>1</td><td>2</td></tr><tr><td>Other</td><td>0</td><td>0</td></tr></table>
Based on the Monitoring Teams' review of DADS' revised policies, including Policy</td><td>Compliance</td></tr>
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#	Provision	Assessment of Status	Compliance
		#021.2 on Protection from Harm – Abuse, Neglect, and Exploitation, dated 12/4/12: Section V: Notification Responsibilities for Abuse, Neglect, and Exploitation; and Policy #002.4 on Incident Management, dated 11/10/12: Section V.A: Notification to Director, they were consistent with the Settlement Agreement requirements related to reporting. According to ABSSLC Policy #021.2, staff were required to report abuse, neglect, and exploitation immediately**.** This was consistent with the Settlement Agreement requirements. With regard to unusual/serious incidents, Facility Policy #002.3 required staff to verbally report unusual/serious incidents immediately or at least within one hour to the Director or designee. This policy was consistent with the Settlement Agreement requirements. Based on responses to questions about reporting, 10 of 10 (100%) staff responsible for the provision of supports to individuals were able to describe the reporting procedures for abuse, neglect, and/or exploitation. Based on responses to questions about reporting, 10 of 10 (100%) staff responsible for the provision of supports to individuals were able to describe the reporting procedures for other unusual/serious incidents. Based on a review of the 26 investigation reports included in Sample #D.1: ▪ 25 (96%) included evidence that allegations of abuse, neglect, and/or exploitation were reported within the timeframes required by DADS/Facility policy. The one that was not was Sample #D.1.2, where an individual was being verbally abused, staff were present and were overheard talking about the verbal abuse, but did not report. ▪ 26 (100%) included evidence that allegations of abuse, neglect, and/or exploitation were reported to the appropriate party as required by DADS/Facility policy. ▪ For the one allegation for which staff did not follow the IM Policy and Reporting Matrix reporting procedures, the one UIR/investigation folders (100%) included recommendations for corrective actions. Based on a review of eight investigation reports included in Sample #D.2: ▪ Seven (88%) showed evidence that unusual/serious incidents were reported within the timeframes required by DADS/Facility policy. The incident that was not reported timely (Sample #D.2.7), involved a peer who kissed another peer on the cheek and hugged her during a kick ball match. Staff were present and witnessed the exchange, but did not view it as sexual. Approximately 10 hours	

#	Provision	Assessment of Status	Compliance
		later, the Campus Administrator reviewed the log entries and found the record of the kiss, which she promptly reported. ▪ Eight (100%) included evidence that unusual/serious incidents were reported to the appropriate party as required by DADS/Facility policy. ▪ For the one unusual/serious incident for which staff did not follow the IM Policy and Reporting Matrix reporting procedures, the one UIR/investigation folder (100%) included recommendations for corrective actions. The Facility did have a standardized reporting format. Based on a review of 34 investigation reports included in Samples #D.1 and #D.2, 33 (97%) contained a copy of the report utilizing the required standardized format and were completed fully. The one that did not was Sample #D.1.15, where the face sheet of the DFPS report did not state the allegation on the first page under "Allegation Detail" as was the standard. Based on this review, the Facility was in substantial compliance with this provision. The one incident of inappropriate contact that was not reported timely was investigated and appropriate recommendations were made. Similarly, the one allegation of verbal abuse that was not reported timely was investigated and recommendations were made. The Facility's self-assessment did not find compliance based on the difficulty in proving that staff had contacted both DFPS and the Director. While the Facility should establish a log of incident calls to the Director, the information available in the reports indicated that the Director was being notified within the first hour.	
	(b) Mechanisms to ensure that, when serious incidents such as allegations of abuse, neglect, exploitation or serious injury occur, Facility staff take immediate and appropriate action to protect the individuals involved, including removing alleged perpetrators, if any, from direct contact with individuals pending either the investigation's outcome or at least a well- supported, preliminary assessment that the employee poses no risk to individuals or the integrity of	In ABSSLC Policy #021.2, the Facility outlined in detail the steps the Facility was required to take to protect the individuals involved in allegations of abuse, neglect, and exploitation, including stopping the abuse, securing medical help, and reporting the incident. According to the policy, a staff member alleged to have been the perpetrator of an allegation of abuse would be placed on temporary work reassignment (TWR). Based on a review of 26 investigation reports included in Sample D.1: ▪ In 16 records, staff were removed to temporary work reassignment; ▪ In four records, staff was not removed because the staff name was unknown; and ▪ In six records, staff was not removed, but monitored or monitored in another location due to the individual having been listed as a chronic caller. Based on a review of 16 investigation files included in Sample #D.1 where the staff was removed to TWR: ▪ Three were not returned to work due to termination or resignation; ▪ Ten were returned to work at the conclusion of the investigation;	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	the investigation.	▪ One was returned after issuance of a first level disciplinary letter; and ▪ Two had no entry on the status-tracking sheet, and as a result, it was not possible to determine if or when they were returned to duty. (Sample #D.1.24 and #D.1.26.) Based on a review of the 26 investigation files, it was documented that adequate additional action was taken to protect individuals in 24 cases (92%). The two were those where the status of return to duty could not be established. In the eight Facility-only cases (i.e., Sample D.2), staff were not removed from duty, since there was no suspicion of abuse or neglect. If the investigation had uncovered any such suspicions, per Facility policy, the case would have been handled as an abuse/neglect case and referred immediately to DFPS. 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, only returning alleged perpetrators to duty at the conclusion of investigations or when it was clear they did not pose a threat, and documenting additional actions to protect the alleged victims in most cases, 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 least yearly, for all staff on recognizing and reporting potential signs and symptoms of abuse, neglect, and exploitation, and maintaining documentation indicating completion of such training.	According to ABSSLC Policy #021.1, all staff were required to attend competency-based training on preventing and reporting abuse and neglect. This was identified in the policy as course ABU0100. This was consistent with the requirements of the Settlement Agreement. The training curriculum for new employee orientation was reviewed in the last report and met the requirements for competency-based. It included content regarding recognizing and reporting signs and symptoms of abuse, neglect, and exploitation. Review of 24 staff records (Sample #C.2), showed that 24 (100%) of these staff had completed competency-based training on abuse and neglect prior to working directly with individuals, and/or had annual refresher training. Review of the Course Delinquency List for ABU0100, dated 4/19/13, showed that 1,294 of 1,300 (99.5%) staff had completed annual refresher training. Based on interviews with 10 staff: ▪ 10 (100%) were able to list signs and symptoms of abuse, neglect, and/or exploitation; and	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		▪ 10 (100%) were able to describe the reporting procedures for abuse, neglect, and/or exploitation. Based on this review, the Facility remained in substantial compliance with this provision. The Facility found the same through its Self-Assessment.	
	(d) Notification of all staff when commencing employment and at least yearly of their obligation to report abuse, neglect, or exploitation to Facility and State officials. All staff persons who are mandatory reporters of abuse or neglect shall sign a statement that shall be kept at the Facility evidencing their recognition of their reporting obligations. The Facility shall take appropriate personnel action in response to any mandatory reporter's failure to report abuse or neglect.	ABSSLC Policy #021.1 required that all staff sign an acknowledgement of their responsibilities to not tolerate and to report suspected abuse, neglect, and exploitation, during their pre-service training and annually thereafter. A sample of 24 staff (Sample #C.2) was randomly selected to determine if annual acknowledgements had been signed. Of the 24, 22 (92%) had signed annual acknowledgments. The two who did not were listed on the document request as TR-5.1.c and TR-5.1.f. A sample of three volunteers was randomly selected to determine if annual acknowledgements had been signed. Of the three, all (100%) had signed the annual acknowledgements. The Facility was asked for a list of staff who had been identified as having failed to report abuse and/or neglect. This generated a list of zero staff. In Sample #D.1.2 an allegation of Verbal/emotional abuse was confirmed. A staff member in the presence of other staff had teased an individual, yet no one stopped the teasing and the incident was not reported for two days. In her review of the investigation report, the IMC added a recommendation that the staff in that home be retrained on reporting procedures and intervention when they saw alleged abuse and that training was provided. While some teasing can be difficult to distinguish from good-natured fun, in this case, it was not fun and failure to intervene and report should have been met with personnel action. The Monitoring Team found the Facility remained in substantial compliance with this provision. The Facility made the same finding. While the teasing incident was determined to be verbal abuse, it was not clear to the staff witnessing it from different vantage points believed that it rose to the level of abuse. The Facility took appropriate action in ordering retraining. However, the Facility should address all such indications that staff might not have recognized and reported abuse with retraining and appropriate discipline.	Substantial Compliance
	(e) Mechanisms to educate and support individuals, primary	According to Facility Policy #021, the Facility maintained a resource guide on recognizing and reporting abuse, and provided it to individuals, Legally Authorized	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	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.	Representatives (LARs), 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 for the Monitoring Team's last report. It was found to include sufficient information. Based on a review of four individuals' ISPs (Sample #D.4), four 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. Based on observation of an annual ISP team meeting on 5/8/13, the individual was informed of the process of identifying and reporting unusual incidents, including abuse, neglect, and exploitation and the informational materials were made available to the LAR via mail. In interviewing a sample of 10 individuals, eight were able to describe what they would do if someone hurt them, or they had a problem with which they needed help. Two were not sufficiently able to use communication skills to convey their understanding. Based on this review, the Facility was in substantial compliance. The Facility did not find substantial compliance, based on inconsistencies found in their monitoring, indicating that it will be important for the Facility to continue its efforts to sustain compliance.	
	(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 eight living units and day programs on campus showed that eight (100%) of those reviewed had postings of individuals' rights in an area to which individuals regularly had access. In addition, the Facility maintained an active Self-Advocacy group, and posted notices about the availability of the Ombudsman. Although not related to compliance, these were positive efforts worth mentioning, because they showed a commitment to zero tolerance and providing mechanisms for individuals to exercise their rights.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		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 16 allegation investigations completed by DFPS (Sample #D.1), in for which a referral to law enforcement was necessary/appropriate, DFPS had made referrals in 16 (100%). Based on a review of eight 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 failure to report an incident in an appropriate or timely manner.	ABSSLC Policy #021.1 prohibited retaliation against staff, individuals, family members, or others who reported abuse. Anyone 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 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 seven cases where allegations of retaliation were	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		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 personnel issues. Any retaliation for reporting of abuse would be referred to the Office of the Inspector General for action, but no case had 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 reminded staff of the prohibition and what to do should someone retaliate against them. Based on interviews with 10 staff, nine (90%) reported they were confident that retaliation would not be tolerated (scoring nine to 10 on a scale of confidence, where one was a low confidence and 10 was high confidence.). On that scale, one staff member reported a level of confidence of six. However, even when asked, did not provide a specific reason. Based on interviews with 10 individuals served by the Facility, eight (80%) 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. Two individuals were not able to communicate sufficiently to respond to the question. Based on a review of investigation records (Sample #D.1 and Sample #D.2), a DFPS investigator noted a concern related to potential retaliation in Sample #D.1.19. In that case, the retaliation involved reporting two staff for abuse based on an invented allegation. The retaliation was not in response to good faith reporting of abuse by the targeted staff, but was related to work issues between the shifts in the home. However, the Unit Director responded to the concern by ordering in-service training for both shifts on abuse reporting with an emphasis on retaliation. The Facility was asked for a list of staff against whom disciplinary action had been taken due to their involvement in retaliatory action against another employee who had in good faith had reported an allegation of abuse/neglect/exploitation. The Facility reported that there were seven cases in which a staff member alleged retaliation, unit managers investigated the claims, and none were found to involve retaliation for reporting of abuse. The Facility remained in substantial compliance with this provision. While it is a concern	

#	Provision	Assessment of Status	Compliance
		that the issue of retaliation was raised in an investigation, the retaliation did not appear to have been in response to good faith reporting of abuse and was addressed through prompt re-training of staff. The Facility made the same finding in its Self-Assessment.	
	(i) Audits, at least semi-annually, to determine whether significant resident injuries are reported for investigation.	A new State Office process for conducting the audits was available at the time of the site visit, but ABSSLC had not implemented it. The Monitoring Teams have presented the State with their comments on the process. When the Facility implements the process, the Monitoring Team will conduct a review of it. The Monitoring Team noted that the Facility had worked on conducting audits in the absence of State Office policy/procedure. Two semi annual audit reports were presented, including for the time periods from: 3/1/12 to 9/30/12 and 8/1/12 to 2/28/13. The first reviewed eight records of individuals with the highest number of injuries. The second reviewed twelve individuals at random. It was not clear how the records were chosen. While the size of the samples, the scope of the reviews, and procedure for conducting the reviews would not align with the recent State policy/procedure, the Facility's effort to comply with this provision was noteworthy. While the Monitoring Team found noncompliance and disagreed with the Facility's determination of substantial compliance, the Facility's efforts to conduct these audits was noteworthy.	Noncompliance
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,	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.	Substantial Compliance

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	including persons with mental retardation, and who are not within 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). The training records for the DFPS investigators were reviewed with the following results: ▪ Six out of six DFPS investigators (100%) had completed the requirements for investigations training. ▪ Six out of six DFPS investigators (100%) had completed the requirements for training regarding individuals with developmental disabilities. The training records for Facility investigators were reviewed with the following results: ▪ Eight out of nine Facility investigators (including the IMC) (89%) had completed the requirements for investigations training. One nurse-investigator had not completed "Conducting Serious Investigations and Root Cause Analysis." However, she was not listed as involved in the investigations in Samples D.1 and D.2. ▪ Nine out of nine Facility investigators (100%) had completed the requirements for training regarding individuals with developmental disabilities. For one investigation (Sample #D.1.17), the Facility investigator for the companion investigation was a name that did not appear on the list of Facility investigators. The Monitoring Team found the Facility remained in substantial compliance with this provision. While the nurse investigator that had not completed the investigator training course should not have conducted investigations, there was no evidence in Samples #D.1 or #D2 that she had. In addition, there was another nurse, listed as an investigator who had the required training to conduct investigations. 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,	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.	Substantial Compliance

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	and exploitation.	As described in the Documents Reviewed section, two samples of investigation files were selected for review. These included Sample #D.1 and Sample #D.2, which consisted of DFPS investigations, and Facility investigations, respectively. ▪ Review of the investigation files in Sample #D.1 showed that in 26 out of 26 investigations (100%), Facility staff cooperated with DFPS investigators. ▪ Review of the investigation files in Sample #D.2 showed that in eight out of eight (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 Self-Assessment, the Facility made the same finding.	
	(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 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 26 the investigation records from DFPS (Sample #D.1), 16 had been referred to law enforcement agencies, including: Sample #D.1.1, 2, 3, 4, 5, 7, 9, 11, 12, 13, 15, 16, 17, 18, 21, and 23. For 16 out of these 16 (100%), there was adequate coordination to ensure that there was no interference with law enforcement's investigations. ▪ Of the eight the investigation records from the Facility (Sample #D.2), none 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.	Substantial Compliance
	(d) Provide for the safeguarding of evidence.	ABSSLC Policy #002.3 explained the need for the initial reporter, as well as the Facility investigator to preserve physical evidence, and referred to Exhibit B for the Guidelines for Securing Evidence. If evidence was present and law enforcement had been called, staff were to leave all evidence in place, if possible. Otherwise, staff were to collect	Substantial Compliance

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		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), 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.	
	(e) Require that each investigation of a serious incident commence within 24 hours or sooner, if necessary, of the incident being reported; be completed within 10 calendar days of the incident being reported unless, because of extraordinary circumstances, the Facility Superintendent or Adult Protective Services Supervisor, as applicable, grants a written extension; and result in a written report, including a summary of the investigation, findings and, as appropriate, recommendations for corrective action.	Based on Facility Policy #002.4, investigations of serious incidents: ▪ 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: ▪ One investigation was returned to the Facility as an administrative referral. ▪ Of the remaining 25 investigations, 25 (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	Noncompliance

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		investigation tasks, as well as documentation regarding the tasks that were undertaken within 24 hours of DFPS being notified of the allegation. In 12 of the records the initial face-to-face contact occurred within the first 24 hours in addition to contact with the Facility to assure the safety of the individual and the securing of records. In 13, the investigation commenced with the contact with the Facility to ascertain the safety of the individual, the securing of records, and any planning for the conduct of the investigation that might have been necessary such as location of witnesses. Based on the nature of the specific allegations, these initial steps appeared sufficient. ▪ 22 out of 25 (88%) were completed within 10 calendar days of the incident, including sign-off by the supervisor. o One did not include a supervisor's electronic signature: Sample #D.1.24. o For the two remaining that were not completed within 10 days, two (100%) had documentation of a written extension request that had been approved by the Adult Protective Services Supervisor, and there was documentation of the extraordinary circumstances that necessitated the extension. ▪ 25 (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 one other, no recommendation was made, but should have been. In eight of the 11 investigations (73%), the recommendations were adequate to address the findings of the investigation. In addition, there were some investigations where recommendations might have been made if the investigations had considered the histories of the individual and the staff (this is discussed with regard to Section D.3.f). The following were the investigations for which concerns were noted with regard to the adequacy of the recommendations: o Sample #D.1.2: the investigator found that staff were present while an individual was being taunted with name-calling and inappropriate language, causing the individual observable distress, yet no recommendation was made about appropriate disciplinary action for those staff who failed to stop the emotional abuse or to report it. o Sample #D.1.19: the investigator found the allegations to be unconfirmed and indicated that the report might have been made as a form of retaliation without indicating what the retaliation might have been for. The only remark recorded under concerns and recommendations was: "possible retaliation." Under the terms of the Settlement Agreement, retaliation against a staff member for good faith	

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		reporting of abuse is a serious matter. It would have been helpful if the investigator had added an explanation of what sort of retaliation was suspected, and/or recommended that this be further reviewed and addressed. o Sample #D.1.24: an allegation of verbal abuse was confirmed and no recommendations were made. However, it was clear from the report that the alleged perpetrator needed to be retrained and the Facility added that recommendation in the related report. The DFPS report should have contained that recommendation. <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 to the UIR was that it be completed within 10 days of the receipt of the DFPS report. Review of these showed: ▪ 26 out of 26 (100%) were commenced timely. (Note that the number is one higher than the number of DFPS reports, since the Facility investigated the DFPS referral for administrative review.) ▪ 24 out of 26 (92%) were completed within 10 days of the receipt of the DFPS report. ▪ Of the two that were not completed within 10 days, neither (0%) had an approved extension. Those two were Sample #D.1.6 and #D.1.16. ▪ 26 out of 26 (100%) included a summary of the findings. ▪ 14 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: In Sample #D.1.5, the Facility investigation added a finding that staff had not followed the individual's PBSP and anger management plan, and recommended discipline and retraining. In 12 of the 14 (86%) the recommendations were adequate. In the two that were not: o Sample #D.1.2: the Facility did not include a recommendation for discipline for failure to intervene in and report verbal/emotional abuse. o Sample #D.1.19: the Facility did not elaborate on the DFPS concern	

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		about possible retaliation, but did forward the concern that elicited a response that included vigorous retraining on retaliation. Facility Investigations The following summarizes the results of the review of Facility investigations: ▪ Eight out of eight (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. ▪ Seven out of eight (88%) were completed within 10 calendar days of the incident, including sign-off by the supervisor. ▪ For the one that was not completed within 10 days, one (100%) had documentation of a written extension request that had been approved by the Facility Director, and there was documentation of the extraordinary circumstances that necessitated the extension. ▪ Eight (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 eight of the investigations reviewed, recommendations for corrective action were included. In eight of the investigations (100%), the recommendations were adequate to address the findings of the investigation. The Facility was not in substantial compliance. The main issue was the lack of recommendations in DFPS reports when recommendations appeared to be needed.	
	(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	Based on the Monitoring Teams' review of DADS revised Policy #021.2 on Protection from Harm – Abuse, Neglect, and Exploitation, dated 12/4/12: Section VII.B, the policy was consistent with the Settlement Agreement requirements. The Facility policies were consistent with the requirements of the Settlement Agreement. 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 separately. DFPS Investigations The following summarizes the results of the review of DFPS investigations (the number was reduced to 25 since Sample #D.1.6 was referred back to the Facility as an administrative referral):	Substantial Compliance

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	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.	▪ In 24 out of 25 investigations reviewed (96%), the contents of the investigation report were sufficient to provide a clear basis for its conclusion. The one case where the contents were not sufficient was Sample #D.1.17 in which there were eight allegations of neglect and one of physical abuse. The investigator returned the eight neglect allegations to the Facility for administrative review or human rights review. It was not clear why this was done. The allegations involved failure to clean people promptly, to provide meals, and to keep the environment clean. It was not clear why these were not considered to warrant investigation as neglect. ▪ The report utilized a standardized format that set forth explicitly and separately: o In 25 (100%), each unusual/serious incident or allegation of wrongdoing; o In 25 (100%), the name(s) of all witnesses; o In 25 (100%), the name(s) of all alleged victims and perpetrators; o In 25 (100%), the names of all persons interviewed during the investigation; o In 25 (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 25 (100%), all documents reviewed during the investigation; o In 22 (88%), all sources of evidence considered, including previous investigations of unusual/serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency. ▪ Sample #D.1.1: the investigation involved an individual with a history of making false allegations. The Facility report indicated he had been involved in 40 allegations within the last year. The alleged perpetrator had been involved in 13 abuse cases, eight of which involved the alleged victim. While these were unfounded or unconfirmed allegations, the number was relevant in that it suggested a potentially unworkable relationship between the alleged victim and perpetrator. If this information was irrelevant to the investigation, some explanation was needed along with a recommendation to the Facility to inquire into the cause and possible solution to the potential issue between these two people. ▪ Sample #D.1.3 involved the same alleged perpetrator and alleged victim as in Sample #D.1.1. This case was handled as streamlined, due to the determination that the individual had been making repeated unfounded allegations. However, the fact that the allegation was against the same staff member was noteworthy in that it could have led to a recommendation for	

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		further inquiry and possible solution. ▪ Sample #D.1.23 involved another streamlined case with a history of 40 allegations, five of which were with the same alleged perpetrator. This information was noted as not relevant by the investigator. An investigation would only be treated as "streamlined" if the situation involved numerous unfounded allegations, so using that information in the findings would not always be necessary. However, when the information includes repeated allegations against one staff member, that information would be relevant in that there could be something in the way that staff member deals with the individual that precipitates the calls. This should be called to the attention of the Facility via a recommendation. o In 25 (100%), the investigator's findings; and o In 25 (100%), the investigator's reasons for his/her conclusions. <u>Facility Investigations</u> The following summarizes the results of the review of Facility investigations: ▪ In eight out of eight 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 eight (100%), each unusual/serious incident or allegations of wrongdoing; o In eight (100%), the name(s) of all witnesses; o In eight (100%), the name(s) of all alleged victims and perpetrators; o In eight (100%), the names of all persons interviewed during the investigation; o In eight (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. While this information was captured in witness statements in the file and noted on the UIR form, it was not always clear in the report whether there were any disputed witness statements and how they were reconciled. In these eight cases, it was possible that there were no such conflicts among witnesses, but the report would be clearer if the investigator discussed any conflicts or entered a statement indicating that no conflicts were found. An example of this was Sample #D.2.5 where the witnesses were identified and statements were taken. However the report did not refer directly to those statements or indicate how they influenced the findings. o In eight (100%), all documents reviewed during the investigation;	

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		o In eight (100%), all sources of evidence considered, including previous investigations of unusual/serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency; o In eight (100%), the investigator's findings; and o In eight (100%), the investigator's 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 the Facility to be in substantial compliance, as did the Facility. However, to sustain compliance the Monitoring Team recommends that the DFPS consider histories of individuals making abuse and neglect allegations and how those histories might contribute to concerns and recommendation, and that the IMC work with the Facility investigators to assure that witness statements are referenced and reconciled in all reports.	
	(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 #002.4, 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 25 DFPS investigations: ▪ In 23 out of 25 investigation files reviewed (92%), there was evidence that the supervisor had conducted a review of the investigation report by signing the report electronically. The two records that did not include an electronic signature by the supervisor were: Sample #D.1.16 and #D.1.24. ▪ In 0 (0%), there was evidence that the review had resulted in changes being made to correct deficiencies or complete further inquiry. ▪ For the three investigations (12%) noted above (Section D.3.f) for which the Monitoring Team identified deficiencies related to the inclusion of previous investigations as source documents. the DFPS supervisory review did not appear to address these deficiencies. ▪ For the same three investigations, the review by the IMC did not identify the deficiencies either. In seven investigation reports, not included in sample D.1, the Facility returned to DFPS for reconsideration, for six (86%), there was evidence that the review had resulted in	Noncompliance

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		changes being made to correct deficiencies or complete further inquiry as reported by the Facility. In response to Document Request #TX-AB-1305-TR-13.1 and 2, the seven investigation reports that were returned represented 3% of the total of 230 investigations in the six months from 11/1/12 to 4/30/13. <u>Facility Investigations</u> The following summarizes the results of the review of Facility investigations: ▪ In eight out of eight investigation files reviewed (100%), there was evidence that the supervisor had conducted a review of the investigation report. ▪ In five there was evidence that the review had resulted in changes being made to correct deficiencies or complete further inquiry. The Monitoring Team found noncompliance based on the lack of supervisory notes from DFPS, and the finding that for three DFPS reports, there were issues that should have been identified by the DFPS supervisor or by the IMT. The Facility found noncompliance as well.	
	(h) Require that each Facility shall also prepare a written report, subject to the provisions of subparagraph g, for each unusual incident.	The Facility-only investigations did meet the requirements outlined in Section D.3.f. As a result, the Facility was found to be in substantial compliance with this provision.	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.	The Facility policy and procedures did require disciplinary or programmatic action necessary to correct the situation and/or prevent recurrence to be taken promptly and thoroughly. In addition, the policy and procedures specified the Facility system for tracking and documenting such actions and the corresponding outcomes. 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 the investigations included in Sample #D.1 and Sample #D.2 were selected for review. This subsample, Sample #D.5, is described in the Documents Reviewed section of this report. Documentation was requested to show what follow-up had been completed to address the recommendations resulting from these investigations. The following summarizes the results of this review:	Noncompliance

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		▪ There were four investigations that confirmed abuse against known staff members. For three out of the four investigations (75%) reviewed where disciplinary action was recommended, it was taken or the staff member resigned. In one (Sample #D.5.24) of verbal abuse, retraining rather than discipline was recommended, but there was no documentation to indicate whether that had been done and no information in the Staff Status Tracking sheet to indicate whether or when the staff member had been brought back to work. In both cases of termination, action was completed within a month. ▪ There were six investigations that resulted in recommendations for retraining, or IDT review of programs. For six out of six of the investigations reviewed (100%), programmatic action had been taken within approximately 30 days and documented. ▪ The programmatic actions addressed the recommendations in five of the six (83%) investigations. The one that did not was Sample #D.1.22 where the finding was system neglect and recommended review of the individual's "plan" by the IDT, followed by retraining. The investigation was about conflicts between the PNMP and the Behavior Plan with regard to how the individual's unsteady ambulation was to be managed. However, the training provided in response to the recommendation focused only on the Behavior Support Plan. ▪ For none out of eight investigations (0%), was there documentation to show that the expected outcome had been achieved as a result of the implementation of the programmatic and/or disciplinary action. For example, while there was retraining on imminent danger and when to use restraint in Sample #D.5.1, there was no evidence to demonstrate that the training resulted in staff having a better set of skills to manage such situations, fewer individuals leaving campus, and/or whether the individual involved in the investigation was leaving campus less as a result of the training. As a result of the identified issues with documentation and tracking of recommendations and desired outcomes, the Facility was in noncompliance with this provision. The Facility's Self-Assessment contained a similar finding. The Facility's Action Plan indicated action on this provision was completed and ongoing, but it might need revision to address measuring the outcomes of the steps taken to address concerns.	
	(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	Based on review of the ABSSLC policy, records of 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	Substantial Compliance

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	particular staff member or individual.	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. 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 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. Trend reports were produced based on the data in AVATAR on at least a quarterly basis, for Unusual Incidents. The report for the 12/1/12 to 2/28/13 quarter included charts and graphs displaying data by type of incident and number of incidents, over a one-year period and over the past two years. The quarterly data was displayed by hour, day, location, cause, and by the top ten types of incident. The reports for 10/1/12, 12/17/12 and 3/11/13 were presented to the QAQI Council and to the IMRT with brief summaries. A key statement in each summary was: "Slips, trips, falls, accidents continue to be the cause of most of the incidents that occurred during this quarter." Additional in-depth analysis was needed to determine the underlying causes of slips, trips and falls so that action could be taken to address those causes, as appropriate. However there were no recommendations recorded to further analyze or address these ongoing issues.	Noncompliance

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		Trend reports for Abuse/Neglect/Exploitation and for Injuries were generated in a similar manner to the Unusual Incident reports with improvements in graphing of data over yearlong periods. The incident trend reports for 12/1/12 to 2/28/13 showed reductions in incidents over time that was encouraging. Other trend reports tracked aggression by home, between peers, and in a variety of other ways. However, while some of the summaries contained details that suggested actions were needed, and graphs and charts displayed information that suggested homes and individuals that might be the focus of corrective attention or efforts to understand causes, there did not appear to be recommendations or action plans recorded as a result of the findings. While there was much progress in use of longitudinal graphic displays of some data, additional analysis was needed to determine the priorities for intervention and to design corrective action plans to address those priorities. Follow-up then needed to occur to see the action plans through to conclusion, measure their effectiveness, and make changes to the plans as needed. As a result the Facility remained out of compliance.	
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 24 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 2012. 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.	Substantial Compliance

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		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 anyone who reported arrests were handled individually, depending on what the arrest was for and whether that had any impact on the person's work at the Facility. It was noted that one staff member remained in employment in spite of having been included on the Employee Misconduct Registry. This happened during the initiation of the checks of the Employee Misconduct Registry, and the employee was terminated when it was discovered. 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 Facility remained in substantial compliance with this provision. The Facility's finding was the same.	

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

1. 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. (D.2.i)
2. 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)
3. 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)
4. 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)
5. As action plans are developed, the Facility should follow the action plans through to conclusion, measure their effectiveness, and make changes to the plans as needed. (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 #003.1: Quality Assurance, dated 10/15/12; o ABSSLC: Review Processes, QA Process/Plan, revised 4/5/13; o Presentation Book for Section E; o ABSSLC Self-Assessment, dated 4/22/13; o A/N/E Trend Report Summaries for 10/1/12, 12/17/12, and 3/11/13; o Client-to-Client Aggression Trend Report Summaries: August 2012, October 2012, and January 2013; o ABSSLC 2012 Quarterly Dental Presentations for July, August, and September 2012; o ABSSLC Trend Analysis Report: Allegations of Abuse/Neglect/Exploitation, 12/1/12 to 2/28/13; o Injury Trend Analysis Report FY12 for Q4 FY12; o ABSSLC Unusual Incidents Trending Report December 1, 2012 to February 2013; o ABSSLC Restraints Trend Analysis Reports: January 2013; o ABSSLC Leadership Council/Quality Assurance/Quality Improvement (QA/QI) Council meeting notes, for the months of October2012 to March 2013; o ABSSLC Leadership Council/Quality Assurance/Quality Improvement Council meeting agenda and handouts for meeting on 5/6/13; o Monitoring tools associated with the Quality Enhancement Plan; o QA/QI Data Summaries for: ▪ Section C: 11/9/12, and 1/11/13; ▪ Section D: 11/9/12, 1/7/13, and 4/1/13; ▪ Section E: none; ▪ Section F: 11/13/12, 1/10/13, and 4/2/13; ▪ Section I: none; ▪ Section J: 9/27/12, and 1/10/13; ▪ Section K: 1/9/13; ▪ Sections G, H, and L: 2/12/13; ▪ Section M: none; ▪ Section N: none; ▪ Section O: 10/3/12, 12/12/12, and 3/3/13 (reported no data); ▪ Section P: 10/3/12, 12/12/12 (no data), and 3/6/13 (no data); ▪ Section Q: 2/11/13; ▪ Section R: 10/3/12, 12/12/12, and 3/6/13; ▪ Section S: 1/10/13 and 4/2/13; ▪ Section T: 10/10/12, 12/6/12, 12/13/12, and 3/6/13; ▪ Section V: 11/9/12, 1/7/13, and 4/1/13; and ▪ Internal Medical Audit: October 2012 and January 2013;

	○ Corrective Action Plan Tracking, undated; and ○ Corrective Action Plans for Section V (three), Section J (one), Section Q (one), Section M (one). ▪ **Interviews with**: ○ Linda Hinshaw, Facility Director; ○ Jolene Willis, Assistant Director of Programs; ○ Pat Smith, Director for Quality Assurance; ○ Tracyl Gandee, Settlement Agreement Coordinator; ○ Program Compliance Monitors (PCMs); and ○ Various staff in residential units, including ten direct support professionals. ▪ **Observations of**: ○ QA/QI Council Meeting, on 5/6/13; ○ Restraint Reduction Committee, on 5/9/13; ○ Interdisciplinary Team Meeting for Individual #241, on 5/8/13; ○ Unit IV Team Meeting, on 5/8/13; ○ IMT meeting, on 5/8/13; and ○ Residences #6690, #6710, #6730, #6740, #6521, #6400, #5971, and #5962.
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section E, dated 4/22/13. 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, but relied on other work products to conduct the self-assessment. The monitoring tool was reported to be ready for use. ▪ The Facility did use other relevant data sources, such as reviews of notes, minutes of meetings, and documents such as the Corrective Action Plans (CAPs) list and tracking sheet. ▪ The Facility did not consistently present data in a meaningful/useful way. Specifically, the Facility's Self-Assessment: ○ Did not present findings consistently based on specific, measurable indicators. For example: for Section E.2, the Facility provided anecdotal information about timely implementation of CAPs, but did not provide data about the number of CAPs and how many were timely, nor was there a graph or chart to illustrate timeliness. ○ Did not consistently measure the quality as well as presence of items. For example, for Section E.2, one observation from the Facility's review of the QA Council minutes was that CAP outcomes were being tracked. However, there was no indication of whether the outcome measures were designed to measure progress (from a baseline to a desired level). ▪ 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 identify areas in need of improvement. For example, for Section E.2, the Self-Assessment indicated that data summaries did not consistently include recommendations for CAPs and that CAPs were not being developed.

	Summary of Monitor's Assessment: Although the Monitoring Team did not find the Facility to be in substantial compliance with any of the provision of Section E, the Facility had made progress with regard to Section E, including: ▪ The QA Council meeting the Monitoring Team observed this time had improved from previous observations: there were data presentations, decisions on steps to resolve an issue, updates on a CAP with a decision on moving forward, and steps to follow-up on decisions. However, there were a number of missed opportunities to correct data, request further analysis of data, and formulate more meaningful action plans. On a positive note, the minutes of meetings captured more discussion and included important information from the QA presentations. ▪ The Facility had Corrective Action Plans (CAPs) in the process of implementation, and while there were only six active CAPS, some had steps, time lines, and were being tracked. ▪ PCMs had a good understanding of what was currently being monitored, how it was being done, and how the results were being shared. ▪ The Facility had a QA Plan and matrix, and could produce the beginnings of a data inventory. While these documents needed some work to come into substantial compliance, there were definite improvements since the last monitoring visit. Some of the areas that will need to continue to improve for the Facility to progress toward substantial compliance with the Settlement Agreement included: ▪ Not all of the monitoring on the QA Plan matrix was being done as listed. Either the matrix needed to be adjusted to reflect actual expectations of each section, or section leads needed to be encouraged to do what is required in the matrix. ▪ Adjustments were needed to the QA Plan, including appending the data inventory and the matrix to the plan. ▪ The Facility had amassed considerable data in many areas. That data needed further analysis and priorities needed to be established to address the results. The limited analysis that had been completed was generally insufficient to identify areas requiring attention. ▪ The Facility needed to work on using the CAP process for more systemic and cross-disciplinary issues, as well as for discipline-specific issues that need the attention and oversight of the QA/QI Council. ▪ The CAP tracking system needed some improvements to make it easier to use. ▪ The Facility needed to develop key indicators of quality across the system and to measure progress through those indicators.

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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	**State QA policy** There was a State policy that adequately addressed all five of the provision items in Section E of the Settlement Agreement. There were no changes to the State policy, entitled #003.1: Quality Assurance, dated 1/26/12. Positive aspects included:	Noncompliance

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	services; areas of care; individual staff; and/or individuals receiving services and supports.	▪ It seemed to have reserved policies for statewide development, and procedures for Facility development. This will keep the terminology consistent and the Facility should not have to re-label the State policy to adopt it. ▪ It included language for CAPs to both remedy and prevent (reduce recurrence), acknowledging both important roles. ▪ The policy language was simple and straightforward and the bullet style will make it easy for staff to read. ▪ It required disciplines to keep account of their databases and the QA Department to keep track of all databases. Other comments: ▪ The policy hinted at addressing both systemic issues and serious individual ones, but stopped short of encouraging the Facilities to have procedures to deal with both. ▪ There did not appear to be a list of key indicators or a directive to develop a list. ▪ The tie between QA and the self-assessment was not well described. This could, however, be covered in procedure or in a guideline for the self-assessment. Also, given that the statewide policy was disseminated more than a year ago, edits may already be needed. State Office should consider this. **Facility QA policies** ABSSLC adopted a Facility policy, ABSSLC Policy: Quality Assurance #003.1, dated 10/15/12, which mirrored the State policy on quality assurance. However, there was not yet a set of facility policies that adequately supported the State policy for quality assurance. More specifically, two Facility policies, adopted prior to the most recent quality assurance policy included "Participating in Quality Assurance and Improvement Council," dated 7/11/11. This policy should be reviewed for congruence with the more recent Policy #003.1 and amended as may be necessary. The document, "Quality Assurance Plan Process/Plan," revised 4/5/13, was written in the format of a Facility policy/procedures, but was offered as the current Quality Assurance Plan. If it was intended to serve both purposes, it would be better to divide the procedural instructions about developing the QA plan from the plan itself. The Facility should consider adopting a policy related to maintaining a data inventory and any other procedures that may be needed to operationalize Policy #003.1. **QA data list/inventory of data** There was not a complete and adequate data inventory at the Facility. The Facility provided a data inventory that it indicated identified data for all sections of the	

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		Settlement Agreement for use in identifying trends related to the requirements of the provisions of the Settlement Agreement sections. These data resided in the Plan of Improvement (POI) database. However, the sections were not broken out separately, so it was not possible to crosscheck data in the data inventory to the matrix. The data inventory included discipline-specific data for most sections of the Settlement Agreement in addition to the POI data, resulting from the application of monitoring tools. The AVATAR database provided information on unusual incidents, abuse and neglect, injuries, and restraints, and included demographic data that could be used to sort by individual, home, unit, date, time, and staff involved. There was no database with key indicators. However, work was reported to be underway in conjunction with the State Office to determine a list of key indicators. When developing the list of key indicators it will be important to select outcomes that are measurable, that include outcomes for individuals as well as process outcomes, and that reflect the priorities of the Facility. Although the inventory was not yet complete, the data inventory did include some data from the following: ▪ Settlement Agreement self-monitoring tools; ▪ Disciplines/departments; ▪ Areas of Care; ▪ Protections; ▪ Supports; and ▪ Services. For the data that was included on the data list/inventory, data was recorded for some sections (but not for QA monitoring data) by: ▪ Program areas; ▪ Living units; ▪ Work shifts; ▪ Individuals; and ▪ Staff. There was no Facility policy on the maintenance of a data inventory or on updating it periodically (i.e., at least every six months). As a result, it was unclear if it was being updated and/or if it was current. **<u>QA Plan Narrative</u>** The QA plan narrative at the Facility was current, but it was not complete and/or adequate. The document offered as the QA Plan was written in the style of a Facility policy or procedure, and had been revised within the last twelve months, on 4/5/13. The	

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		QA matrix was attached, but it was labeled as the QA Plan Matrix for FY2012. The QA Plan described the QA program: ▪ With regard to the organizational structure of the QA process, including individual roles and responsibilities: o It included a matrix listing the sections of the Settlement Agreement with corresponding tools and timeframes for administering the tools; o A description of how data would be summarized and analyzed; and o The role of other departments in the quality assurance process (including QA Department and discipline department collaboration/meetings); ▪ But it did not include: o A description of the purpose of the QA program; o A description of the data list/inventory; o A description of how key indicators of performance would be determined; o A description of how the QA Department interfaced with quality assurance-related committees and workgroups; o A description of the QA report, how it would be structured, and how often it would be made available to the QA/QI Council; o QA/QI Council and its role in reviewing data and guiding the entire QA process; and o A description of how corrective actions/CAPs would be determined and tracked. The QA Plan document needed to be separate from the procedures that govern its development and include all the information bulleted above. **QA Plan Matrix** Key Indicators (process and outcome) for each Settlement Agreement section For the 20 sections of the Settlement Agreement, a set of key indicators was included for none of the 20 sections (0%). The following metrics could not be assessed due to the lack of key indicators. However, they will be assessed during future monitoring reviews: ▪ Of these ___, both process and outcome indicators were identified for ___ (%) of the sections. ▪ Of these ___, in ___ (%) the indicators provided data that could be used to identify the information specified in E1: 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.	

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		Self-monitoring tools for all Settlement Agreement provisions Although the matrix listed some self-monitoring tools, the QA plan matrix did not include self-monitoring tools/self-monitoring procedures for all of the 20 sections of the Settlement Agreement. Copies of tools were provided for 11, and tools for three other sections were in use. Based on review of the matrix and documentation the Facility submitted for Section E, there were six sections that did not appear to have current tools (i.e., Sections I, K, N, O, R, and U.) Of those six, five were reported to be under revision or development. Section U did not appear to be using a tool or have one under development/revision. Of those sections that had tools, some had more than one (e.g., Section M and Section T.) The self-monitoring tools listed in the matrix included the following information: ▪ The monitoring tool; ▪ The frequency of monitoring; and ▪ The person(s) responsible for monitoring. All Data Collected by QA Department All data that QA staff members collected themselves were listed on the matrix, except for Family/LAR survey data. Includes Satisfaction Measures and Follow-up Although this was not related to substantial compliance, there were surveys of families/LARs at least annually. Surveys of individuals, staff, and relevant community partners were not available. It was not clear if follow-up on significant findings was completed within 90 days. All Items in QA Plan Matrix Also Appear in the QA Data List/Inventory The data inventory that was available for review did not contain enough detail to determine if all items in the QA Plan Matrix were contained in the data inventory. All data in QA plan matrix are submitted and received, and reviewed and analyzed ▪ Of the 19 items in the QA plan matrix (excluding Section E), 10 (53%) were submitted/collected/received by the QA Department for the last two reporting periods for each item (e.g., monthly, quarterly). Those that were not were for: Sections G, H, I, K, L, N, O, R, and U. ▪ Of the 19 items in the QA plan matrix, 14 (74%) were documented to show some review or analysis by the QA Department and/or the department section leads for the last two reporting periods for each item (e.g., monthly, quarterly). The quality of the analyses is addressed with regard to Section E.2. This metric only addresses whether or not some level of analysis was completed. This was determined by interview of PCMs and by review of the QA data summaries	

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		provided in response to document request #TX-AB-1305-IV.4. Those items that did not have a data summary showing some review or analysis were: Sections I, M, N, U, and V. Some of the 20 sections in the matrix included multiple monitoring tools: for example Section M included 13 separate tools and Section V included six separate tools. Since many of the tools were reported to be undergoing revision or consolidation, this metric considered whether there was at least one tool per section in the matrix. In future reports, all items listed will be considered separately. There were nine additional monitoring tools listed on the matrix, but not connected to a section. These were not reviewed since their role in the overall QA monitoring plan was not clear. However, in the future, all items listed on the matrix will be reviewed separately and evidence will be sought as to whether data from the item was submitted to and received by the QA Department. There were also additional review processes listed on the matrix that did not include a tool, such as a review by the Psychology Department of all restraints and the review of all injuries by Incident Management semi-annually. If such reviews are conducted without the use of a tool, it will be important to describe what the reviews involve. **Implement the QA Plan as Written (i.e., narrative and matrix)** The following metric could not be assessed, but will be assessed during the next review: ▪ Of the ___ components of the QA Plan narrative and the QA plan matrix, the Facility implemented ___ (%). **QA Staff Assist Disciplines/Departments in Analysis of Data** For the 19 sections of the Settlement Agreement (Section E excluded), in none of the summaries or other documentation reviewed was there indication that QA staff had assisted the section leads with analysis and none had documentation of the reasons assistance was not needed. While many of the reviews summarized monitoring data, including lists of items that scored less than 70% and recommendations, none of the reviews appeared to include a comprehensive analysis of that data such that it could provide guidance in determining what corrective action plans might be needed. Often recommendations addressed problems with the monitoring tools and obtaining accurate and reliable data. Some included recommendations for corrective action plans, but then did not result in corrective action plans. An example of this would be for Section J (summary report dated 1/10/13), where there were a number of indicators on the tool that scored below 90%. However, the recommendations in the summary report involved working harder to make the tool more reliable rather that addressing the identified issues.	

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		Self-monitoring Tools/Activities for All Sections of Settlement Agreement Of the self-monitoring tools for the 14 sections (excluding Sections I, K, N, O, R, and U that had tools under revision or not available) 14 of the tools, (100%) had instructions for the user or as in the case of Section C, the tool was self-explanatory. Any comments on the adequacy of the tools can be found in the specific sections of the report. As the QA Director and the Department section leaders work towards improving the self-monitoring tools, the Facility should be prepared to present to the Monitoring Team the following information on aspects of the self-monitoring tools: 1. Content/validity: A description of how the content of the tools were determined to be valid (i.e., measuring what was important) and evidence that each tool received a review by QA/QI Council at least twice within the past six months. [Metric to be measured: Of the ___ self-monitoring tools for the Settlement Agreement included in the sample, (a) the content of ___ (%) appeared to be appropriate and (b) __ (%) were reviewed within the past six months, and revised as appropriate.] 2. Adequate instructions: A description of how it was determined that the instructions given to the person who was to implement each of the tools were adequate and clear. [To be measured: Of the ___ self-monitoring tools for the Settlement Agreement included in the sample, ___ (%) had adequate instructions for the user.] 3. Implementation: A report or summary showing whether the tools were implemented as per the QA matrix. [Metric to be measured: Since the last onsite review, of the self-monitoring tools for the 20 sections of the Settlement Agreement, ___ (%) were implemented as per the QA plan (e.g., number, schedule, person responsible, inter-observer agreement).] 4. QA review: A report or summary showing that there was documentation of QA Department review of the results of the monitoring, at least once each quarter, for each of the 20 sections of the Settlement Agreement. [Metric to be measured: Since the last onsite review, of the 20 sections of the Settlement Agreement, there was documentation that the implementation (including inter observer agreement) and results (including outcomes) of self-monitoring were reviewed with the department staff at least once each quarter for ___ (%) of the 20 sections.] The Facility remained in noncompliance with Section E.1, because the QA Plan, the Matrix and the Data Inventory needed the work described in this report to be complete, the Facility needed to develop and implement key indicators/outcome measures, the self-monitoring tools required revision, they needed to be implemented as specified in the matrix, and the results reviewed with the QA/QI at least quarterly.	

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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.	**Data Summaries, Graphs, and Analyses** Data from the QA plan matrix for none of the 19 (0%) sections of the Settlement Agreement (not Section E) were summarized, graphed showing trends over time, and analyzed, as appropriate, across: a) program areas; b) living units; c) work shifts; d) protections, supports, and services; e) areas of care; f) individual staff; and/or g) individuals. To determine if the data from the QA Plan Matrix had been summarized, graphed and analyzed, the Monitoring Team reviewed the summary reports provided in response to TX-AB-1305-IV.5 for FY 2013 quarters 1 and 2 (Q1 was September, October and November 2012, and Q2 was December 2012, January and February 2013.). The summary reports for the 13 sections provided (Sections C, D, F, G, H, L, J, K, Q, R, S, T and V) included data summaries and graphs for the quarter, but did not graph data over time or analyze it across a) program areas; b) living units; c) work shifts; d) protections, supports, and services; e) areas of care; f) individual staff; and/or g) individuals. Data must be presented over time for a long enough period to permit assessment of trends; graphs need to present data in ways that facilitate analysis; and the analysis needs to occur that results in the identification of common issues and/or underlying causes of those trends or issues. Little analysis had been completed for any of the sections. Detailed analysis is a key to providing guidance in determining what corrective action plans might be needed. This is an area on which the Facility should focus. **Regular Meetings Between Discipline Department and QA Staff** Based on a review of a sample of five of the sections of the Settlement Agreement (Sections D, I, M, Q, and U), the minutes of meetings between QA staff and discipline heads for the last two quarters (Q1 and Q2 of FY2013) had been kept, as evidenced by minutes provided for the meetings. However, they did not document: ▪ Review of the data listing/inventory and matrix; ▪ Discussion of the data and outcomes; ▪ Review of the conduct of the self-monitoring tools; ▪ Creation/proposal of corrective action plans; and ▪ Review of previous corrective action plans. In future reviews, the Monitoring Team will assess the following metrics: ▪ Since the last onsite review, a meeting occurred at least twice for ___ of the sampled (%) sections of the Settlement Agreement, and the five topics (the five topics listed above) were conducted during ___ of the ___ (%) meetings that occurred. ▪ Since the last onsite review, during ___ of the ___ (%) meetings, data were available to facilitate department/discipline analysis of data. ▪ Since the last onsite review, during ___ of the ___ (%) meetings, data were	Noncompliance

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		reviewed and analyzed. Since the last onsite review, during ___ of the ___ (%) meetings, action plans (and/or CAPs) were created for systemic problems and for individual problems, as identified. Comments should be included in the minutes on any issues with the conduct of the meetings, the availability of data or the process that led to creation of CAPs. **QA Reports** Since the last onsite review, a Facility QA report (for dissemination at the Facility and for presentation to the QA/QI Council) was created for all of the six (100%) months. ABSSLC did not prepare system-wide QA reports. Instead, the QA reports were at the monthly QA/QI meetings on Settlement Agreement sections by the discipline head with additional comments by the QA Director as appropriate. Sections listed on the matrix were scheduled for quarterly reports. It was not clear how wide the distribution of the QA/QI Council minutes were and whether staff in general were afforded the opportunity to read the QA reports contained in the minutes. Of the 20 sections of the Settlement Agreement, 13 (65%) appeared in a QA report at least once in each quarter since the last onsite review. Of the sections of the Settlement Agreement that were presented, none of 13 (0%) contained the following components: a. Self-monitoring data i. Reported for a rolling 12 months or more; and ii. Broken down by program areas, living units, work shifts, etc., as appropriate; b. Key indicators i. Reported for a rolling 12 months or more; and ii. Broken down by program areas, living units, work shifts, etc., as appropriate; and c. Narrative analysis. **Facility QA/QI Council** Design: There was an adequate description of the QA/QI Council in the QA plan narrative. The narrative listed the Facility Director as chairing the QA/QI Council, and listed the discipline heads and other key members such as the Settlement Agreement Coordinator, as members. The narrative provided for additional department staff as necessary to attend or facilitate a discussion.	

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		Schedule, agenda, and attendance: Since the last onsite review, the QA/QI Council did meet at least once each month. Minutes from 11 of the 11 (100%) QA/QI Council meetings since the last review indicated that: ▪ Meetings occurred according to schedule or reasons for changes were documented; ▪ Agendas included topics/presentations related to QA; and ▪ There was attendance/representation as per policy. Data and Analysis Presented: Minutes from none of the 11 (0%) QA/QI Council meetings since the last review documented that: ▪ Data from QA plan matrix (key indicators, self-monitoring) were presented; ▪ The data presented were trended over time; and ▪ Comments/interpretation/analysis of data were presented. However, while key indicators were not presented, and there were a few presentations of data from the QA Monitoring tools by the QA Director, the Section Leads did sometimes note whether monitoring tools had been used and the degree of inter-rater reliability. It was not clear from the minutes and the attached quarterly section reports whether the monitoring tool data were proving helpful in evaluating progress and designing CAPs. Some sections such as Sections C and D appeared to rely more on incident data that was trended over time, graphed, and included some analysis than on the QA Monitoring data. Recommendations and Action Plans: ▪ Of the six Corrective Action plans presented, six (100%) were based on the data presented; and None of the six Corrective Action Plans presented addressed both high-risk individuals and systemic issues. However, one (dental appointments) did address both the systemic issue of missed dental appointments and the homes with the highest number of missed appointments. The remaining five plans addressed systemic issues, but did not consider the individuals that were at highest risk as a result of those systemic issues. For example: one CAP (Section V: record-keeping: legibility, dates, misfilings, etc.) addressed the systemic issue of accuracy of documents, but did not address homes with the most issues and, therefore, with the individuals most at risk for having orders for treatments or services carried out incorrectly. **Corrective Actions and CAPs** System for generating CAPs: A written description did exist that indicated how CAPs	

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		were generated. It was found in the ABSSLC Review Processes: Quality Assurance Process/Plan. The description included: ▪ Criteria for a CAP; and ▪ A description of how to evaluate indicators for criteria which was by percentage of performance according to the QA monitoring tool audits. The system should include a description of methods other than use of percentages for evaluating data to determine when a CAP may be needed, such as: when data identifies a specific home or unit as having an issue, when issues cross over disciplines, or otherwise need the oversight of the QA/QI Council. <u>CAP development</u>: When considering the full set of six CAPs, six (100%) appeared to have been chosen following the written description policy or procedure. While these six CAPs followed the current description, that description needed some improvement, as noted above. <u>Content of each CAP</u>: Of the six CAPs reviewed by the Monitoring Team, six (100%) appeared to address the specific problem for which they were created. <u>CAPs contain all necessary components</u>: Based on a sample of six CAPs, which represented 100% of the total of six CAPs: ▪ Six (100%) included the actions to be taken to remedy and/or prevent the reoccurrence. ▪ One (17%) included the anticipated outcome of each action step, although the outcome for the CAP was presented for the remaining five. The one was for Section V - Recordkeeping: Audits of charts, and it had only one action step. Where outcomes were presented, they were generally not measurable in terms of showing how the outcome was expected to improve. For example, the CAP on dental attendance had an expected outcome: "missed appointments will average 5% or less over the calendar year 2013." Although this technically was measurable, a better outcome-based statement would have read: "missed appointments will improve from an average of 10% per year to an average of 5% for calendar 2013." An even better statement might have read, " Individuals will improve their attendance at dental appointments from an average of 80% to an average of 90% in calendar 2013." ▪ Six (100%) included the person(s) responsible ▪ Six (100%) included the time frame in which each action step must occur. Based on the limited presentation of the data and analyses conducted, limited scope of the meetings between QA staff and discipline staff, the lack of criteria for CAPs other than variance from an established percentage of performance, and lack of outcome measures for each action step in the CAPs, the Facility was not in compliance with this provision of	

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		the Settlement Agreement. The Facility found noncompliance as well.	
E3	Disseminate corrective action plans to all entities responsible for their implementation.	Based on a sample of six CAPs, which represented 100% of the total of six active CAPs: ▪ How each CAP was disseminated could not be confirmed. In discussion with the QA Director it was learned that CAPs were disseminated via email and some emails were provided. However, the emails did not identify the CAPs in a manner (such as by an assigned number) that made it clear which CAPs had been disseminated. ▪ When each CAP was disseminated could not be confirmed. This was not noted in the tracking sheet and emails did not make clear which CAP was being disseminated. ▪ The specific person(s) responsible was indicated in each of the six CAPs. However, to whom the CAP was disseminated was not clear. The emails did not identify the CAPs and the tracking sheet did not include a list of who needed to receive a copy. The Facility was found to be in noncompliance with this provision. The Facility found noncompliance as well.	Noncompliance
E4	Monitor and document corrective action plans to ensure that they are implemented fully and in a timely manner, to meet the desired outcome of remedying or reducing the problems originally identified.	**Implementation of CAPs** Based on a sample of 12 CAPs (six completed CAPs and six active CAPs), five (42%) had been implemented, but only one (8%) was implemented in a timely manner (T.1g on 3/8/12). For those that were not implemented timely, there was no information about what had been completed, nor was information available about the steps that could not be taken. Those for which implementation had begun included: medication station maintenance, dental attendance, T.1g on 3/8/12, T.1g on 12/16/11, and D.2E. For those that were not implemented timely, it was not possible to determine implementation because no running status updates were provided to compare to target dates or to determine whether or not they had not been implemented at all. **Tracking CAP status** There was a sheet for tracking the status of CAPs. Of the 12 CAPs being tracked by the Facility, for 10 (83%), the tracking sheet included some limited information about the status of the CAP. ("Records rev" 2/22/13 and "Psychotropic medication reduction rev." 4/4/13 had nothing recorded in the status column.) Status was sometimes indicated by "completed" without a date, making it difficult to determine if it was completed timely. Or, in some, the status indicated that the time frame had been revised and a new target date for completion had been entered. In one, the status was indicated as "not achieved" and information was provided about the probable date for submission of a new CAP. The CAPs were difficult to identify. The tracking sheet needed to include an assigned identifier (CAP #!, for example) rather than a date and an issue that could include a	Noncompliance

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		paragraph of text. To achieve substantial compliance the Facility will need to record reviews of CAPs by the QA/QI Council in the status column with dates of reviews or dates of completion and any actions taken as a result of the reviews. **Management of CAPs** The Facility QA Director: ▪ Did maintain summary information/data regarding CAPs and their status (number of CAPs and number overdue) that was updated within the month prior to the onsite review for the sample of CAPs; and ▪ Did present this information to QA/QI Council at least quarterly. The Facility was not in substantial compliance with this subsection. While there was a process for tracking status, it was not easy to follow. The tracking sheet needed to assign an identifier such as assigned numbers to each CAP rather than a date or a paragraph, and the status updates needed to include a running account of action steps completed and/or actions taken. When a CAP was completed, the completion date needed to be added to the tracking sheet.	
E5	Modify corrective action plans, as necessary, to ensure their effectiveness.	**Evaluate effectiveness of CAPs** Of the 12 CAPs listed on the tracking sheet, five active CAPs had revised target dates, and one did not achieve the desired results, and there were plans to submit a new CAP. Of the inactive CAPs, three had ended without achieving the desired outcome and three were complete. The three completed CAPs did not include evidence of whether the desired outcome had been achieved. While the system for tracking included indications of completion and revision, there was not sufficient information documented in the status tracking to fully assess the following metrics. For this to be possible, the status needed to include dates of review, explanations of changes and evaluations of outcomes. ▪ For one out of 12 CAPs (8%), documentation showed review of their effectiveness (i.e., outcomes) (11/28/12: Medication Station Maintenance), and for one out of 12 CAPs (8%), documentation showed review of their timely completion (11/28/12: Medication Station Maintenance). ▪ There was insufficient information recorded on the status tracking sheets to rate the following: o Of the ___ CAPs that appeared to need modification, ___ (%) were modified. o For ___ out of ___ (%) modified CAPs, evidence was present to show timely implementation. o For ___ out of ___ (%) modified CAPs, evidence was present to show full	Noncompliance

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		implementation. ▪ There was insufficient information on the status tracking sheets or in the QA/QI minutes to determine if the 12 CAPs were discussed and with what result. The following will be rated in future reports: o Based on a sample of ___ completed CAPs and ___ in process CAPs, (%) were discussed at QA/QI Council.	

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. (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. (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 Recommendations #1 through #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 Policy Number 004.1: Individual Support Plan (ISP) Process (Integrated Protections, Service, Treatments, and Supports) with attachments, 11/20/12; o Draft ABSSLC Policy on ISPs; o A list of Qualified Developmental Disabilities Professionals (QDDPs) with their current assignments, and the number of individuals on their caseloads, dated 4/5/13; o Section F – Integrated Protections, Services, Treatments and Supports: Annual ISP Meeting Preparation Checklist, revised 1/2/13; o The last 10 monitoring tools that the QDDP Department completed and the last 10 the QA Department completed; o Supporting Visions Lesson Plan and Content, and Workbook, dated 9/12; o Quiz for Supporting Visions training; o Some Things to Remember for Referrals, dated 8/5/11; o Living Options format; o Completing the Community Living Discharge Plan (CLDP), dated 3/8/13; o In response to request for a list of QDDPs deemed competent with regard to the facilitation of ISP meetings, the following response: "There is no information for this request"; o An alphabetical list of each individual at the Facility, with the most recent ISP meeting date, the date on which the ISP document was completed/filed, and the date of the previous ISP meeting date; o ISP Listing Breakdown, undated; o Annual Assessment Filed 10 Days Prior to ISP by Assessment, from 8/24/12 to 3/31/13; o Overall Facility Attendance Compliance: All Meeting Types, from 8/24/12 to 3/31/13; o ISP Required Attendance Compliance: All Meeting Types, from 8/24/12 to 3/31/13; o Based on monitoring/audit data, or other reviews or data that the Facility has collected in relation to integrated protections, services, treatments, and supports, reports showing analysis of such data, as well as descriptions of actions taken or corrective action plans developed, including Program Implementation Meeting minutes, dated 12/13/12, 2/14/13, and 3/21/13; o A list of individuals admitted to the Facility since the last review, including the date of their admission and the date of their initial ISP meeting; o Individual Support Plans, Sign-in Sheets, Assessments, Individual Support Plan Addenda (ISPAs), Preferences and Strengths Inventory (PSI), Community Living Options Information Process (CLOIP) worksheet, skill acquisition and teaching programs, Rights Assessment, monthly reviews, and ISP Preparation Meeting documentation for: Individual #255, Individual #447, Individual #418, Individual #218, Individual #40, Individual #120, Individual #127, and Individual #517;

	○ For individuals included in pre-review sample of ISPs, data from Facility's spreadsheets showing for each individual: a) timeliness of each assessment; and b) attendance at ISP meetings; ○ Handouts from ISP meeting for Individual #241; ○ Quality Assurance (QA)/Program Compliance Monitor (PCM) Summaries, dated 11/13/12, 1/10/13, and 4/2/13; ○ Quarterly Section Review of Progress, dated 11/19/12, and 1/14/13; ○ Plan of Correction related to monthly reviews, including training materials and training roster; ○ ABSSLC Self-Assessment, updated 4/22/13; and ○ Presentation Book for Section F. ▪ **Interviews with**: ○ Kristin Wyrick, QDDP Coordinator; ○ Jolene Willis, Assistant Director of Programs (ADOP); and ○ Jeff Branch, Director of Active Treatment; ▪ **Observations of**: ○ ISP Meeting for Individual #241, on 5/8/13; ○ ISP Meeting for Individual #49, on 5/9/13; and ○ Activities in homes and day programs.
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section F, dated 4/22/13. 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: ▪ The Facility used monitoring/auditing tools. 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 reportedly included: Section F – Integrated Protections, Services, Treatments, and Supports: Annual ISP Meeting Preparation Checklist, dated 1/2/13. However, of concern was the fact that the indicators in the audit tool did not consistently align with the indicators in the Self-Assessment. For example, many of the indicators in the Self-Assessment were not on the audit tool, and vice versa. As a result, it was unclear from where the data in the Self-Assessment came, and how the data from the audit tool was being used. ○ Although this auditing tool included some valuable indicators to assist the Facility in determining its compliance with the requirements of the Settlement Agreement, some significant concerns remained with regard to the indicators. Some of them could be answered in the affirmative without the auditor assessing the quality as opposed to just the mere presence of an item. This, amongst other factors, likely contributed to the much higher ratings the Facility calculated for specific sections of the Settlement Agreement in contrast with the Monitoring Team. The following are just a couple of examples: 1) Were

	plans developed to increase awareness of Living Options for individual and LAR/Family/Advocate; or 2) Was the ISP meeting Guide completed, including the personal preferences and strengths? Either of these could be rated as compliant without the quality being assessed. The guidelines often did not point to the need for the auditor to review quality either. In addition, as noted above, a clear correlation was not found between the Self-Assessment indicators and those in the monitoring tool. Those indicators included in the Self-Assessment did not represent the full set of indicators necessary to assess compliance, and there seemed to be a number of misunderstandings on the Facility's part of what substantial compliance entailed. Again, quality as well as the presence of items seemed to be frequently overlooked. For example, the Facility indicated that with Section F.2.e, related to competency-based training, once refresher training was instituted, substantial compliance would be achieved. This completely overlooked the need for "competency-based" training, which had not been put into place. As the Facility revises its monitoring tools, the Facility continues to be encouraged to review the Monitoring Team's report to identify indicators that are relevant to making compliance determinations. o Based on review of the audit tool, it generally included adequate methodologies, such as observations, and record reviews. However, although some improvements were seen, these methodologies were not sufficiently detailed 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). o The current monitoring/audit tools did not have adequate instructions/guidelines to ensure consistency in monitoring and the validity of the results. However, as discussed in further detail with regard to Section F.2.g, the Facility's was continuing its efforts to modify the instructions/guidelines. o The following staff/positions were responsible for completing the audit tools: the Program Compliance Monitor, the QDDP Coordinator, the QDDP Educator, the QDDP Settlement Agreement Liaison, and three QDDPs. From the information included in the Self-Assessment, it was unclear whether or not the data represented data collected by all of these auditors. o Although all of the staff responsible for auditing had some level of relevant programmatic experience, 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. However, this was an area in which work was continuing. ▪ The Facility was using some other data sources. For example, the Facility was tracking the timeliness of ISPs, as well as the date the final ISP document was completed and made available for implementation. This data was included in the Self-Assessment. However, since the last review,

	the Facility had developed a database to allow aggregation of information related to IDT member meeting attendance, as well as assessment timeliness. 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 Generally, presented findings based on specific, measurable indicators. However, as noted above, at times, it was unclear what criteria had been used. 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 substantial compliance with the following sub-sections of Section F: Section F.1.a, related to facilitation of ISPs; Section F.2.a.3, related to the integration of all protections, services, and supports, treatments, clinical care plans, and other interventions provided to the individual; Section F.2.a.4, related to the identification of the methods for implementation, timeframes for completion, and staff responsible; Section F.2.a.6, related to the identification of the data to be collected or documentation to be maintained, and the frequency of data collection to allow objective analysis, and the persons responsible for the data collection and review; and Section F.2.b, related to the coordination and collaboration between disciplines. This 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 these discrepancies. ▪ The Facility's data identified areas in need of 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 referencing 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, a variety of training had been offered to ABSSLC staff on the ISP process, or specific components of it. For example, in October 2012, the ABSSLC QDDP Coordinator, Chief Nurse Executive, and Director of Habilitation Therapies provided training to team members on the ISP and Risk processes. In October 2012, DADS State Office consultants provided additional training to two teams on the ISP Preparation Meeting process and Preferences and Strengths Inventory, and in January 2013, DADS State Office provided training to teams on the Enhanced At-Risk process, including the revised Integrated Risk Rating form and Integrated Health Care Plan format. In April 2013, the State Office QDDP Discipline Coordinator provided more training to Facility staff on ISP development. At the time of the Monitoring Team's review, the Facility was still in the initial phases of implementing some of these forms and processes, and ABSSLC had not had the benefit of the more extensive training that two Facilities currently were undergoing. However, some improvements were noted. Generally, ISP meetings were being held annually, and individuals newly admitted to the Facility were having ISP meetings within 30 days of their admission. However, although efforts were underway to improve timely completion of ISPs, challenges remained in finalizing the ISP documents and having them available in the records for teams' use within 30 days of the meeting.

	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. However, further refinement 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. Development of community skill acquisition goals was slow. 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." However, the need remained for the plans to more comprehensively address the identified needs, and for the methodologies to be strengthened, as well as measurable objectives/clinical indicators to be included in plans to provide teams with information to determine whether or not the supports and strategies were having the desired outcome (e.g., were they effective in improving the individual's health, or maintaining his/her current status). The Facility had adopted a new monthly report format. It was positive that QDDPs were now expected to complete these reports. However, because the ISP action plans did not include many of the healthcare and other clinical supports the individual was provided, the monthly reports focused mainly on skill acquisition programs, and did not provide information about individuals' progress or lack thereof on issues related to behavior, psychiatry, healthcare issues, and/or habilitation therapy. The Facility had made progress with regard to its quality assurance system related to the ISP process. The QA, QDDP, and Active Treatment Departments had continued to work together to revise the tool they used to monitor ISP meetings, as well as ISP documents. They were working on establishing inter-rater reliability, including modification of review tools and the related instructions. Efforts were in the very initial stages of analyzing the data, and determining if current action plans were sufficient or if additional ones needed development. However, all of these activities remained in the early stages of implementation and revision, 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	Since the Monitoring Team's last review, DADS had issued Policy #004.1: Individual Support Plan Process, dated 11/20/12. As appropriate, comments on the policy are provided below in relevant subsections.	

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	years, the IDT for each individual shall:	The Monitoring Team's previous reports had identified the need for ABSSLC to tailor its policies to not only meet the requirements of the State policy, but also to describe in further detail some of the procedures or expectations that were specific to the Facility. The Facility indicated that the policy on ISPs was in draft format and the Policy Review Committee was still reviewing it. However, from information the Facility provided in the Presentation Book, efforts were being made to tailor the State policy to include relevant items at the Facility-level. In order to review this section of the Settlement Agreement, a sample of ISPs was requested, along with sign-in sheets, assessments, ISPAs, PSIs, Rights Assessments, Integrated Risk Rating Forms, Integrated Health Care Plans and/or risk action plans, CLOIP worksheet or most recent Permanency Plan, skill acquisition and teaching programs, the last three monthly, and the last two quarterly reviews, individual's daily schedule, Special Considerations list, and ISP Preparation Meeting documentation as available. A sample was requested of the most recently developed ISPs from each residence on campus, and the eight most recently developed plans were selected for review. Therefore, a variety of QDDPs and interdisciplinary teams (IDTs) had been responsible for the development of the plans. This sample included plans for: Individual #255, Individual #447, Individual #418, Individual #218, Individual #40, Individual #120, Individual #127, and Individual #517. This was a limited sample due to the fact that based on the Monitoring Team's initial review of the smaller sample, there was minimal improvement of the ISP documents, and State Office had identified two Facilities at which concentrated efforts were being made to improve the ISP process. Although ABSSLC had undergone some training on the new IRRF and IHCP processes, teams at the Facility had only begun using them fully at the end of January 2013, and teams had not had the full benefit of the more intensive training that was currently being offered to a couple of other Facilities. It was anticipated, therefore, that additional changes would occur to the ISPs at ABSSLC with both experience with the new process and additional training and technical assistance. It is the Monitoring Team's hope that the additional efforts to improve ISPs system-wide will positively impact the ISPs at ABSSLC.	
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: ▪ Policy #004.1 in Section II.F.1.b indicated that the QDDP would assist the individual and LAR, as appropriate, in leading the team in an interdisciplinary discussion.	Noncompliance

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		▪ 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. Observations of team meetings and reviews of ISPs also illustrated that the QDDP was the team leader and responsible for ensuring team participation. For example, for Individual #241, the QDDP led the discussion, assured that team members had opportunities to contribute to the discussion, and followed the guideline for the meeting. ▪ With regard to staffing, in addition to the QDDP Coordinator, a QDDP Educator remained in place, as well as a QDDP Settlement Agreement Liaison. Based on the caseload list provided, dated 4/5/13, a total of 18 QDDPs were in place. There were 21 homes on campus, and some QDDPs were sharing caseloads or were assisting in covering caseloads where vacancies existed. Given the list provided, it was difficult to calculate an average caseload or a range, because when vacant caseloads were shared, the numbers of individuals each QDDP was assigned was not indicated. At the time of the review, there were two QDDP vacancies, and eight of the QDDPs were new since November 2012. As the QDDP Coordinator noted, the fairly consistent turnover presented challenges with regard to training new QDDPs. As discussed below, none of the QDDPs had been deemed competent in facilitation, and clearly turnover was one factor that made this difficult. ▪ As further discussed with regard to Section F.2.e, various training had been provided to QDDPs and team member. On October 8 and 9, 2012, the QDDP Coordinator, Director of Habilitation Therapies, and Chief Nurse Executive provided training to QDDPs and Team members on the ISP process and Risk. In October 2012, State Office staff/consultants provided the two teams for Residences 6710 and 6500 additional training on the completion of the Preferences and Strengths Inventory, and Pre-ISP Meetings. In January 2013, training regarding the Enhanced Risk Rating system was conducted through State Office. On 4/24/13, the DADS SSLC QDDP Discipline Coordinator provided training on the ISP to team members. ▪ In mid-January, all teams began using the revised At-Risk process. However, as noted above, the more intensive training on the revised process was anticipated in the future. ▪ During the week of the review, the Monitoring Team observed the ISP annual team meetings for Individual #241 and Individual #49. Progress continued to occur with regard to the facilitation of meetings. Based on this limited observations 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	

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		members strayed from them, and moved the meeting along when it stalled. o Efforts were made to include the individual, and focus the discussion on him or 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. 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 some 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 acquisition programs, PBSPs, and measurable objectives related to risk plans. It was positive, though, that the teams were discussing objective clinical data in some areas. o Based on the observations of the ISP meetings, 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 teams discussed functional action plans, and related a number of them back to the individual's preferences. However, based on review of ISPs, only limited improvement was noted with regard to action plans. Many essential action steps were still missing, even though some of these were now detailed in the "current supports" section of the IRRF, and few measurable clinical indicators were included to allow teams to assess whether or not a person was improving, or remaining the same. 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 eight plans reviewed or two meetings 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	

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		Agreement. Areas in which improvements should be made in order to achieve compliance, included: ▪ As is discussed in further detail with regard to Section F.2.e, the Q Construction: Facilitating for Success training was still provided to new QDDPs, and it included a competency-based component. The Annual ISP Meeting Preparation Checklist also assessed some of the competencies that QDDPs needed to demonstrate. As the QDDP Coordinator pointed out, it did not identify specifically which indicators were related to a QDDP's competence versus other team members' competence, or define the competency measures. However, it provided a number of important insights into the QDDP's facilitation skills, as well as completion of the ISP document. Such competency measures should be clearly defined and include criteria for achieving competence. At the time of the review, the QDDP Coordinator recognized that more work was needed, and indicated that none of the QDDPs had been deemed competent. As noted above, turnover was certainly impacting the competency issues, given that during previous reviews, the Facility reported that seven out of the nineteen QDDPs (37%) had previously been deemed competent in facilitation. ▪ Based on review of ISPs as well as during the observation of meetings 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 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. Although some improvement was seen since the last review, 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	

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		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 meeting was somewhat decreased, a large part of the time at the ISP meeting for Individual #241 that 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 less 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. While there was improvement in the preparation before the meetings, time was still spent on reading information aloud that was in the preparation, which consumed time that might have been spent on the clinical discussions that needed to occur. Additional time was needed to develop 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 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	In Section II.A, DADS Policy #004.1 described the interdisciplinary team (IDT) as including the individual, the Legally Authorized Representative (LAR), 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.	Noncompliance

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	supports to the individual. Other persons who participate in IDT meetings shall be dictated by the individual's preferences and needs.	Attendance requirements now were determined at the ISP Preparation Meeting held 90 days prior to the annual meeting. According to the Provision Action Information and interview with the QDDP Coordinator, beginning on 1/21/13 and going back to information for meetings held beginning in November 2012, the information from the ISP preparation meetings regarding attendance requirements was entered into a database, as well as actual attendance. The Facility provided data from 8/24/12 to 3/31/13. However, given that teams did not begin using the new process until November 2012, it was unclear what this data represented. Based on data the Facility provided for ISPs held between October 2012 and January 2013, average attendance rates were between 65% and 100%, with the majority between 80 and 100%. This data was broken down by discipline. However, in addition to the question about why the data included information from before the time the new process was put in place, based on review of individuals' records, teams were not providing sufficient justifications when they decided a team member did not need to be present. As a result, the high rates of attendance that the Facility's data showed were questionable. Further significant concerns arose regarding the validity of the data when the Monitoring Team reviewed the information the Facility provided for the individuals in the sample. In addition to requesting the ISP Preparation information and the sign-in sheets from the ISP meetings, the Monitoring Team requested the Facility's data for attendance for each of the individuals in the sample. For some individuals, discrepancies were found between the Facility's data, and the list of required team members and/or the sign-in sheets (e.g., Individual #447 for whom the Facility's data showed attendance of team members who were not on the sign-in sheet, such as the OT and SLP; Individual #418 for whom, per the sign-in sheet, the DSP and Dietician were not present, but, the Facility's data showed they were; and Individual #218, for whom the Facility data showed the PT attended, but the sign-in sheet did not.). Based on the sample of eight ISPs the Monitoring Team reviewed: ▪ One individual was newly admitted, and had not had an ISP Preparation meeting (i.e., Individual #255). For the remaining seven, at the ISP Preparation Meeting, six (86%) teams defined the members of the team that should attend the annual meeting. The one that did not was for Individual #517. ▪ Three of the six individuals had strengths, preferences, or needs that potentially required additional team member participation. For none of these three individuals (0%), the team had adequately justified why such team members' participation was not necessary. Those that did not have adequate justification included: Individual #218, Individual #127, and Individual #40. Of note, in	

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		identifying team members that needed to be present, the team often used phrases such as "only one representative from hab therapies is needed for meeting attendance in order to cover and hab therapy issues," or "PCP does not need to attend unless medical concerns are noted, and she needs to provide more during ISP than what is documented in the annual medical summary." These did not provide adequate justification. They were not individualized and did not explain why for this particular individual the team member's attendance was not needed. The specific reasons that an assessment is sufficient need to be provided, or a further explanation of the individual's status or lack of needs in a specific area is necessary. ▪ For one of the eight (13%), it appeared that a duly constituted team participated in the annual meetings. The one was for Individual #40 who appeared to have the appropriate people at the team meeting even though not all the needed members had been specified in advance. The Facility had made progress in beginning to use the ISP Preparation Meeting to identify team members for participation in the ISP meetings, and had a working system to track and trend the resulting data. However, based on the Monitoring Team's review, the data did not show when teams failed to identify an appropriate team member, and justifications on ISP Preparation Meeting documentation generally were not sufficient to explain why team members supporting the individuals did not need to be present. The Facility's data was not an accurate representation of appropriate disciplines' attendance at meetings. 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.	DADS Policy #004.1 no longer defined "assessment" in a comprehensive fashion. The former draft had defined it 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." The revised policy did not include a definitions section, and Section III.C focused on the assessments' role in focusing on the individuals' personal goals and appropriateness of transition to the community. Although these were two important roles of assessments, they were not the only ones. Progress had been made and/or sustained with regard to the conduct of assessments. Positive developments included: ▪ The State Office had developed an Assessment/Report Schedule – Minimum Requirements, dated 10/15/12, which was an attachment to the revised policy. Although it will be important to ensure that this document addresses the Settlement Agreement as well as regulatory requirements, it appeared to	Noncompliance

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		provide a good framework from which teams could work to determine the standard assessments that should be completed, and the timeframes for their completion. ▪ In reviewing a sample of ISPs, individuals' teams had begun to identify necessary assessments at the ISP Preparation Meetings. As noted below, problems were identified with this process, including a lack of justification for assessments related to individuals' specific needs. Areas of concern included: ▪ The Facility was tracking the timeliness of assessments. Based on the data generated for ISPs meetings held between 8/24/12 and 3/31/13, significant issues were noted with regard to the timeliness of assessments. The data was presented by discipline/ type of assessment, and the range of timeliness was from 0% to 100%, with many falling below 50%. It should be noted that: 1) some disciplines were not listed (e.g., medical, psychiatry, psychology, and speech); and 2) some of this data was from before the time period in which teams were identifying needed assessments at the Pre-ISP meeting, so it was unclear what the data represented (i.e., assessments teams had decided individuals needed or all listed assessments for everyone). ▪ 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 detail throughout this report with regard to the sections of the Settlement Agreement that address nursing services (Section M), physical and nutritional supports (Sections O), and vocational, habilitation and skill acquisition (Section S). Some assessments in which improvements were seen included psychiatry and speech and language 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. ▪ As discussed in previous reports, although since the last review, some limited improvement was seen, assessments also frequently did not include adequate recommendations. Some of the issues noted included no or limited specific recommendations, or an incomplete list of recommendations; and recommendations not oriented to the development of action plans. Based on the sample of eight ISPs: ▪ One individual was newly admitted, and had not had an ISP Preparation meeting (i.e., Individual #255). For the remaining seven individuals, at the ISP Preparation Meeting, the team defined the assessments that were needed for the annual meeting for six (86%). The needed assessments were not defined for	

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		Individual #517. ▪ In reviewing the ISPs for six individuals, the teams for four individuals (67%) 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. This included Individual #218, Individual # 447, Individual #127 and Individual #40. For the remaining individuals, they had needs for which assessments were not requested, and the teams did not provide adequate justification for not requesting assessments. ▪ For none of the eight (0%), the necessary assessments were completed and available to the teams at least 10 working days prior to the ISP meeting. 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. Most often, the teams did not adequately analyze the information and/or identify areas in which changes might be made to attempt to reduce the frequency of such occurrences. Although some improvements were seen with the quality of some assessments, and some infrastructure and guidance had been developed regarding the frequency and/or indications for completion of assessments, concerted efforts of all team members will be necessary to bring the Facility into substantial compliance with this provision.	
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 eight 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. ▪ As noted above, although some improvements were seen, the quality of assessments was lacking. Of particular concern were the issues related to the recommendations included in assessments. There was a need for assessments to summarize in the recommendations the detailed protections, services, and supports that needed to continue for the individual, as well as changes to support either assessment findings or the need to improve the configuration of services the individual required. To the extent possible, these recommendations	Noncompliance

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		should be written in specific, observable, measurable terms to facilitate their inclusion in action plans. Efforts were needed to improve the recommendations included in assessments, as well as to ensure that teams considered, and either incorporated recommendations or provided justification for not incorporating them. The Facility remained out of compliance with this provision.	
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 regarding community living options: ▪ On 3/8/13, the Admissions Placement Coordinator provided the QDDPs training on living options, referrals, and obstacles pertaining to living options both in ISP and ISPA meetings. 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. Five plans were reviewed including those for: Individual #255, Individual #447, Individual #418, Individual #218, and Individual #374. The following highlights some of the findings: ▪ In order for the State Office requirement to be met, each discipline's assessment needed to include an opinion/recommendation about the individual's appropriateness for a more integrated/less restrictive setting. In addition, at the ISP meeting, the team needed to make a recommendation to the individual/guardian. Based on the review of records: o Of the five ISPs reviewed, for none (0%), all of the assessments included the applicable statement/recommendation. This had definitely improved over time, but the ones that sometimes did not include a statement were dental and psychiatry (although some of these did), and recreation. o Of the five ISPs reviewed, none of the individuals had been referred for transition to the community. Four individuals' ISPs (80%) included a recommendation from the professionals on the team to the individual and LAR (i.e., as discussed below, Individual #218's team did not make a definitive recommendation). However, for none of these four individuals (0%) was adequate justification provided for the team's recommendation. The following provide examples of the problems identified: ▪ The ISP for Individual #447 summarized the team's recommendations that had been included in assessments. All of these indicated that the individual could be supported in a more	Noncompliance

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		integrated setting. The individual also had previously requested community placement. She did not have a guardian, but the team had determined that she could not make decisions in most areas. It appeared that the team was concerned about the ability of a community provider to meet her medical needs, but this was not reflected in their assessment recommendations. In the body of the ISP, the team stated: "It was discussed that the services could be offered in the community that doesn't mean (sic) that she will actually get them 1) in a timely manner 2) changing PCP's (sic) and nursing staff is disruptive to her well-being and continuity of care 3) no amount of "tech" support can replace actual nurses or doctors when it comes to dealing with someone who has serious health concerns. It would be negligent on our part to allow her to pursue community living as an option to getting a quieter environment when what her true desire is just a quieter environment. The QDDP asked [individual] what she wanted to do and she stated that she would like to move to a quieter home on campus versus a community referral at this time." The team then indicated: "The **facility discipline members** (independent of the resident and LAR) determined that [Individual] would benefit from moving to a less restrictive environment at this time. This is based on: [Individual's] supports and services could be met in a less restrictive environment. The IDT will not be making a referral due to: Individual Choice - Individual has been provided information and exposure to community living options, but is not interested in alternative placement... Medical Issues." This was not an accurate summary, and was very concerning. It appeared that the team had concerns about supports available to meet Individual #447's needs in the community, but instead of stating that, and providing a justification, the team recommended community transition, but convinced the individual, whom they indicated in other parts of the ISP could not make informed decisions related to programming, medical, etc., to retract her request to move to the community. ▪ Based on the ISP for Individual #218, the team's conclusion was: "... the team has mixed feelings about whether or not the community setting would be able to provide for all of [Individual's] safety and security needs as effectively as the	

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		SSLC does." This was not a clear recommendation one way or the other, and although some discussion was documented about the reasons for this, it was not clear which team members modified their recommendations from their assessments (i.e., all but psychiatry had said she could be supported in a less restrictive setting). ▪ For Individual #418, although many assessments included statements regarding appropriateness for community transition and all of these indicated that the individual could be served in a more integrated setting, the team concluded the following without justification: "[Individual] would not benefit from moving to a less restrictive environment at this time. This determination is based on the level of services required at this time to ensure his health and safety." ▪ For Individual #255, the assessments that included a statement/recommendation indicated he could be supported in a less restrictive environment. However, the team concluded in the ISP that he could not, due to his medical needs, but no specific justification was provided. ▪ All of the assessments that did include recommendations indicated that Individual #374 could be supported in a less restrictive/more integrated setting. However, without justification, the team concluded: "The IDT considered all information and preferences identified. The facility discipline members (independent of the resident and LAR/family) determined that [Individual] wouldn't benefit from moving to a less restrictive environment at this time. This determination is based on: [Individual] and his family/LAR's desires to continue to live at ABSSLC." This appeared to be the conclusion of the whole team, not one that was separate from the LAR and/or individual. ▪ 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, teams were identifying obstacles, but the lists were not consistently complete, including the identification of the specific reasons for LAR's choice not to pursue transition to the community. Action plans generally were being developed, but they were not sufficiently individualized and often did not address the actual obstacle.	

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		Although team members generally were including statements in their assessments with regard to individuals' appropriateness for community transition, and making recommendations to the individuals and/or LARs, these recommendations most often were not justified. The plans to overcome obstacles to transition were not yet addressing the specific issues related to individuals and their LARs reluctance to consider a referral, and were not individualized. 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 barrier that is not addressed, identifies the supports that are needed, and encourages community participation;	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. DADS 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 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; and 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 last report, teams were making efforts to identify individuals' preferences. As part of the new ISP process, the Facility had begun to utilize the	Noncompliance

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		Preferences and Strengths Inventory. Based on review of the sample of ISP: ▪ All eight of the ISPs reviewed (100%) included a listing of individuals' preferences and strengths. There was some expansion of individuals' preferences beyond items, food, or activities to include routines and interactions with others, which was positive. However, although sometimes these preferences were integrated into action plans, largely, these appeared to be lists of preferences that the teams did not use to further expand individuals' opportunities. 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, etc. ▪ Two of the individuals' teams (25%) had effectively incorporated their preferences into related action plans (i.e., Individual #447 and Individual #418), or 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. ▪ None of the individuals' teams (0%) had effectively incorporated their strengths into related action plans. Strengths were not regularly built upon to address other need areas. <u>Prioritization of Needs and Explanation for Any Need or Barrier Not Addressed</u> Based on a review of sample ISPs and ISP Preparation Meeting documentation: ▪ None of the plans reviewed (0%) included a list of priority needs. ▪ In none of the plans (0%) was an explanation provided of how the team had determined which supports or training needed to be prioritized over other needs. Although the ISP Preparation Meeting documentation now included a list of goals the team had decided upon, no explanation was provided of how the team made these decisions. For example, no rationale was provided regarding why one of the individual's specific needs (e.g., one daily living skill as opposed to another, or a particular medical need) took precedence. ▪ In none of the eight ISPs reviewed (0%) were barriers identified and addressed. Individual #218 had an objective the previous year for a vocational assessment, but this was not completed, and the individual showed minimal interest in the day program activities that had been offered to her. However, besides mentioning that vocational assessments were behind schedule and individuals in this residence were not on the priority list, no plan was developed to overcome the barrier. In addition, although anecdotally, teams were concerned about lack of staffing or transportation to address individuals' needs, careful delineation of barriers to addressing needs was generally not found. Moreover, teams sometimes cited individuals' behaviors or attitudes as preventing them from	

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		participating in activities (e.g., work), but teams had not clearly defined such issues as barriers, and/or implemented plans to address them. <u>Identification of Supports Needed to Encourage Community Integration</u> Based on a review of individuals' ISPs: ▪ None of the eight ISPs (0%) reviewed included specific skill acquisition action plans for implementation in the community. ▪ Eight of the eight individuals' ISPs (100%) included at least one measurable objective to enhance individuals' general participation and integration into their communities. Some plans (e.g., Individual #447 and Individual #418) included a number of objectives designed to provide community opportunities. However, some of these were quite limited (e.g., for Individual #218, the objective was for her to be involved in community activities, and no detail was provided regarding what such activities might entail). Although since the last review, progress was noted, the following problems continued to exist: ▪ 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. Although ABSSLC had made some progress, the Facility remained out of compliance with this provision. Although teams were identifying some preferences and strengths of individuals, these remained limited. In addition, teams were not yet effectively incorporating individuals' preferences and strengths into action plans, or using them creatively to expand individuals' opportunities or address their needs. Prioritization of individuals needs was not evident in the ISPs or ISP Preparation Meeting documentation reviewed. As is discussed in the subsections below, individuals' needs were not comprehensively addressed in action plans. Some of the ISPs reviewed had action plans that addressed community skill acquisition, but they generally did not encourage participation in the community with nondisabled peers.	
	2. Specifies individualized, observable and/or measurable goals/objectives, the treatments or strategies to be employed, and the necessary supports to: attain identified outcomes related to each preference; meet needs; and overcome	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 Facility recognized that this was an area in which additional training and technical assistance was needed. The following summarizes the findings related to action plans: ▪ None of the eight plans reviewed (0%) included a full complement of	Noncompliance

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	identified barriers to living in the most integrated setting appropriate to his/her needs;	individualized goals or objectives and/or strategies to address the array of supports and services the individual required. ▪ None of the plans (0%) included a full set of measurable objectives. ▪ This negatively impacted the intensity of individuals' active treatment and habilitation, the supports they were provided, and the teams' ability to measure progress, or lack thereof. ▪ In the section below that addresses Section T.1.b.1, there is extensive discussion regarding the Facility's status with regard to identifying obstacles to individuals moving to the most integrated setting, and plans to overcome such barriers. This also requires the development of action plans in ISPs. In summary, action plans related to obstacles were not sufficiently individualized, and often did not address the obstacles identified. The following summarizes concerns related to action plans: ▪ As noted in the last monitoring report, ISPs generally included some individualized and measurable goals/objectives, treatments or strategies, and supports. Since the last review of ABSSLC, the scope of these goals and objectives had continued to increase. This was a positive development. Action plans in ISPs continued to include skill acquisition plans, and teams had begun to develop the Integrated Health Care Plans as part of the ISP process. However, it remained a separate document that the team discussed, but the plans developed were not part of the ISP action plans. Generally, specific PBSP objectives were not included, but often only a reference was made to implementation of the PBSP. Similarly, psychiatric plans were noted as having been "approved" in the ISP narrative, but they were not incorporated into the ISP through the inclusion of measurable goals or objectives. PNMPs and nursing protocols were often referenced in IHCPs, but they generally were not individualized and/or presented in measurable ways, including measurable clinical indicators. ▪ Of ongoing concern, the objectives or actions steps for vocational and day program activities were extremely limited, and usually related to attending during certain hours (many of which represented part-time schedules without adequate justification), or "continuing" to work on specific projects or activities. Limited, if any, goals or objectives were targeted towards expanding individuals' day and vocational options or helping them to learn new skills. ▪ Many goals and action steps were not measurable, and at times, included more than one item to be measured. Examples included: "maximize optimal health by minimizing frequency of falls," "encourage fluids," "Behavioral Health will be monitored by Psychology to ensure effective management of current concerns," or "will continue to be offered job opportunities that become available in the workshop and that might be of interest to him." ▪ The plans had begun to include some clinical indicators in the form of	

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		measurable goals. Sometimes, these "goals" were measurable, because the action plan included processes for collecting data, completing laboratory work, etc., and someone was assigned to monitor the information on a regular and specifically stated basis (e.g., for Individual #418, his goals related to weight, cardiac disease, and fluid imbalance, with one missing piece being the baseline information). However, in other instances, it was unclear how the goal would be measured, by whom, and/or how often (e.g., for Individual #418, his choking and constipation objectives/goals). ▪ As is discussed in further detail with regard to Section I, the action plans teams had developed for individuals' at-risk issues did not adequately address their needs, and did not include measurable objectives necessary to determine: a) if the supports outlined were provided as required; or b) whether or not the supports and strategies were having the desired outcome (i.e., were they effective in improving the individual's health, or maintaining his/her current status). ▪ Objectives often were not individualized. For example, in some plans the nursing protocols had simply been copied, and did not appear to have been individualized to address specific needs. ▪ Rights restrictions were another area in which very limited action plans were identified to assist in potentially reducing the need for the restriction. ▪ In most plans, objectives were not seen in relation to staff training requirements. An exception was for Individual #447, in which some of the important training components were included. Some progress had been made in the expansion of the scope of measurable objectives, and efforts clearly were being made to improve the measurability and individualization of objectives and action steps. However, as the Facility recognized, these remained areas in which significant 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;	Based on observations of meetings and team discussions, and review of ISPs, the following comments are made with regard to the comprehensiveness of ISPs: ▪ Integration of various plans (e.g., PBSP, psychiatric treatment plans, crisis intervention plans, etc.) in a measurable way into the ISPs, through, for example, measurable objectives was generally not seen. The counseling plan for Individual #447 appeared to have been integrated through an ISPA, although the documentation was not specific about the team discussion and acceptance of the plan. Although the PNMPs were sometimes identified in action plans and the team "approved" other plans, such as the PBSPs and psychiatric treatment plans, reference usually was not made to the specific plan approved (i.e., by date), and limited, if any, goals/objectives/action steps were included in the ISPs in relation	Noncompliance

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		to the plans. ▪ Delineation was not sufficiently clear of various staff's responsibilities through measurable action steps (e.g., development of plans, ongoing monitoring, staff training, implementation, etc.). The focus tended to be on implementation, and other areas often were missing or not well defined. Frequently action plans simply stated what would happen without detailing all of the steps and the staff who needed to work in an integrated fashion to achieve the stated outcome. ▪ The IHCPs did not consistently include the supports that the team identified in the IRRF. ▪ Most plans included reference to skill acquisition plans, as well as service objectives. Skill acquisition plans were generally included as overall topic areas that the SAPs would cover. It was unclear whether once approved, the teams approved the SAPs, and they were incorporated into the ISP through an ISPA. ▪ In general, individuals' work and day activities, and staffing needs were inadequately defined. Previous reports have provided details about what was missing. None of the eight plans reviewed (0%) integrated all of the protections, services and supports, treatment plans, clinical care plans, and other interventions provided for the individual. The Facility remained out of compliance with this provision. Although the Facility had begun to implement the revised ISP template and process, including the IHCPs, this 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;	The following findings are based on reviews of the sample of ISPs: ▪ For none of the eight ISPs (0%), action plans included adequate timeframes for completion. ▪ For none of the eight ISPs (0%), the roles of the persons identified as responsible were clearly defined. The following summarizes some of the problems noted: ▪ Often two positions were identified as responsible for the completion of the same action step, but it was not clear who was responsible for what. As a couple of examples, when direct support professionals and nursing staff were responsible for "Monitor for skin wounds and impairments and for signs of infection," or direct support professionals and Habilitation Therapies staff were responsible for "[Individual] will be provided with correct texture diet and dining techniques per PNMP," it was difficult to determine for what staff were	Noncompliance

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		responsible, or what the associated timeframes meant. ▪ An issue related to the identification of staff responsible noted was the use of terms "Nursing" or "Habilitation Therapies" as opposed to a specific member(s) of the IDT (e.g., the Nurse Case Manager, or the PT, or OT, etc.). Particularly, when it comes to monthly monitoring of programs/supports, it will be important for one person to be identified. In addition, by using this broad description everyone in a department was responsible, but no specific staff member was responsible, reducing the level of accountability. ▪ Generally, direct support professionals were identified in the action plans as having responsibility for certain components of the plans. 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. For example, as noted above, when direct support professionals and clinical staff were listed as both being responsible for the same action steps, definition was needed of for what the direct support professionals were specifically responsible as opposed to clinical staff. With regard to methodologies in action plans: ▪ In none of the eight plans reviewed (0%) was the methodology sufficiently described for the action plans included. Some of the problems identified included: ▪ Although more of the methodology was included than seen during past reviews, steps were often missing. ▪ As noted above, sometimes methodology was included in the IRRFs for addressing at-risk issues, but the ISPs did not include action plans with the necessary detail. ▪ In addition, as is discussed with regard to Section I, action plans for individuals, identified as being at risk, frequently did not include adequate methodologies to reduce the at-risk factors to the extent possible. The IHCPs 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 for the various steps required to complete the action plans.	
	5. Provides interventions,	Most plans included some practical and functional interventions (e.g., Individual #418,	Noncompliance

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	strategies, and supports that effectively address the individual's needs for services and supports and are practical and functional at the Facility and in community settings; and	and Individual #447). Some of the teams had clearly tried to identify interventions to expand individuals' independence in a functional manner. Some examples included training on the use of the making jewelry, washing their hands, purchasing items, etc. However, none of the eight 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, OT/PT treatment plans, and PBSPs. In addition, as noted in previous reports, 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. None of the eight plans reviewed included a goal related to cooking. None of the plans reviewed included goals related to housekeeping or yard work, which would be typical activities for independent adults. Likewise, because pedestrian safety skills on campus were different than those in the community due to strict speed limits and minimal traffic at ABSSLC, skills that individuals were learning or practicing daily on campus were not practical or functional in the community. In addition, many individuals at the Facility had part-time schedules for work or day activities, and teams did not appear to view timeliness and attendance issues as priorities to be resolved (i.e., in an integrated fashion with assistance from psychology staff, when appropriate). Similarly, lengthy lunch breaks during which individuals went back to their residences did not allow opportunities for individuals to learn to either bring lunch and eat at their work sites or in the vicinity of their activity or vocational setting. These low expectations failed to provide individuals with functional skills to allow successful transition to a community setting, where regular participation in a day program or job would be expected. The different set of rules on campus coupled with individuals' limited exposure to the community could become a disadvantage for individuals who decide to transition to the community. The Facility remained out of compliance with this provision.	
	6. Identifies the data to be collected and/or documentation to be maintained and the frequency of data collection in order to permit the	Based on the review of the sample of ISPs: ▪ None of the eight ISPs reviewed appeared to be driven by a review of objective data for each of the related action plans, and the presence or lack of progress on measurable objectives and outcomes. In reviewing ISPs, often the action steps in the IHCPs identified the frequency of data	Noncompliance

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	objective analysis of the individual's progress, the person(s) responsible for the data collection, and the person(s) responsible for the data review.	collection, but not how frequently the person responsible for reviewing progress and efficacy would review the data. Generally, in the IHCPs reviewed, in the column for "Persons Responsible for Reviewing Progress and Effectiveness & Frequency of Review," the Persons Responsible were identified, but not the "Frequency of Review." 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., goals/objectives related to integrated health care plans, psychiatric treatment plans, PBSPs, etc.). As a result, appropriate data was not being collected to assist teams in decision-making. Although teams discussed data in the context of the IRRF, the data available on the IRRFs varied in quality and comprehensiveness. This is discussed in further detail with regard to Section I. Of ongoing concern was the lack of data presented in the ISP and/or IRRF in relation to SAPs, behavioral health plans (i.e., PBSPs, psychiatric treatment plans, and counseling plans), as well as direct therapy plans. As is discussed below with regard to Sections K and S of the Settlement Agreement processes were not yet fully implemented 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. Since the last review, improvement continued to be seen with regard to data being used to inform some of the at-risk discussions. However, 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. The Facility remained in noncompliance with this requirement.	
F2b	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that goals, objectives, anticipated outcomes, services, supports, and treatments are coordinated in the ISP.	As noted in the previous reports, and based on the current review of ISPs, this was an area that required 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 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.	Noncompliance
F2c	Commencing within six months of	DADS Policy #004.1 at I.C.22 required the ISP to be accessible and comprehensible to	Noncompliance

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	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.	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, such as skill acquisition plans. 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 15 ISPs reviewed, ISPs were found to have been written in the Flesch-Kincaid Readability Level range of 8.9 to 12.2, with an average score of 10.4." 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 ISPs reviewed was the lack of delineation of responsibility for the implementation of the plan. Although as noted above, the role of direct support professionals was becoming better defined, 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). The Facility remained out of compliance with this provision. Additional work was needed to ensure various staff's responsibilities were clearly delineated in easily understood terminology.	
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	Monthly reviews were being completed more consistently than in past reviews. More specifically: ▪ Based on the sample of eight records, one (13%) had timely monthly reviews each month for the previous three months. That one was Individual #418. ▪ For none of the monthly reviews completed (0%), the responsible	Noncompliance

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	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.	interdisciplinary team member(s) for each program or support included in the ISP assessed the progress and efficacy of the related interventions. The reports only included the QDDPs' review of skill acquisition programs, other service objectives at the end of the ISP document (i.e., not in IHCPs or other plans referenced in the ISP), and some brief updates on specific topics (e.g., incidents and allegations, hospitalizations, etc.). No summary was provided with regard to various team members' review of "each program or support included in the ISP." Very brief and not always useful summaries were provided with regard to the action plans that were discussed. ▪ For none of the individuals, a lack of expected progress was noted requiring action. As a result, no assessment could be made of whether necessary action was taken. As noted above, the reviews conducted did not comprehensively address all action plans included in individuals' ISPs. Therefore, it remained unclear if problems existed that should have been addressed. An ongoing concern about the monthly reviews was the lack of data to substantiate individuals' progress or lack thereof. The narrative summaries should provide a description/analysis of the data, so it is clear to the reader what the data means. Moreover, examples are provided in various sections of this report of individuals experiencing changes in status and their teams not taking appropriate action to modify their plans and/or treatment. Numerous examples of this are provided with regard to medical and nursing care, as well as physical and nutritional management supports. Although some progress had been made in timely monthly reviews, the Facility did not yet have an adequate monthly review process in place. The Facility remained out of compliance with this provision.	
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	Previous reports have described training ABSSLC staff underwent with regard to the ISP process. Updates included: ▪ In September 2012, the Supporting Visions: Person-Centered Planning curriculum used at New Employee Orientation (NEO) was updated. Based on documentation the Facility provided, it was first developed in July 2010, rolled out at ABSSLC in October 2010, and new employees continued to attend the training. ▪ On October 8 and 9, 2012, the QDDP Coordinator, Director of Habilitation Therapies, and Chief Nurse Executive provided training to QDDPs and Team members on the ISP process and Risk. The training appeared to cover many of the important components of the process in an understandable way. Again on October 12, 2012, these trainers provided training on the IRRF process using an individual scenario. Although sign-in sheets were provided for both of these	Noncompliance

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	employment, on an as-needed basis, and on a refresher basis at least every 12 months thereafter. Staff responsible for implementing ISPs shall receive competency-based training on the implementation of the individuals' plans for which they are responsible and staff shall receive updated competency- based training when the plans are revised.	training sessions, the number of staff expected to attend and the number that did attend were not included in the documentation the Facility provided in the Presentation Book. ▪ In October 2012, State Office staff/consultants provided the two teams for Residences 6710 and 6500 additional training on the completion of the Preferences and Strengths Inventory, and Pre-ISP Meetings. In January 2013, training regarding the Enhanced Risk Rating system was conducted through State Office. ▪ On 4/24/13, the DADS SSLC QDDP Discipline Coordinator provided training on the ISP to team members. Again, the Facility's Presentation Book provided copies of sign-in sheets, but not numbers of staff who completed or were expected to complete the training. ▪ The Q Construction: Facilitating for Success training was still provided to new QDDPs. This training included a written test that each participant completed at the end of the classroom training. It also included a competency checklist. As indicated in previous reports, as the checklist is implemented, changes likely will need to be made to further define certain competencies, and to ensure reliability across reviewers. The Annual ISP Meeting Preparation Checklist also assessed some of the competencies that QDDPs needed to demonstrate. As the ADDP Coordinator pointed out, it did not identify specifically which indicators were related to a QDDP's competence versus other team members' competence, or define the competency measures. However, it provided a number of important insights into the QDDP's facilitation skills, as well as completion of the ISP document. ▪ QDDPs attended training on other topics. For example, on 11/2/12, they participated in training on Rights Information and Incident Management, and on 3/8/13, the Admissions and Placement Coordinator provided training to the QDDPs. Areas in which additional work was needed to reach compliance with the Settlement Agreement included: ▪ As indicated in previous reports, QDDPs should be required to demonstrate competency in meeting facilitation and the development of an appropriate ISP document. Such competency measures should be clearly defined and include criteria for achieving competence. As noted above, work was underway to address the facilitation component of competency-based training, and the monitoring checklist included some indicators that could be used to assess QDDPs' facilitation skills as well as their skills in finalizing the ISP document. At the time of the review, the QDDP Coordinator recognized that more work was needed, and indicated that none of the QDDPs had been deemed competent. ▪ Competency measures for other team members also should be identified and	

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		used to evaluate whether additional training is needed. ▪ As recommended in previous reports, 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 strengths and 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 the individual's interests, priorities and vision for his/her living arrangements, while reconciling these with the individuals' medical and safety needs. The Facility's Action Plans indicated that efforts were underway or planned to provide training in a number of these areas, including: o Creation of meaningful goals, and measurable and objective action plans; o Tying goal areas to assessment recommendations, as well as ensuring assessments incorporated individuals' preferences and strengths; o Inclusion of plans and assessments into ISP discussion and facilitation, as well as action plans. ▪ This section of the Settlement Agreement also requires: "Staff responsible for implementing ISPs shall receive competency-based training on the implementation of the individuals' plans for which they are responsible and staff shall receive updated competency-based training when the plans are revised." This was an area requiring focused efforts. 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, QDDPs' competence with meeting facilitation as well as the development of the ISP documents should be assessed, 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 often as needed, and shall be put into effect within thirty days of its preparation, unless, because of extraordinary circumstances, the	Based on data the Facility provided, since the last review in August 2012, seven individuals had been admitted to the Facility. All seven individuals' 30-day ISP meetings (100%) had been held within 30 days of their admission. Based on data the Facility provided, 396 ISP meetings were held over the last one-year period. Two ISP meetings occurred after the 365-day timeline. This resulted in a compliance rate of slightly less than 100%. The Facility tracked the dates that ISPs were completed and filed. This involved the QDDPs notifying the QDDP Coordinator of the dates on which ISP documents were completed and sent to filing, and File Clerks notifying the QDDP Coordinator when ISP	Noncompliance

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	Facility Superintendent grants a written extension.	documents were filed. Based on email correspondence provided in the Presentation Book, some lapses had occurred with information coming from the File Clerks. However, the Unified Records Coordinator was working with the QDDP Coordinator and the File Clerks to resolve this issue. For the last one-year period, of the 396 ISP meetings held, 132 of the plans were filed more than 30 days after the ISP meeting. An additional 41 ISPs did not have the file date stamped on them. As a result, an accurate compliance rate could not be calculated. However, it was somewhere between 44% and 67%. A number of steps had been taken to facilitate the completion of the ISP documents within 30 days. This included QDDPs developing draft ISPs before the meetings. In addition, the Facility had assigned QDDP "Buddies" to each QDDP. The QDDP Buddy attended the ISPs of the individuals on the assigned QDDP's caseload, and took notes and/or made changes to the draft ISP. The day after the ISP meeting, the QDDP took a "ghost" day and spent time finalizing the ISP, while the QDDP Buddy helped address any issues that came up on the QDDPs caseload. Facility staff recognized that for the ISP to be "put into effect" within 30 days, the ISP needed to be completed and filed, but actions also were needed to ensure it was being implemented. The Facility had begun to take some other steps to address this, such as checking to make sure skill acquisition plans were developed and in individuals' Individual Notebooks for staff to implement them. 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., hospitalizations resulting in changes to status, etc.). The Facility remained out of compliance with this provision. However, the Facility continued to pursue 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	Progress had been sustained with regard to the implementation of quality assurance processes that identify and remediate problems to ensure that ISPs are developed consistent with this section of the Settlement Agreement. Positive aspects of the process included: ▪ DADS 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.	Noncompliance

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	the ISPs are developed and implemented consistent with the provisions of this section.	▪ A Program Compliance Monitor (PCM) from the QA Department, as well as the QDDP Coordinator, QDDP Educator, QDDP Settlement Agreement Liaison, and three QDDPs were conducting the reviews. At the time of the review, the PCM selected a sample of between four and seven ISP meetings per month with the goal of monitoring each QDDP once per quarter. Two auditors monitored each selected ISP meeting, and then followed it through to completion of the ISP document. Although two staff conducted the monitoring, they did it separately, and then compared results. ▪ As noted in other subsections of this report, the Facility also had mechanisms in place to collect other relevant data, such as the timeliness of the submission of assessments, and attendance at ISP meetings. It was not clear whether or not this information was currently being shared with the QA/QI Council, because it was not included in the Quarterly Section Review of Progress reports submitted. However, based on the 1/14/13 report, it appeared it was early in the process, and the intent was to share it. ▪ A group was meeting approximately monthly to review the results of monitoring activities, and had continued to maintain minutes. This memorialized actions taken, formalized decisions that the group made, and documented recommendations, including persons responsible for their completion. Review of the minutes of these meetings continued to show good collaboration between the QA Department and QDDP Department 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 and other Active Treatment staff 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: ▪ ABSSLC was conducting reviews/audits of ISPs using the Section F – Annual ISP Meeting Preparation Checklist. According to the QDDP Coordinator, ABSSLC was one of a few Facilities that chose to use this tool. It had been revised a couple of times. As noted with regard to the Facility Self-Assessment, although this tool included some valuable indicators more work was needed to ensure: 1) the indicators comprehensively assessed the ISP development process and the final ISP documents; 2) the quality as well as the presence of items was assessed; and 3) the guidelines/instructions provided were sufficient to produce accurate (i.e., valid) and reliable (i.e., congruent between auditors) results. In addition to describing the methodology to be used, the guidelines also should clearly articulate the criteria to be used in assessing compliance. ▪ For the audit tool, inter-rater reliability needed to be established with the QA	

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		and programmatic staff responsible for conducting audits. This will be particularly challenging given the multiple staff responsible for monitoring activities, and it was unclear whether or not the Facility had established a process to do this. More specifically, although inter-rater reliability scores were produced, it was not clear whether inter-rater reliability was being established between all staff responsible, or whomever happened to be paired with one another for a particular month. However, on a positive note, it appeared staff were trying to meet regularly to discuss discrepancies in findings. The staff had figured out that they also needed to conduct reviews at the same time to avoid the problem of records being available to one reviewer, but not the other, resulting in different findings. ▪ In response to a request for reports showing analysis of monitoring/audit data, as well as descriptions of actions taken or corrective action plans developed, the Facility submitted reports entitled: QA/QI Data Summary for the fourth Quarter of Fiscal Year 2012, and the first and second Quarters of 2013; as well as Quarterly Section Review of Progress Section F, dated 11/19/12, and 1/14/13. On a positive note, the QA/QI Data Summaries summarized data from both the QDDP Department and the QA Department. They provided data in graph format, and also summarized the data from the audit tools, as well as the inter-rater reliability scores. Although the majority of the summary was a description of the data (i.e., indicators that fell below the "preset" cutoff of 70%), some limited analysis of the data was beginning to be conducted. Much more was needed, particularly to assist in identifying underlying causes for the problematic trends. The recommendation section included some broad recommendations, such as continuing to meet to address inter-rater reliability, and developing corrective action plans to address deficient areas. Although the QDDP Department had Action Plans for the Settlement Agreement, which generally included some valuable action steps, the Facility reported that no formal Corrective Action Plans had been developed in relation to Section F. The Quarterly Section Reviews provided narrative information that was helpful in identifying accomplishments, challenges, and priority areas for the upcoming quarter. However, they provided no real review of the data being generated through the internal monitoring process or analysis to assist in the development of corrective actions. Although progress had been made, further work was needed to analyze the data, and develop and implement action steps to address concerns identified. Although progress clearly had been made since the last review, when a revised monitoring tool was just being developed and implemented, the Facility remained out of compliance with this provision. It was positive that data was being collected, and some	

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		minimal analysis had begun. However, more work was needed to ensure the comprehensiveness, validity, and reliability of the data, and fully utilize the data for quality assurance purposes.	

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. 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)
4. When an individual has needs in a particular area, but the team is not requiring an assessment, the ISP Preparation Meeting documentation should include a justification that specifies the team's reasons for it decision. (Section F.1.c)
5. 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)
6. 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)
7. The State and the Facility should ensure that person-centered concepts are integrated with the need to develop comprehensive, integrated plans. Many individuals require plans with multiple supports. The State, working in conjunction with the Facility, should figure out ways to have adequate, technical team discussions and incorporate such discussions into comprehensive ISPs, while focusing on the individual and his/her preferences, strengths, etc. (Section F.1.d, F.2.a.1, F.2.a.2, and F.2.a.3)
8. ISPs should integrate the recommendations from assessments, not just reference them, and make the health care, therapeutic, and behavior support plans a part of the ISP, rather than stand-alone documents. The IDT should review and approve all related plans, and the specific plan that has been approved should be referenced in the ISP, including the title and date of the plan. The team should approve any modifications of the approved plans through an ISPA. IDTs also should include a set of objectives in the ISP related to each of the plans, including, but not limited to the expected outcomes for the plans, any related skill acquisition plans, as well as defining what supports need to be implemented, who is responsible, how success will be measured, who is responsible for data collection, as well as who is responsible for monitoring and/or data review. (Sections F.1.d, F.2.a.2, and F.2.a.3)
9. Team members should be provided ongoing training and technical assistance on the interdisciplinary process, including the integration of information and development of strategies to address individuals' preferences, strengths, and needs, and to identify and overcome barriers. (Section F.2.a.1)
10. The Facility should address barriers such as transportation, and ensuring adequate staffing is available to enable individuals to participate in community activities in small groups. Individuals' ISPs should identify these clearly, if they are barriers to providing the individual with adequate supports and services. (Section F.2.a.1)
11. Additional training should be provided on how to develop integrated action plans that draw together the information gathered in assessments, how to analyze that information and incorporate the individual's preferences, and how the priorities can be translated into clear directions for those working with the individual. (Sections F.2.a.2, F.2.a.3, F.2.a.4, F.2.a.5, and F.2.a.6)

12. Individualized, measurable goals and objectives should be defined in individuals' 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)
13. 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)
14. The Facility should be creative in ensuring that skills that are functional in community settings, but are not regularly taught or practiced at the Facility, such as cooking, cleaning, and realistic community safety skills, become a regular part of training programs for individuals served. (Section F.2.a.5)
15. 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)
16. 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)
17. 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. Facility policy and/or procedure should set forth the parameters with regard to actions that will be taken to assist QDDPs who do not originally meet the competency requirements, as well as other steps that would need to be taken if competency could not be achieved. Competency measures for other team members also should be identified and used to evaluate whether additional training is needed. (Section F.2.e)
18. As previously recommended, 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)
19. 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)
20. 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)
21. 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)

22. The Facility's QA processes with regard to ISPs should be refined by improving the instructions as appropriate (i.e., methodologies and standards), training auditors on their use, establishing inter-rater reliability, ensuring the accuracy of monitoring results, fully analyzing data, and developing and implementing corrective action plans, as appropriate. (Facility Self-Assessment and Section F.2.g)

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 during the prior six months, copies of follow-up ISPAs for the following individuals: Individual #87's ISPA 3/14/13, Individual #180's ISPA 1/14/13, Individual #452's ISPA 4/3/13, Individual #197's ISPA 12/17/12, Individual #197's ISPA 3/14/13, Individual #268's ISPA 3/28/13, Individual #301's ISPA 3/14/13, Individual #253's ISPA 2/4/13, Individual #385's ISPA 4/3/13, Individual #287's ISPA 3/7/13, Individual #142's ISPA 3/28/13, Individual #409's ISPA 8/1/12, Individual #211's ISPA 3/14/13, and Individual #16's ISPA 4/1/13; and o For one individual from each residence, copies of all consultant reports (medicine and surgery inclusive of subspecialties) since the Monitoring Team's last visit, all integrated progress notes (IPNs) commenting on consultant reports (agreeing or reason not agreeing), and any ISP addendum related to the consultant report: Individual #250 Neurology 1/10/13, Individual #250 Cardiology 10/4/12, Individual #250 Gastroenterology 11/1/12, Individual #250 Urology 3/1/13, Individual #250 Urology 9/7/12, Individual #250 Dermatology 2/20/13, Individual #250 Dermatology 1/15/13, Individual #250 Dermatology 12/5/12, Individual #250 Gastroenterology 11/16/12, Individual #19 Neurology 2/11/13, Individual #19 Neurosurgery 1/24/13, Individual #19 Neurology 11/27/12, Individual #19 Neurology 11/26/12, Individual #19 Orthopedics 3/6/13, Individual #19 Orthopedics 2/6/13, Individual #19 Orthopedics 1/16/13, Individual #19 Orthopedics 12/27/12, Individual #19 Orthopedics 12/12/12, Individual #19 Orthopedics 12/5/12, Individual #19 Orthopedics 11/29/12, Individual #19 Podiatry 11/20/12, Individual #517 Neurology 10/22/12, Individual #517 Optometry 1/9/13, Individual #517 Cardiology 11/16/12, Individual #517 Podiatry 10/16/12, Individual #180 Ophthalmology 11/17/12, Individual #180 Podiatry 2/19/13, Individual #180 Endocrinology 2/6/13, Individual #480 Optometry 9/26/12, Individual #480 Radiology 1/18/13, Individual #26 Neurology 3/11/13, Individual #26 Urology 10/22/12, Individual #308 Hematology 11/26/12, Individual #308 Hematology 1/7/13, Individual #308 Podiatry 11/20/12, Individual #308 Neurology 10/22/12, Individual #308 Optometry 9/26/12, Individual #283 Gynecology 3/5/13, Individual #306 Neurology 11/12/12, Individual #306 Dermatology 2/20/13, Individual #306 Dermatology 1/16/13, Individual #306 Dermatology 10/3/12, Individual #306 Dermatology 3/20/13, Individual #268 Neurology 2/11/13, Individual #268 Cardiology 12/7/12, Individual #462 Podiatry 1/15/13, Individual #462 Urology 1/4/13, Individual #462 Urology 12/7/12, Individual #462 Gastroenterology 12/4/12, Individual #462 Cardiology 1/2/13, Individual #462 Ophthalmology 2/13/13, Individual #462 Optometry 1/30/13, Individual #462 Ophthalmology 10/4/12, Individual #462 Optometry 8/15/12, Individual #492 Surgery 10/3/12, Individual #492 Gastroenterology 9/20/12, Individual

	#343 Neurology 2/11/13, Individual #343 Neurosurgery 1/15/13, Individual #343 Neurology 1/14/13, Individual #343 Neurosurgery 12/29/12, Individual #343 Neurosurgery 1/8/13, Individual #343 Neurology 11/13/12, Individual #343 Neurology 10/22/12, Individual #343 Podiatry 10/16/12, Individual #529 Podiatry 11/20/12, Individual #529 Gynecology 11/28/12, Individual #215 Neurology 3/11/13, Individual #215 Neurosurgery 10/30/12, Individual #215 Neurology 12/10/12, Individual #215 Urology 12/19/12, Individual #215 Urology 12/7/12, Individual #159 Ophthalmology 1/22/13, Individual #159 Podiatry 2/19/13, Individual #159 Hematology 2/4/13, Individual #159 Hematology 12/17/12, Individual #159 Rheumatology 1/7/13, Individual #159 Rheumatology 10/5/12, Individual #159 Rheumatology 11/1/12, Individual #159 Rheumatology 3/18/13, Individual #141 Optometry 11/14/12, Individual #141 Allergy 3/6/13, Individual #148 Neurology 3/11/13, Individual #148 Neurology 12/10/12, Individual #148 Orthopedics 1/31/13, Individual #148 Orthopedics 1/16/13, Individual #148 Orthopedics 12/20/12, Individual #148 Orthopedics 12/7/12, Individual #148 Gastroenterology 1/4/13(?), Individual #165 Neurology 9/10/12, Individual #165 Podiatry 9/18/12, Individual #165 Cardiology 9/24/12, Individual #165 General Surgery 10/22/12, Individual #165 Psychiatry 1/11/13, Individual #165 Dietary 12/11/12, Individual #377 Neurology 3/11/13, Individual #377 Neurology 12/10/12, Individual #377 Neurology 2/11/13, Individual #377 Neurology 1/28/13, Individual #377 Neurology 10/22/12, Individual #377 Dermatology 10/3/12, Individual #182 Neurology 1/10/13, and Individual #182 Genetics 10/2/12. ▪ **Interviews with**: o Richard Chengson, MD, Medical Director; and o Elizabeth Greer, RN, Medical Program Compliance Monitor. ▪ **Observations of:** o Quality Assurance/Quality Improvement Council, on 5/6/13.
	Facility Self-Assessment: For Section G, in conducting its self-assessment: ▪ The Facility did not use monitoring/auditing tools, except the same audit tool used for Section L.2. For Section G.2, the internal general medical audit was used to assess tracking of follow-up of consultation recommendation. ▪ The Facility used some other relevant data sources and/or key indicators/outcome measures that contributed to an awareness of whether or not the intended outcomes of the Settlement Agreement were being reached. However, the quality of the data maintained in the databases could not be determined for completeness or accuracy. There appeared to be few databases, such as annual medical assessment tracking, quarterly medical review tracking, and attendance tracking at ISPs. ▪ Examples of databases/data sources that were not available and/or used as part of the self-assessment included tracking IDT referrals for ISPAs, and consultation reports discussed at the morning medical meetings. The Medical Department had not yet begun to track the quality of the information in the referral note to the consultant. Many areas of the active medical record remained in need of active monitoring (e.g., quality and completeness of family history, preventive

	care flow sheet updates, etc.). ▪ The Facility presented data in a meaningful/useful way, but had little data to present. Additionally, the Facility appeared not to go beyond the indicators in the medical peer review audit. This is considered a start, and an example of the audit process and audit tools, but the Facility needs to expand the content to every area of integrated clinical services. Specifically, the Facility's Self-Assessment: o Presented a limited set of data, and only audit results from the medical peer review audit. o Consistently did not measure the quality as well as presence of items. o The QA Department did not participate in the Medical Department QA process other than follow-up of corrective actions from the external and internal medical review audit. This was due to the lack of departmental quality indicators developed to allow review of other areas of medical services. ▪ The Facility rated itself as being in noncompliance with Section G. This was consistent with the Monitoring Team's findings. ▪ For those areas of need, the limited scope of the Facility Self-Assessment did not provide an analysis of the information to guide the Medical Department.
	Summary of Monitor's Assessment: The challenge remained for the Facility to provide evidence of integrated clinical services. There had been collection of data related to attendance at the morning medical meetings and at ISPs, but the Facility presented little other evidence to show integrated clinical services. For example, the minutes of the morning medical meeting did not reflect integrated clinical discussions amongst the relevant departments. Based on observations, such discussions did occur, but at times were not reflected in the minutes. The IDTs appeared not to develop ISPAs in response to hospitalizations, and Primary Care Providers' (PCPs') attendance rate at post-hospitalization ISPAs was not tracked. PCPs' attendance and guidance at these meetings was critical. The consult request form had been revised to include more space for pertinent history and questions, and the Settlement Agreement Compliance Physician tracked this to ensure completion. Although this was positive, problems remained with PCPs signing consultant reports to show they had reviewed them, indicating their agreement or not with recommendations in consultant reports, following up with IPNs and/or ISPA meetings. Minimal progress was noted, and the Facility remained out of compliance with this section.

#	Provision	Assessment of Status	Compliance
G1	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall provide integrated clinical services (i.e.,	A sample of morning medical meeting minutes was requested for the week prior to the Monitoring Team's visit. These documents were not submitted. A member of the Monitoring Team attended three morning medical meetings, and three sets of minutes were submitted. These are discussed with regard to Section L.1.	Noncompliance

	general medicine, psychology, psychiatry, nursing, dentistry, pharmacy, physical therapy, speech therapy, dietary, and occupational therapy) to ensure that individuals receive the clinical services they need.	Membership at the morning medical meeting was formalized in a policy entitled "ABSSLC Participation in Morning Medical Meeting," approved 3/18/13 and implemented 4/1/13. This policy identified who was expected to attend. Membership included several departments, including the Medical Department, Nursing Department, Psychiatry Department, Dental Department, Nursing Administration, Infirmary Nurse, Habilitation Services/Physical and Nutritional Management Team (PNMT), Pharmacy, Psychology, QDDP Department, Unit Director, Direct Support Professionals (DSPs), Hospital Liaison Nurse, QA Department, Laboratory, and Infection Control. The policy provided an order to the agenda and the minutes. Attendance tracking was submitted from September 2012 through March 2013. Specific staff and departments were followed by the percentage attendance in September 2012 followed by the percentage attendance in March 2013. The following information was from the September 2012 and March 2013 graphs. ▪ Medical Director: 84%/81% ▪ PCPs: 53% to 100%/67% to 95% ▪ Psychiatry: 68%/0% ▪ Dental: 79%/81% ▪ Medical Program Compliance Monitor (PCM): 42%/90% ▪ Nursing: 53%/67% ▪ Charge nurse: 95%/71% ▪ PNMT: 84%/81% ▪ Pharmacy: 95%/62% ▪ Psychology: 37%/0% ▪ QDDP: 100%/95% ▪ Unit Director: 84%/81% ▪ Direct Support Professional: 95%/81% ▪ Hospital Liaison Nurse: 68%/52% ▪ QA: 0%/67% ▪ Lab: 16%/14% ▪ Infection Control Nurse: 16%/19% ▪ Dietary: 11%/0% This indicated a wide spectrum of participation. However, despite the policy and focus on integrated services, several departments had challenges in being able to attend. Some had improved attendance. The variation within a department over time might reflect vacancies in the department. As discussed while the Monitoring Team was on site, the Facility needs to ensure that the morning meetings are meaningful and have necessary participation, while not having unnecessary attendance. For example, other Facilities were not requiring attendance by certain representatives every day (e.g., psychiatry, dental, PNMT, etc.), but had developed a schedule to ensure that these groups were represented periodically (e.g., weekly or bi-weekly), and, if more urgent issues surfaced	

in between, the discipline-specific representatives could be asked to attend. Such a schedule allowed regularly structured time for these groups to make presentations, provide input, and address any systemic issues, while at the same time making good use of everyone's time.

Submitted was a document entitled "ISP Attendance/Assessment tracking database, attendance data on 101 annual ISP meetings held from 1/1/2013 thru 3/31/13; recorded clinician attendance at required annual ISPs from the following disciplines." The following information was provided in this document, with the department, followed by the attended number of meetings compared to the total required meetings, followed by percentage compliance:

- Medical: 71/65 = 92%;
- Psychology: 48/53 = 91%;
- Psychiatry: 29/32 = 91%;
- Nursing: 95/96 = 99%; and
- Dental: 27/35 = 77%.

Other departments listed included Speech, Occupational Therapy (OT), Physical Therapy (PT) and Dietary Services. This was the same data provided in the Facility Self-Assessment.

Bar graphs were provided for "ISP Required Attendance Compliance" for January 2013, February 2013, and March 2013. Twenty-five members of the IDT were tracked at the ISPs. The following attendance rates per month were noted for specific departments/staff:

Department	January 2013	February 2013	March 2013
PCP (Medical)	100%	82%	88%
Dental	60%	100%	75%
Pharmacy	0%	0%	50%
Psychiatry	94%	92%	75%

Core attendance at the PNMT meetings was tracked from 8/20/12 through 3/20/13. Five of six participants [i.e., nurse, PT, OT, Speech and Language Pathologist (SLP), Registered Dietician/Licensed Dietician (RD/LD)] attended over 90% of all meetings. The PCP only attended 5%. To resolve this situation, the Settlement Agreement Compliance Physician became a participant at the meeting.

The Facility was asked to submit ISPAs for hospitalizations that occurred during the six months prior to the Monitoring Team's visit. Fourteen ISPAs were submitted, but only six of these ISPAs focused on post-hospitalization. The other eight involved concerns

		unrelated to hospitalizations, such as counseling. Of the 69 hospitalizations, from October 2012 through mid-March 2013, from a list the Facility provided, only one post-hospitalization ISPA was submitted. There were five other ISPAs concerning post-hospitalization from 3/28/13 through 4/3/13. Of the six ISPAs discussing post-hospitalization, two of six (33%) discussed triggers and events prior to the incident. Three of six (50%) discussed preventive steps to reduce the risk of re-hospitalization. One discussed the need for increased monitoring. The absence of ISPAs following a hospitalization, with focus on record review for triggers and events prior to the illness or injury, and preventive steps to be implemented to reduce the risk of recurrence indicated this aspect of IDT involvement and response to meeting the health and safety of the individuals had not occurred. Attendance of PCPs at annual ISPs was tracked. However, attendance at post-hospital ISPA meetings was not tracked, even though this represents a time when PCP input is essential. It is recommended that PCPs' participation in post-hospital ISPAs be tracked. An in-service was provided to six PCPs on 4/9/13 in which the role of PCPs in writing orders for PNMT recommendations was reviewed. These recommendations were to be signed and dated at time of review, with an IPN in which the PCP agreed or disagreed with the recommendations along with rationale. These reports were to be processed similar to other consultation reports. This was a positive effort to increase the collaboration between PCPs and the PNMT. However, it will be important to follow-up to ensure that completion of orders and/or IPNs for PNMT recommendations that require a PCP order. One way to do this would be through an audit of a sample for each PCP. ABSSLC had made limited progress in this area. Although some disciplines' attendance at ISP and PNMT meetings was improving, the Facility was still struggling with ensuring adequate and well-planned attendance at morning medical meetings. In addition, documentation was not presented to show that IDTs, including individuals' PCPs, were conducting meaningful reviews of individuals that experienced hospitalizations to identify triggers and/or preventative measures to try to prevent future hospitalizations.	
G2	Commencing within six months of the Effective Date hereof and with full implementation within two years, the appropriate clinician shall review recommendations from non-Facility clinicians. The review and documentation shall include whether or not to adopt the recommendations or whether to	The Facility submitted consultant reports from the prior six months for one individual from each residence, as well as any IPNs commenting on the consultant reports. Consultations for 21 individuals were submitted, with a range of one to 12 consultations per individual. A total of 102 consultant reports were submitted. These are listed above in the documents reviewed section. Review of these documents revealed the following: ▪ Of the 102 reviewed, 77 (75%) included the PCP initials, indicating review by the PCP. ▪ Of the 102 reviewed, 78 (76%) included the date on which the PCP conducted the review.	Noncompliance

	refer the recommendations to the IDT for integration with existing supports and services.	▪ To determine whether there was agreement or not concerning consultant recommendations, follow-up IPNs and ISPAs were requested. When submitted, these were reviewed. o Of the 102 reviewed, 30 (29%) consults included documentation of agreement or not with the consultant recommendations. o Of these 102 reviewed, 45 (44%) included PCP IPN entries. ▪ Of these 102 reviewed, 10 ISPAs were submitted which discussed one or more aspects of the consultation. Not all of the 102 consultation reports required an ISPA follow-up. On a positive note, to ensure the consultant responded to the needs of the individual, the consultant request sheet was revised to include more space to include a detailed history, with specific concerns to be addressed. The Settlement Agreement Compliance Physician monitored this. The Facility remained out of compliance with this provision. In addition to problems with the PCPs conducting and documenting their review of consultation reports, there was a lack of PCP IPN entries, as well as a lack of ISPAs for individuals for whom this was indicated based on the recommendations in the consultations.	

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

1. PCP attendance at post-hospital ISPAs should be required, unless justification is provided for their not attending, and tracked. (Section G.1)
2. In addition to assessing the completion of PNMT recommendations that require a PCP order, the quality/completeness of the orders/IPNs should be assessed and feedback provided, as appropriate. (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 four individuals from each PCP's caseload, four diagnoses identified from the active problem list of the most recent annual medical assessments, with criteria for justification from the active record, including copies of supporting documentation, for the following individuals: Individual #122, Individual #105, Individual #300, Individual #209, Individual #528, Individual #92, Individual #485, Individual #454, Individual #394, Individual #276, Individual #197, Individual #212, Individual #315, Individual #546, Individual #18, Individual #430, Individual #287, Individual #525, Individual #353, Individual #469, Individual #468, Individual #386, Individual #64, and Individual #103. ▪ **Interviews with**: o Richard Chengson, MD, Medical Director; and o Elizabeth Greer, RN, Medical Program Compliance Monitor.
	Facility Self-Assessment: For Section H, in conducting its self-assessment: ▪ The Facility did not use monitoring/auditing tools other than the external medical and medical management audit tools discussed with regard to Section L.2. o The Facility used some other relevant data sources and/or key indicators/outcome measures that had limited scope to determine whether the intended outcomes of the Settlement Agreement were being reached. o The quality of the data maintained in the databases was not evaluated. o Examples of databases/data sources that were not considered included osteoporosis evaluation and treatment, and other clinical areas beyond the external medical management audit. o The Facility consistently presented data in a meaningful/useful way, but did not include the many clinical areas needed. Specifically, the Facility's Self Assessment: • Had limited information to present. • Did not measure the quality as well as presence of items. o The Facility rated itself as being in noncompliance with all of the sub-sections of Section H. This was consistent not with the Monitoring Team's findings. The Monitoring Team found the Facility to be in compliance with Section H.2, related to accurate diagnoses. o For those areas of need, the Facility Self-Assessment did not provide an analysis of the information.
	Summary of Monitor's Assessment: The Facility had a limited database related to the Medical Department. Tracking was possible of the timeliness of annual medical assessments and quarterly medical reviews. Little information was available regarding how the information from these limited databases

	were analyzed and at what frequency to provide guidance to the PCPs. The Facility continued to focus on the external general medical, and medical management audit indicators. Although these were an important start, they should lead to monitoring of all aspects of medical care. On a positive note, the Settlement Agreement Compliance Physician was developing a foundation for compliance with Section L, which also was having a positive effect on Section H. The PCPs had completed an in-service on the clinical guidelines the State Office developed. They also had been in-serviced on the general medical audit and medical management audit indicators to ensure the PCPs were changing their clinical practices. Other clinical indicators had been identified that focused not on the PCP quality care role, but on the outcome for the individual. However, these indicators had not been incorporated into a monitoring tool or data collection system at this time. It will be important for information management systems to be set up for this section to track many areas of clinical care (e.g., osteoporosis management, reasons for transfer to the ER, etc.). Measuring quality of care by quantifying the outcomes for individuals as well as the types of clinical supports and expertise provided for a diagnosis would reflect the requirement of this section – minimum common elements of clinical care. As more diagnoses are added to the database, documentation of services provided to the individual for specific diagnoses should reflect the minimum common elements required. The Facility was in substantial compliance with Section H.2. The Facility remained noncompliant with other subsections of this Section.

#	Provision	Assessment of Status	Compliance
H1	Commencing within six months of the Effective Date hereof and with full implementation within two years, assessments or evaluations shall be performed on a regular basis and in response to developments or changes in an individual's status to ensure the timely detection of individuals' needs.	Based on documents the Facility submitted, several routine and periodic assessments were reviewed for timeliness for several clinical departments. These included: ▪ Three hundred nineteen of 393 (81%) of the medical annual assessments were completed in a timely manner. For 21 of the most recent medical annual assessments, completion within 365 days of the prior assessment was 19 out of 21 (90%). A review of nine active records indicated that a medical annual assessment had been completed in the last 365 days in eight of nine (89%). ▪ Three hundred sixty nine of 378 (98%) dental annual evaluations were completed in a timely manner. ▪ During the past two quarters, 100% of Quarterly Drug Regime Reviews (QDRRs) were completed in a timely manner. ▪ As discussed with regard to Section J.6, the Facility's internal compilation of individuals with completed Comprehensive Psychiatric Evaluations (CPEs), including the corresponding data for Psychiatric Treatment Plans (PTPs) that served as annual CPE updates, indicated that from 5/1/12 through 4/30/13, these documents had been completed for 153 (84%) of the 182 individuals prescribed psychotropic medication.	Noncompliance

#	Provision	Assessment of Status	Compliance
		The Medical Department had a database to track completion of annual medical assessments as well as quarterly medical reviews. However, the frequency with which this information was reviewed, and shared/documented with the PCPs was not determined. As discussed with regard to Section P.1 related to OT and PT assessments: ▪ None of 15 (0%) individuals' OT/PT assessments and/or updates were dated as having been completed at least 10 days prior to the annual ISP. ▪ Eight of the 15 individuals in Sample P.1 had experienced a change in status. None of eight (0%) individuals had received an assessment update that was current within 12 months for individuals who were provided PNM supports and services. With regard to speech and language assessments, as discussed with regard to Section R: ▪ Five of 10 individuals' SL assessments (50%) in the sample reviewed were dated as completed at least 10 working days prior to the annual ISP. In addition, nursing assessments of changes of status resulting in hospitalizations remained problematic. This is discussed in detail with regard to Section M.1. Based on the low number of ISPAs generated from hospital admissions (as discussed with regard to Section G.1), the IDTs did not appear to have reviewed changes in an individual's needs when there was a change in health status. Based on meeting minutes and observation of the morning medical meeting, PCPs did appear to react rapidly in response to health status change. If an individual was admitted to the Infirmary, there was discussion the next business day concerning background information, findings, a critical review including differential diagnosis, and a plan of action. On-call PCPs reported findings over the past 16 hours at the next morning medical meeting, and the discussion with the assigned PCP led to prompt clinical review and plan of action (i.e., evaluation, treatment, consultation, etc.). The Facility remained out of compliance with this provision. Although some annual and quarterly assessments were timely, others were not. In addition, assessment of changes of status, particularly with regard to nursing services, remained a significant 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	A sample of diagnoses listed in individuals' active problem lists was submitted. The sample was derived from four active records from each PCP's caseload, for individuals for whom annual medical assessments were most recently completed. All six PCPs submitted the required information. The PCPs were asked to provide the criteria or evidence used to determine whether the diagnoses clinically fit the information in the	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	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.	corresponding assessments or evaluations. Evidence was provided through various sources (e.g., consultant reports, test reports, etc.). For 24 of 24 (100%) diagnoses selected, criteria/evidence was submitted as supportive documentation for the listed diagnoses. The Facility indicated there was no in-service of PCPs concerning International Classification of Diseases (ICD) and Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnostic criteria in the prior six months. Although not necessary for compliance, it would be helpful training for PCPs to have. As discussed in detail with regard to Sections J.2 and J.6, based on the sample reviewed for Section J, there was adequate clinical justification for the diagnosis of record for 27 of the 27 individuals (100%). With the completion of Comprehensive Psychiatric Evaluations, annual Psychiatric Treatment Plans, and ongoing quarterly updates for everyone prescribed psychotropic medication, the Facility had improved its diagnostic practices related to psychiatric disorders. Based on the consistency between the diagnoses and the assessment documentation for both medical and psychiatric diagnoses, the Facility was found to be in substantial compliance with this provision.	
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.	One of the new initiatives in the Medical Department was to update the annual medical assessment to ensure that the Active Problem List included the diagnosis of "intractable seizure disorder," if applicable, using criteria developed by the State Office. Another initiative was the addition of dosages of medications, along with indications, to the medication list of the annual medical assessments. A third initiative, to ensure timely review and intervention planning at the time of the annual medical assessment, was a more thorough plan of care (identified as "Discussion of significant problems") in the annual medical assessment. This allowed a succinct review of each significant diagnosis, the current status, and any plans for further intervention. On 3/1/13, the Medical Director provided an in-service, which reviewed the documentation necessary to ensure treatments and interventions were timely and appropriate to the diagnosis. This was entitled "#17. Medically appropriate diagnostic tests and/or therapeutic procedures ordered." As a first step to ensure all the PCPs had the basic knowledge and expectations of diagnosis and treatment of common conditions at ABSSLC, a series of in-services were provided to review the clinical guidelines developed by the State Office. In-services were held for "Reducing the Risks for Aspiration Pneumonia for the PCP: Aspiration Guidelines from State Office" on 3/9/13, "Constipation/Bowel Management" on 4/9/13, "Seizure Management Instructions for the PCP" on 3/26/13, "Urinary Tract Infection" on	Noncompliance

#	Provision	Assessment of Status	Compliance
		4/16/13, "Osteoporosis Guidelines for the PCP" on 4/16/13, "Diabetic Ketoacidosis and Hyperosmolar Hyperglycemic State for the PCP: Hypoglycemia for the PCP" on 4/23/13, and "Preventive Health Care Guidelines 8/30/11" on 11/30/12, 12/7/12, and 2/1/13. Although these were positive steps, the Facility did not yet have a mechanism to determine if the full range of treatments and interventions were timely and clinically appropriate. The Facility remained out of compliance with this provision. It is recommended that in-service of common conditions continue to occur. The focus should not only be these indicators, as listed in the external medical management peer review audit, but on a number of other common conditions, and conditions that lead to hospitalization, ER visits, and Infirmary admissions.	
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.	To further improve compliance with these areas, the indicators from the external medical management peer review audits were reviewed during formal in-service training. Each component was listed and discussed to ensure the PCPs were aware of the audit indicators and were changing clinical practice to include these areas. In-services were held for the following clinical indicators on the following dates: ▪ "Aspiration" on 3/19/13; ▪ "Diabetes Mellitus" on 3/8/13; ▪ "Seizures" on 3/8/13; ▪ "Urinary Tract Infection" on 3/8/13; ▪ "Osteoporosis" on 3/6/13; and ▪ "Constipation" on 3/6/13. Additional quality indicators (based on recommendations from the Agency for Healthcare Research and Quality and Physician Consortium for Performance Improvement) were identified but had not been part of a monitoring schedule: ▪ "Quality Indicators for Constipation;" ▪ "Quality Indicators for Diabetes;" ▪ "Quality Indicators for Osteoporosis;" ▪ "Quality Indicators for Seizures;" ▪ "Quality Indicators for Hypertension;" ▪ "Quality Indicators for Metabolic Syndrome;" ▪ "Quality Indicators for Down Syndrome;" and ▪ "Quality Indicators for ER/Hospital Visits." As discussed in previous reports, the 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.	Noncompliance

#	Provision	Assessment of Status	Compliance
		The Facility was in the initial stages of identifying and implementing clinical indicators to assess the efficacy of treatments. ABSSLC remained out of compliance with this provision.	
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.	From the data the Facility provided from the past year and as detailed with regard to Section L.1, there were 227 of 585 (39%) timely medical quarterly review notes for the past two quarters. From an active review of nine records, there were 14 out of 27 (52%) quarterly medical reviews, but there appeared to be less in the first quarter of 2013 than in the prior quarter. For the prior two quarters, 100% of QDRRs were current. The morning medical meeting was currently in a development phase. It was the forum in which change of status was identified, reported, discussed, and followed to closure. However, there were several components that had not been developed, such as open record reviews by the Nursing Department to identify early signs and symptoms of illness, referral to the IDT for an ISPA for specific concerns, and review and follow-up of consult reports. The lack of ISPAs for individuals hospitalized could indicate teams might not have knowledge of current health concerns/changes, or might not respond in a timely manner to ensure the health and safety of the individual. Although the ISPAs following hospitalizations were requested, few ISPAs were submitted. The presence of a significant number of pressure ulcers might indicate preventive steps were not in place, and/or that once identified, analysis of health and environmental issues did not occur. In January 2013, the Skin Integrity Committee began to meet to assist in resolution of the number of pressure ulcers at ABSSLC. The lack of data, and conflicting data required in-service education concerning the basics of definitions of pressure ulcer staging and location to determine the prevalence of this condition at ABSSLC. Based on the presentation the Monitoring Team observed during the QA/AI Council meeting, the issues related to valid data had not been resolved. Monitoring of health status should include a focus on preventive steps to ensure health status is maintained. When individuals' health status changes, early intervention is necessary to minimize long-term sequelae of acute illness, and prevent permanent physical and functional loss when possible. 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	Noncompliance

#	Provision	Assessment of Status	Compliance
		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.	As the PCPs had recently completed in-service training on specific common clinical conditions, clinical indicators for these conditions were to be used to assess care from the perspective of PCP documentation (i.e., ordering of tests, etc.) The additional quality indicators mentioned appear to focus on the health of the individual. However, these indicators had not been used at this point. Data collection from these quality indicators would potentially be used to maintain current treatment or indicate a need to change treatment. 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. The Facility remained out of compliance with this provision.	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.	There was one process developed that was inter-disciplinary and provided guidance on the use of medical and dental restraints. This was submitted and entitled "Process for Medical Restraint Plans (for Medical and Dental)." No policies, procedures, or guidelines were submitted for integrated clinical services that had been implemented. 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 were in place and were 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	Noncompliance

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		health status will require clinical acumen and integration of clinical disciplines. To ensure there is no overlap and to improve efficiency and effectiveness, the Facility should provide the framework and clarify the roles of the various clinical departments in ensuring all aspects/elements of quality clinical care. 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. The Facility remained in noncompliance with this provision.	

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

1. 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. Quarterly reports should be generated, including trend analysis and a description of quality initiatives based on this information. (Section H.1)
2. Acute illness resulting in a hospitalization should be tracked to determine whether an ISPA was created, included the necessary changes/interventions, and was timely. (Section H.1)
3. The conversations concerning health status change (e.g., Infirmary admissions, ER visits, hospitalization admissions and discharge, on–call events, etc.) at the morning medical meeting should be quantified and tracked, as they reflect the response from the PCPs. (Section H.1)
4. In-service of common conditions should continue to occur. The focus should not only be the indicators listed in the external medical management peer review audit, but on a number of other common conditions, and conditions that lead to hospitalization, ER visits, and Infirmary admissions. (Section H.3)
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 6/18/12; o ABSSLC's Self-Assessment; o ABSSLC's Section I Presentation Book; o ABSSLC At-Risk Individuals list; o The following documents: Integrated Risk Rating Forms (IRRFs), Action Plans for Risk Assessments, ISPs and/or ISP Addendums, Comprehensive Nursing Assessments, and Health Management Plans/Integrated Health Care Plans (IHCPs) for the following individuals: Individual #418, Individual #199, and Individual #545 for weight issues; Individual #383, Individual #463, and Individual #55 for seizures; Individual #217, Individual #315, and Individual #127 for dental issues; Individual #226, Individual #535, and Individual #37 for fluid imbalance; Individual #165 for choking; Individual #138, and Individual #26 for urinary tract infections; Individual #76, Individual #27, and Individual #146 for skin issues; Individual #297, Individual #447, and Individual #493 for infections; and o For the following individuals' active records, selected documents: 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, MRIs, ultrasound reports, hospital discharge summaries past one year, ER reports past one year, consults and procedure reports past one year, DNR forms if applicable, physician orders past one year, most recent PSP/ISP and subsequent addendums, most recent BSP, past three medical quarterly reviews, integrated risk rating form (IRRF) past one year, risk action plan past one year for the following individuals: Individual #119, Individual #413, Individual #311, Individual #97, Individual #524, Individual #465, Individual #493, Individual #386, and Individual #14. ▪ **Interviews with**: o Amy Jo Bramlett, LVN, At-Risk Coordinator; and o Cathy Northrup, RN, MSN, CPN, Chief Nurse Executive. ▪ **Observations of**: o ISP Meeting for Individual #241, on 5/8/13; and o ISP Meeting for Individual #49, on 5/9/13;
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section I. In its Self-Assessment, for each subsection, 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 process of reviewing and modifying its monitoring tool for Section I. In doing so, the Facility should

include all the provisions of the Settlement Agreement for the different subsections of Section I. Based on a review of the Facility's Self-Assessment:

- Many of the metrics/indicators used by the Facility for this section, were not in alignment with the Monitoring Team's metrics/indicators. As the Facility continues to revise its monitoring tools, the Facility is encouraged to continue to review the Monitoring Team's report to identify indicators that are relevant to making compliance determinations. In addition, the Facility should include adequate instructions addressing methodologies to be used with regard to specific indicators, such as observations, record reviews, and specific criteria for compliance. Without adequate instructions, it is likely that different auditors would, for example, look at different documents, or different portions of documents in conducting their reviews resulting in inaccurate data. In addition, further definition is needed with regard to the criteria auditors should use to rate the various indicators. Thus, there is a need for clear instructions for all monitoring tools and the establishment of inter-rater reliability to ensure the data generated from the tools are an accurate reflection of the area being audited.
- Regarding identifying the sample and sample sizes, a description of the process for determining how the total population from which the samples were pulled (e.g., everyone with a completed risk rating tool, individuals identified with high-risk ratings, etc.) will be necessary to determine the relevance of the data. After clearly identifying the total population (N) used to define the sample selected, (n), an adequate sample size would be needed to consider the data representative of the actual practices being monitored.
- Regarding the monitoring for Section I, in order for the Facility to generate accurate data reflecting the clinical quality of the supports provided and documentation maintained, auditors for this area should be deemed competent in the use of the tools and deemed programmatically/clinically competent in the relevant area(s). As noted during several past reviews and in the Monitoring Team's previous 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. In order to ensure the accuracy of the data, the Facility should evaluate who would best audit this highly clinical area.
- Adequate inter-rater reliability should be established for the final Section I monitoring tool.

- Due to the lack of an adequate written procedure addressing the process of developing and implementing monitoring tools, lack of established inter-rater reliability, and overall data presentation, at the time of the review, the Facility did not yet have a consistent system for presenting data in a meaningful/useful way. Specifically, the Facility's Self-Assessment:
  - Did not present most findings based on specific, measurable indicators. For example, the Facility needs to be clear regarding what specific criteria had been used to determine compliance. In addition, items contained on the monitoring tool should not include more than one item, making it impossible to determine which of these requirements was found to be in compliance and which had not.
  - Did not measure the quality of the documentation versus merely the completion of the documentation.

	The Facility rated itself as being in substantial compliance with none of the subsections of Section I. This was consistent with the Monitoring Team's findings. However, the Monitoring Team's findings addressed the quality aspect of the supports provided and documentation reviewed. In reviewing the Monitoring Team's report, the Facility should determine how it will assess quality, and also identify reasons for any compliance score discrepancies found between the Monitoring Team and the Facility's data.
	Summary of Monitor's Assessment: Since the last review, the Facility reported that in September 2012, they had begun the implementation of the revised At-Risk Process using two teams from Residences 6500 and 6720. In November 2012, additional new revisions to the process were implemented, and in January 2013, training regarding the Enhanced Risk Rating system was conducted. In April 2013, the SSLC QDDP Discipline Coordinator provided additional training regarding the ISP Process. In addition, in January 2013, the Facility began using a revised Integrated Risk Rating Form that included sections addressing the History, Current Supports, Current Status, Proposed Recommendations, Team Deliberations, Final Recommendations, and the Risk Rating. Regarding some of the Facility's auditing data for Section I, the Monitoring Team noted that the Facility was incorporating a few of the metrics/indicators the Monitoring Team used for this area. However, most were not in alignment with the Monitoring Team's metrics/indicators. Since the initiation of the At-Risk system, numerous changes had occurred, and as a result, the documentation submitted varied and continued to include many deficiencies. Specifically, the quality of the IRRFs varied, and the Integrated Health Care Plans generally were of poor quality. The overall lack of clear documentation included in the ISPs, the IHCPs, and the associated disciplines' assessments regarding specific actions that were taken in response to pertinent events or health issues, and the lack of supporting documentation addressing actions and completion of actions continued to negatively impact the supports that were planned for and provided to individuals, and made the Monitoring Team's review of the Enhanced At-Risk system difficult. Although from the ISP meetings the Monitoring Team observed during the onsite review, some positive changes were noted, there continued to be significant issues regarding the accuracy of the risk levels, the reflection in the IHCPs of the necessary clinical intensity to address designated risk levels, the identification of functional and/or measurable objectives, the inclusion of adequate preventative measures, and clear documentation of this 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	Since the last review, interviews with the Facility staff, and ABSSLC's Self-Assessment indicated that the following steps had been implemented, and assessments conducted regarding the At-Risk process: ▪ Since the last review, the Facility reported that in September 2012, they had	Noncompliance

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	implement a regular risk screening, assessment and management system to identify individuals whose health or well-being is at risk.	begun the implementation of the revised At-Risk Process using two teams from Residences 6500 and 6720. In November 2012, additional new revisions to the process were implemented and in January 2013, training regarding the Enhanced Risk Rating system was conducted. In April 2013, the SSLC QDDP Discipline Coordinator provided additional training regarding the ISP Process. However, no specific information was provided regarding the percent of staff members required to attend the training (N) and the number of staff members that actually attended (n). ▪ In addition, in January 2013, the Facility began using a revised Integrated Risk Rating Form that included sections addressing the History, Current Supports, Current Status, Proposed Recommendations, Team Deliberations, Final Recommendations, and the Risk Rating ▪ The Facility's Self Assessment indicated that a review of 100% (69) of December 2012 and January 2013 IRRFs found the following: 59 of the 69 (86%) IRRFs reviewed were finalized with discussion, rationale or risk rating; 41 of the 69 (59%) IRRFs reviewed did have the data, support and baseline prepopulated in at least one risk category; none of the 69 (0%) IRRFs reviewed did have adequate team discussion; four of the 69 (less than 5%) IRRFs reviewed did have appropriate rationale that led to risk rating; and six of the 69 (8.7%) IRRFs reviewed did have appropriate risk rating based on discussion and rationale. Although some of the overall data presented in the Facility's Self Assessment were promising, most of the metrics/indicators used by the Facility were not in alignment with the requirements of the Settlement Agreement for this area. <u>Self-rating</u>: The Facility's Self-Assessment indicted that: "Based on the results of the self-assessment, the ABSSLC facility is not in compliance with Provision I.1. Done well, the new IRRF and IHCP are effective tools to pinpoint the risks of each individual. This completed, the team with a comprehensive discussion can compile and disseminate a plan for care which can prevent health issues as well as handle current issues. To do this will take time, accountability, and effective monitoring of each team and each process. As shown above, during this 2-month period, finalization of the IRRFs was good, however the teams had problems discussing and analyzing the assessments. With no more changes to the process and mentoring activities, the teams will learn to discuss openly supports and action plans needed to effectively reduce risks." Although the Monitoring Team noted some improvement from the ISPs that were observed on site, there continued to be significantly problematic issues as noted below for Section I. The numerous changes to the At-Risk system that had resulted in fragmented documentation made it difficult, if not impossible, in many cases to sequentially follow the assessment and care plan processes for a sample of 21 individuals	

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		discussed with regard to Sections I.2, and I.3, who the Facility determined to be at high risk regarding health and/or mental health issues. A review of the ISP and addendum documentation indicated that most of the individuals' teams were discussing the individuals' status, and including more pertinent clinical information in the Integrated Risk Rating Forms than found during previous reviews. However, the overall lack of clear documentation included in the ISPs, the Risk Action Plans/Integrated Health Care Plans, and the associated disciplines' assessments regarding what actions were taken and when in response to pertinent events or health issues, and the lack of dates and supporting documentation addressing actions and completion of action plans continued to negatively impact the supports that were planned for and provided to individuals, and made the Monitoring Team's review of the At-Risk system difficult. The consistent lack of progress noted in this area was troubling at this juncture of the compliance process. To assess the Facility's revised risk screening process, members of the Monitoring Team observed two individuals' ISPs meetings (i.e., Individual #241, and Individual #49) while on site. Specifically, the observations of the ISP meetings indicated that: ▪ All appropriate disciplines were present at two (100%) of the observed ISPs. ▪ The staff present at the ISP meetings were the actual staff that worked with the individual, and not substitute staff sitting in for other staff members for both (100%) of the ISPs. ▪ The individual was present at all (100%) of the ISPs meetings observed. ▪ The IDT consistently used the Risk Level Guidelines when determining risk levels at two (100%) of the ISP meetings. • The IDT consistently used supporting clinical data when determining risks levels for none (0%) of ISPs observed. ▪ Overall, the risk levels the IDT designated were appropriate for each category for none of the ISPs observed (0%) from information and data provided by the IDTs. ▪ There was adequate and appropriate clinical discussion among appropriate team members in decisions regarding risk levels in both (100%) of the ISPs meetings observed. ▪ Team disagreements regarding risk levels were noted in none of the ISP meetings. ▪ Based on all ISPs observed by the Monitoring Team, the ISP facilitators kept the team focused in both (100%) of the ISPs meetings observed. In addition, other positive observations from the Monitoring Team regarding Individual #241's ISP meeting included: ▪ The Direct Support Professional who was present at the ISP very caring, and	

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		very attentive to the individual throughout the meeting. ▪ It appeared that the team was familiar with the Risk Guidelines and made recommendations for identified risk levels that reflected this knowledge. ▪ Information regarding the history, current supports, and current status had been completed prior to the ISP meeting. ▪ Good interdisciplinary discussions were observed particularly between the Dental staff and the Occupational Therapist related to dental hygiene and care issues. ▪ The Facilitator for the ISP was very animated, included the individual in discussions, and appeared well prepared. ▪ The Psychologist on the team persisted in asking the team some important questions prompting team discussions. ▪ The Activities Specialist was able to call the team's attention to problematic issues regarding some skill training programs that lacked progress and was subsequently discontinued by the team. Also, other positive observations from the Monitoring Team regarding Individual #49's ISP meeting included: ▪ The team frequently worked to integrate the individual's preferences into skill acquisition programs. ▪ The team members were actively involved in the ISP process. ▪ While the physical therapist presented the entire PNMP, the team members made appropriate suggestions for revisions. Problematic areas needing focus or improvement included: ▪ Individual #49's IRRF stated he had "11 episodes of choking with watery eyes in the past one year in correlation with oral feedings." However, the IRRF did not include the dates of these choking incidents and his OT/PT assessment, dated 4/18/13, did not include these choking incidents. In addition, there was no discussion of mealtime monitoring results. Also, the team did not discuss any identified individual-specific triggers related to the choking episodes, the need for any revisions to recreational eating techniques, or recommendations for mealtime monitoring. ▪ The team for Individual #49 did not discuss triggers for risk categories that were rated medium and/or high. ▪ The IRRFs for both Individual #241 and Individual#49 did not include specific clinical data in a number of risk areas, making it difficult for the team to accurately evaluate the level of the risk. ▪ Nursing was not using the nursing protocols when discussing needed interventions and assessments for the high and medium health issues for both	

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		Individual #241 and Individual #49. From the Monitoring Team's observations and record reviews, some positive steps were noted regarding the structure and format of the ISP meetings. However, more efforts were needed to ensure that the risk levels are accurate, that the IHCPs reflect the needed clinical intensity in alignment with the appropriately designated risk levels, that objectives included are functional and/or measurable, that adequate preventative measures are discussed and are included in the integrated health care plans, and teams clearly document this process. In addition, ABSSLC should continue to provide training and mentoring for the IDTs regarding the At-Risk process. The Facility remained out of compliance with this provision.	
I2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall perform an interdisciplinary assessment of services and supports after an individual is identified as at risk and in response to changes in an at-risk individual's condition, as measured by established at- risk criteria. In each instance, the IDT will start the assessment process as soon as possible but within five working days of the individual being identified as at risk.	The Facility's Self-Assessment for this provision indicated the following: ▪ The Facility's review of 100% (69) of December 2012 and January 2013 IRRFs found that since 10 of 69 IRRFs were not finalized, only 59 IHCP could be reviewed to determine compliant completion and transcription date prior to annual ISP. A review of these IHCPs indicated that seven of 59 Annual Medical Summaries (12%) reviewed were completed and transcribed 10 to 30 days prior to annual ISP; 0% of 69 IRRFs reviewed followed policy related to procedures for the risk assessment process; and 23 of the 59 Annual Nursing Assessments (39%) reviewed were completed 10 to 30 days prior to annual ISP. As mentioned previously, although some of the Facility's data were promising, they lacked information regarding what criteria was used to determine compliance. In addition, most of the metrics/indicators used by the Facility were not in alignment with the requirements of the Settlement Agreement, especially regarding the quality of the teams' identification of needed assessments, the completion of assessments, and the related documentation. <u>Self-rating</u>: Based on the results of the self-assessment, the facility reported it was not in compliance with this provision. Based on a review of records for 21 individuals determined to be at risk (i.e., Individual #418, Individual #199, and Individual #545 for weight issues; Individual #383, Individual #463, and Individual #55 for seizures; Individual #217, Individual #315, and Individual #127 for dental issues; Individual #226, Individual #535, and Individual #37 for fluid imbalance; Individual #165 for choking; Individual #138, and Individual #26 for urinary tract infections; Individual #76, Individual #27, and Individual #146 for skin issues; Individual #297, Individual #447, and Individual #493 for infections), 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	Noncompliance

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		(0%) individuals. Problematic issues that resulted in noncompliance included: ▪ Integrated Risk Rating forms did not consistently include specific clinical data, such as the number of bowel medications and supplemental laxatives/stool softeners regarding constipation risks, or dates and the types of injuries/fractures when addressing falls, to support the risk ratings for the health indicators. As a result, it was unclear whether 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; ▪ When recommendations for further assessment were found on the Risk Action Plans/IHCPs, 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 impossible to determine what precipitated the recommended assessment, and if it was actually timely completed; and ▪ A number of the current IRRFs and IHCPs were missing from the Active Records. <u>Nursing Assessments</u> Based on a review of 21 individuals' records for which assessments were to be completed to address the individuals' at-risk conditions, none (0%) included an adequate nursing assessment to assist the team in developing an appropriate plan. Records that did not contain documentation of this requirement included: Individual #418, Individual #199, and Individual #545 for weight issues; Individual #383, Individual #463, and Individual #55 for seizures; Individual #217, Individual #315, and Individual #127 for dental issues; Individual #226, Individual #535, and Individual #37 for fluid imbalance; Individual #165 for choking; Individual #138, and Individual #26 for urinary tract infections; Individual #76, Individual #27, and Individual #146 for skin issues; Individual #297, Individual #447, and Individual #493 for infections More specific details are provided with regard to Section M.2. In addition, a review of the most current quarterly or annual Comprehensive Nursing Assessments for the above 21 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. As noted in previous reports, nursing had no specific procedure in place addressing the process regarding the nursing assessments and the analysis of the identified risk indicators. As noted based on past reviews, the nursing assessments for the At-Risk individuals were not adequate in addressing the health risks	

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		of the individuals reviewed. In addition, regarding the Integrated Risk Rating forms, a review of these 21 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 the Monitoring Team found that there was an overall increase in some of the specific clinical information contained on the IRRF forms, for some of the areas that nursing was responsible for assessing and/or providing information, such as constipation, weight issues, cardiac, falls, injuries, and/or fractures, there was a lack of individual-specific information noted that made it difficult to determine the accuracy of the risk rating that was assigned. 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 a review of nine individual records for whom assessments had been completed to address the individuals' at risk conditions (i.e., Individual #119, Individual #413, Individual #311, Individual #97, Individual #524, Individual #465, Individual #493, Individual #386, and Individual #14.), numerous concerns were identified regarding the completion of an adequate medical assessment to assist the team in developing an appropriate plan, and subsequently, developing adequate plans. The following provide some examples of concerns related to the assessment and planning for individuals at risk: ▪ Individual #493 had a significant change of health status in the prior six months. On 11/14/12, there was a change of status IRRF created along with numerous ISPAs during the months of September 2012 through January 2013 (as listed below). There was documentation of inter-disciplinary discussion. Important questions were raised, but there appeared to be no clear next steps identified. It was noted that the PCP was not in attendance at most meetings. A PCP might have been able to answer some of the concerns at that time. However, there were significant concerns about an esophageal stricture with gastritis, as well as osteoporosis. It was noted that on 1/14/13, the individual had an order for nothing by mouth (NPO), but there was no further change of status IRRF to reflect that important change in health. At one time the individual was scheduled for a thoracic surgery consult, and the gastroenterology (GI) consultant did not appear to be aware that the consult had been discontinued, according to a January 2013 consultation report. The active record did not record the reasoning for discontinuing the consultation request, nor was the consultant informed at that time. Further discussion of the concern	

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		of recurrent stricture with subsequent pooling of oral secretions and aspiration could not be found. The GI specialist recommended frequent oral suctioning to prevent accumulation of secretions, but this appeared to be interpreted from a dental hygiene perspective. Vacuum tooth brushing was reduced to twice a day from five times a day (the individual had several small meals a day prior to the G-tube placement), but the active record did not indicate the PCP addressed the need for or frequency of oral suctioning as a nursing intervention to prevent pooling or secretions independent of vacuum tooth brushing (the individual was edentulous). This information might have been located elsewhere in the record (such as a PNMP), but the rationale of clinical care from the PCP was difficult to follow. The team brought up other surgical procedures, which may or may not have been indicated, but there was no PCP present to respond and provide a clinical perspective. Additionally, the ISPA of 11/1/12 reviewed the diagnosis of osteoporosis and lack of treatment. The individual was known to have hypogonadism (prior bilateral cryptorchidism and orchiectomy), but was not treated with hormonal replacement. The reason for not currently treating the secondary cause of osteoporosis could not be determined from the record review. However, the individual was no longer able to take a bisphosphonate orally or by feeding tube, and the individual was not a candidate for Prolia, according to the IDT notes. For such complex cases, an endocrinologist or other specialist would have been helpful to assist in identifying additional options, but there was no next step identified. As discussed above, it was noted the IDT met several times during this individual's health decline. ISPAs were held on 9/11/12, 9/26/12, 10/2/12, 10/14/12, 11/1/12, 11/14/12, 11/29/12, 1/3/13, 1/14/13, and 4/29/13. It was noted a PCP was only in attendance at the 9/26/12 and 10/2/12 IDT meetings. The PCP also did not attend the at-risk/IRRF meeting of 9/5/12. Given the complex medical concerns, it is recommended that the PCP attend such meetings to guide the IDT, but also that the QDDP ensure the meeting is scheduled at a time when the PCP can attend, and provide sufficient advance notice to ensure medical coverage can be arranged while the PCP attends the ISPA meeting. As mentioned, there were many questions and concerns raised, some of which could have been quickly dispelled, and some of which could have led to further actions, but the absence of the PCP appeared to reduce the quality and timeliness of the IDT's decision-making. In such complex cases, the PCP should take a leadership role in the clinical discussion and decision-making.	

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		In addition, the active problem list did not include dysphagia or GERD, and the preventive care flow sheet had not been updated in over a year. These documents are helpful to the IDT members in understanding the medical conditions of the individual, but these tools did not provide current information. ▪ Individual #465 had change of mental status with history of falling, and was found to have recurrent elevations in Dilantin level. This individual was admitted to the Infirmary in April 2013. There was no ISPA to document the IDT was aware of the work-up at that time, or discussion and development of an action plan based on the change in health status. The ISP did provide some details concerning the work-up completed for falls, such as the results of a CT of the head in the prior months, but did not add it to the information included on the IRRF. Results of the, cardiology consult and psychiatry consult/review of medications did not appear to be reported through the IRRF process. Additionally, there did not appear to be PCP guidance to the IDT in the interpretation of results and incorporating this guidance into the IRRF. For example, many of the findings on the CT report were consistent with prior findings, and not new concerns (the prior CT scan date was inaccurate as it was documented as occurring in 3/8/14). There was one potential recommendation listed in the CT report, but there was no information in the ISP or IRRF concerning discussion or follow-up by the PCP or IDT. When reviewing the fall, fracture, and seizure sections of the IRRF, this report was not summarized in any of these sections. Additionally, the last quarterly medical review was September 2012. The IDT could not depend on the quarterly medical review process to confirm important tests had been completed or test results reviewed and addressed. ▪ Individual #524 had ongoing risk concerns. This individual had a DEXA scan in May 2008, with a T-score of -2.05. The individual was not a candidate for Fosamax at the time. The individual had been prescribed calcium and Vitamin D. However, there was no further DEXA, despite a recent x-ray of the foot, which showed diffuse osteopenia. There were no other medication options discussed, and rationale could not be found for not further monitoring the osteopenia/osteoporosis. As the individual was wheelchair and bedbound, the risk was high for development of worsening osteopenia/osteoporosis. The individual had had decubiti of the sacrum/coccyx/buttocks over the past several months, with intermittent healing and then breakdown. There was pressure mapping of the mattress and the wheelchair. There was mention of an additional recliner that was used, but no information concerning optimal positioning in the recliner and whether pressure mapping had been completed on this or whether it was no longer used. On 2/6/13, a seating system	

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		assessment of the wheelchair was completed, but the submitted documents did not indicate whether or not the individual had received the new wheelchair at the time of the Monitoring Team's visit. It was noted from a 2/6/13 nursing IPN that the dressing change had not been followed and there was a lack of non-adhesive dressing when the dressing was removed and this created three open skin areas. There was an evaluation of the most physiologically appropriate range for head of bed elevation. The individual had a positioning schedule in which the individual was not to be in the wheelchair more than two hours at a time, but it was not clear who was to monitor the positioning schedule to ensure it was occurring according to schedule. Given the large number of decubiti needing constant review and dressing changes for individuals at ABSSLC, it is recommended the Nursing Department consider having one nurse focused on decubiti throughout the campus, who primarily changes dressings and teaches staff, as well as monitors quality of the dressing process. Training in decubitus care would then be focused on one assigned nursing staff rather than training all nurses on campus, which might reduce complications of dressings done incorrectly. On 6/5/12 and 1/2/13, the individual had pneumonia, both of which resolved after treatment in the Infirmary. However, the annual medical assessment indicated that "since no recent aspiration pneumonia, preventative measures seem to be working," while in the prior paragraph, the history of the 1/13 aspiration pneumonia was reviewed. The individual had a follow-up modified barium swallow study (MBS), which was normal. The individual continued to have wheezing and hypoxia, but there was no information of further assessment and role of GERD/gastroparesis in contributing to these episodes. The individual had a history of GERD and was taking a proton pump inhibitor, but there was no further information whether this was sufficient to meet the needs or whether the GERD was worsening and contributing to respiratory compromise. The individual's head-of-bed elevation had been slightly reduced by the PNMT, but this might increase the risk of reflux and aspiration. ▪ Individual #413 was hospitalized from 4/15/13 to 4/23/13 for fever and hypoxia. The initial ER diagnosis was pneumonia, which was changed to respiratory distress, fluid overload, and pneumonitis. The discharge diagnosis included diastolic heart failure, with normal lab values in follow-up. The PCP documented a thorough hospital review in a form entitled "Post/ER Hospital Transfer Medical Chart Review Progress Record" of 4/24/13, with follow-up lab completed and reviewed. At the time of the Monitoring Team's review, there was no follow-up ISPA submitted to indicate awareness or discussion by the IDT. The PCP IPN reviewed the various labs of the recent hospitalization, but did not	

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		review the past history to determine the need for updating information. As an example, there was no information recorded whether the PCP or IDT reviewed the history of GERD that was last evaluated in 1995 (along with G-tube placement and Nissen fundoplication at that time) as a contributing cause for possible aspiration/pneumonitis. There was no information as to whether there was consideration of the need to verify that the Nissen fundoplication was intact. There was no information discussed about a review of residual gastric volume prior to enteral feeding and whether gastroparesis was a concern. 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 days of the plan's finalization, for each individual, as appropriate, to meet needs identified by the interdisciplinary assessment, including preventive interventions to minimize the condition of risk, except that the Facility shall take more immediate action when the risk to the individual warrants. Such plans shall be integrated into the ISP and shall include the clinical indicators to be monitored and the frequency of monitoring.	Based on a review of 21 records for individuals determined to be at risk (i.e., Individual #418, Individual #199, and Individual #545 for weight issues; Individual #383, Individual #463, and Individual #55 for seizures; Individual #217, Individual #315, and Individual #127 for dental issues; Individual #226, Individual #535, and Individual #37 for fluid imbalance; Individual #165 for choking; Individual #138, and Individual #26 for urinary tract infections; Individual #76, Individual #27, and Individual #146 for skin issues; Individual #297, Individual #447, and Individual #493 for infections), 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%). Only 12 individuals (57%) were found to have a care plan addressing their high or medium health/mental health risk indicator in the Active Record. Individuals who did not have a related care plan included Individual #418, Individual #199, Individual #463, Individual #226, Individual #37, Individual #165, Individual #76, Individual #447, and Individual #27. ▪ Implemented a plan within fourteen days for each individual, as appropriate in none (0%) of the cases reviewed. The 12 Integrated Health Care Plans that were found in the Active Records included a date of implementation. However, there was no supporting documentation verifying that the action steps contained in the plans 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 to encourage adequate fluids, because these interventions were not written in measurable terms to allow them	Noncompliance

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		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%). ▪ Integrated the plans into the ISPs in 12 of the 21 cases (57%). Individuals who did not have their IHCPS/Risk Action Plans in the Active Record included: Individual #418, Individual #199, Individual #463, Individual #226, Individual #37, Individual #165, Individual #76, Individual #447, and Individual #27. ▪ None (0%) of the plans reviewed 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 Plans contained a heading addressing "Monitoring Frequency," the frequency was either noted generally as daily or weekly without the specific shift or day included to ensure accountability or it was not addressed. At the time of the review, the Facility indicated it was not in compliance with the requirements of the Settlement Agreement for this area. This finding was consistent with the findings of the Monitoring Team. ABSSLC should continue to focus its efforts on the process of developing specific and clinically appropriate IHCPs. These 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. In prioritizing involvement in the ISP/at-risk process, PCPs should be expected to attend the at-risk discussion to ensure teams arrive at clinically appropriate conclusions. (Section I.1)
2. The PCP should provide background information concerning the diagnostic tests already completed, the dates of completion, with a brief entry concerning results. The IDTs cannot arrive at correct risk ratings without sufficient information, nor can further assessments be recommended if it is not known what assessments have already been completed. (Section I.1)
3. 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)
4. Additional training on the at-risk process should be provided to the IDTs. This is necessary to ensure that the at-risk process adequately

identifies the critical issues, and that appropriate and clinically sound action plans are developed to address the risks identified. (Sections I.1, I.2, and I.3)

5. 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)
6. Each IDT member should obtain all relevant information ahead of the meeting, especially information on which the team will base a risk rating. (Section I.1)
7. There should be evidence to confirm the team's rationale for each category of risk reviewed. (Section I.1)
8. 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)
9. It is important to create a standardized approach to differentiate the original plan/information from updates and other information that is entered into the plan, with dates of each additional entry. (Sections I.1, I.2, and I.3)
10. The PCPs should ensure complete and timely assessments are ordered, and results incorporated into the individual's treatment and care. The risk action plan requires critical clinical thinking on how to prevent recurrences such as ER visits or hospitalizations to improve the quality of life by improving the health of the individual. (Sections I.2 and I.3)
11. The Facility should create a tracking system listing dates of action that follow the identification of individuals at risk, including the assessment process and the development and implementation of risk action plans. (Sections I.2 and I.3)
12. The areas that the At-Risk Individuals policy designates that nursing is to assess should be reviewed to determine which discipline is the most appropriate to conduct those assessments. (Section I.2)
13. The Facility, in conjunction with the State, should define specifically the assessment process regarding at-risk individuals for all disciplines. (Section I.2)
14. Given that IDTs, at times, do not realize when more assessment is indicated, department heads should review IDT findings relevant to their department to ensure appropriate guidance is provided to the teams in determining needed assessments. (Sections I.1, and I.2)
15. A summary list of the assessment(s) being requested as a result of the IRRF or ISPA should be created to assist in tracking the completion of the assessments. To use this as a tracking tool, it would be helpful if it included the date of request, date completed, date received by the IDT, date discussed at an IDT meeting, and date of ISPA at which it was discussed and acted upon, if applicable. (Section I.2)
16. The Facility should decide upon a system for quarterly/monthly updates, including whether these should be maintained in the documents themselves, or in a separate document. (Section I.3)
17. The ISP and/or IRFF and related action plans should capture the interdisciplinary discussion about the risks defined for the individual. (Section I.3)
18. 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)
19. 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)
20. Regarding the Facility's self-assessment 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)
21. 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 is more appropriately used to summarize the analysis of the data. (Facility Self-Assessment)
22. As the Facility's self-assessment processes evolve, additional data should be analyzed, addressed, and included in the Self-Assessment to substantiate compliance or noncompliance with the Settlement Agreement. Such data could come from a variety of sources, including audits, as well as other data sources, such as databases or outcome indicators. (Facility Self-Assessment)

SECTION J: Psychiatric Care and Services	
Each Facility shall provide psychiatric care and services to individuals consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o State Supported Living Centers Nursing Protocol for Pre-Treatment and Post-Sedation Monitoring; o An alphabetical spreadsheet of individuals 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 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 prior six months; o List of individuals currently prescribed Reglan; o MOSES and DISCUS assessments for the prior year for the following six individuals prescribed Reglan: Individual #296, Individual #162, Individual #265, Individual #117, Individual #333, and Individual #385; o List of individuals prescribed each of the following: a) anti-epileptic medication being used as a psychotropic medication; b) Lithium; c) Tricyclic antidepressants; d) Trazodone; e) Beta-blockers being used as a psychotropic medication; f) Clozaril/Clozapine; g) Mellaril; and h) Reglan; o List of individuals admitted within the prior 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 referred for a Psychiatric Evaluation as a result of an elevated score on the Reiss screen within the prior six months, including the Reiss Scoring Sheet and the results of the Comprehensive Psychiatric Evaluation (CPE) performed as a result of the elevated Reiss Screening Scores, as appropriate; o List of all psychiatrists, including Board status; o The caseload distribution for Staff Psychiatrists; o Curricula Vitae (CVs) of all psychiatrists; o Spreadsheet of the status of individuals selected for Desensitization Plans; o List of individuals who had a change in their psychiatric diagnosis over the last year, including rationale for the change;

	o Analysis of psychiatric time allocation, dated 4/1/13; o For the prior 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 six episodes of chemical restraint: Individual #304 on 3/8/13 and 3/29/13; Individual #323 on 3/19/13 and 3/20/13; Individual #304 on 3/8/13; and Individual #397 on 3/6/13; o Documents reviewed in the context of the 5/7/13 Psychotropic Polypharmacy Committee meeting; o Minutes reviewed and discussed at the 5/8/13 Pharmacy and Therapeutics Committee meeting; o Spreadsheet of oral pre-treatment sedation medications used for medical and dental appointments for the prior 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 List of individuals psychiatrically hospitalized over the prior 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 Current spreadsheet listing the dates of CPEs and Psychiatric Treatment Plans (PTPs) by individual; o Total of individuals that had either a CPE or PTP in the time frame 5/1/12 through 5/8/13; o The following sections of the active medical records were requested: a) Data Record; b) Social History Evaluation; c) Individual Support Plan section; d) Positive Behavior Support Plan (PBSP), including addendums; e) Annual Medical Summary; f) Active Problem List; g) Inactive Problem List; h) Psychiatric Problem List; i) Hospital 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, for the following: • The Facility selected the records of the following 10 individuals and submitted them as part of the pre-review document request: Individual #461, Individual #320, Individual #518, Individual #462, Individual #478, Individual #355, Individual #168, Individual #534, Individual #460, and Individual #4; • The records of the following 17 individuals were chosen during the onsite review

	by a member of the Monitoring Team: Individual #363, Individual #405, Individual #397, Individual #170, Individual #304, Individual #529, Individual #180, Individual #139, Individual, #530, Individual #87, Individual #324, Individual #510, Individual #517, Individual #278, Individual #525, Individual #323, and Individual #94. ▪ **Interviews with**: o Marla Knight, Pharm. D., Michael Murray, M.D., and David Daniels, Program Compliance Coordinator, on 5/8/13; o Toni Wilson, R.N., Psychiatric Nurse, Kevin Copeland, Psychiatry Assistant, and Marcus Perez, Psychiatry Assistant, on 5/8/13; o Michael Murray, M.D., Chief Psychiatrist, on 5/6/13, 5/8/13, and 5/9/13; o Jerry Griffen, D.D.S., Director of Dental Services, on 5/6/13; o Marla Knight, Pharm. D., Clinical Pharmacist, on 5/6/13; o Ron Manns, Director of Behavioral Services, on 5/6/13; o Shae Butts, Human Rights Officer, on 5/7/13; o Brian Luster, System Analyst Two, in conjunction with Michael Murray, M.D. to review Facility Self-Assessment, on 5/9/13; o Stephen Milstead, R.N., D.M., M.H.N.P., on 5/9/13; o John Crowley, M.D., on 5/7/13; and o Barry Rosson, M.D., on 5/8/13. ▪ **Observations of**: o Psychiatric Clinic for Residence 5971 Service Avenue, on 5/7/13; o Psychiatric Clinic for Residence 6400 Plum Avenue, on 5/7/13; o Psychiatric Clinic for Residence 6760 Circle Drive, on 5/9/13; o Psychiatric Consultations performed by Dr. Crowley, on 5/7/13, related to Individual #397 and Individual #405; o Medication Variance Committee Meeting, on 5/8/13; o Pharmacy & Therapeutics Committee Meeting, on 5/8/13; o HRC Meeting, on 5/7/13; o Psychotropic Polypharmacy Committee Meeting, on 5/7/13; o ISP meeting for Individual #241, on 5/8/13; and o The following individuals during the Psychiatric Clinics, and visits to the vocational areas, and the individual residences: Individual #418, Individual #242, Individual #278, Individual #397, Individual #87, Individual #442, Individual #184, Individual #166, Individual #51, Individual #592, Individual #444, Individual #245, Individual #273, Individual #247, Individual #246, Individual #305, Individual #405, Individual #478, Individual #181, Individual #365, Individual #36, Individual #533, Individual #209, Individual #308, Individual #510, Individual #180, Individual #46, Individual #27, Individual #293, Individual #105, Individual #189, Individual #288, Individual #523, Individual #211, Individual #30, Individual #99, Individual #104, Individual #168, Individual #479, Individual #342, Individual #184, Individual #88, Individual #300, Individual #462, Individual #82, Individual #483, Individual #490, Individual #198, and

	Individual #246.
	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 5/9/13. The Presentation Book for Psychiatry also was reviewed with the Chief Psychiatrist at that time. At the time of the Monitoring Team's prior review, the Program Compliance Monitor indicated that he reviewed two individual records per month, which were randomly selected 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. This system changed in February 2013 in response to guidance from the DADS State Office, which provided a new monitoring tool and a new sampling strategy. As a result of these changes, the Program Compliance Monitor no longer reviewed individual records, but continued to be involved in the selection of the random sample. He also continued to participate in a monthly meeting with the entire Psychiatry Team, during which they reviewed the results of their inter-rater reliability data. During these monthly meetings, the Team also focused on ways to improve inter-rater reliability in the future. The system developed in response to the new DADS directive involved the Chief Psychiatrist reviewing at least one record per month in conjunction with a blind review of the same record by another member of the Psychiatry Team. This second member could be the Psychiatric Nurse, the Psychiatric Nurse Practitioner, or one of the two Psychiatric Assistants. Each of these staff reviewed one record independently for a total of four per month, one of which was used for the inter-rater reliability determination, as described above. The one record that was used for the inter-rater reliability assessment each month rotated among the psychiatry staff so that over time the inter-rater reliability assessment process would take into account all of the potential raters. The Program Compliance Monitor selected two individuals from the random sample that had a Quarterly Review that month. The others were randomly selected from the entire Psychiatry caseload. As a result of the guidance from the DADS State Office, there were also changes in the monitoring tool. However, the ABSSLC Psychiatry Department had been using the prototype of this new audit tool, so the changes were minor. The current goal was to perform reviews for two percent of the individual records of those receiving psychotropic medication each month, which would equate to 24 percent per year. At the time of the Monitoring Team's prior review, the QA/QI monitoring system had been modified so that, overall compliance scores were replaced with indicator-specific scores. The work product of the QA/QI review at that time reported 27 indicators related to 11 provisions of Section J of the Settlement Agreement. The provisions 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. These issues were addressed through separate databases. The most recent iteration of the audit tool encompassed 34 items related to 13 of the 15 provisions of Section J. The two that were not covered were Section J.1 and Section J.5.

	The Program Compliance Monitor entered this data and prepared a report based on the results. The reports could be customized to report by provision or by item. The inter-rater reliability was reported as a simple percentage of agreement, which took into account the three potential ratings for each item, which were basically "Yes – No – NA." Any variation in the two responses was rated as non-agreement. The overall inter-rater reliability score could then be reported for the entire audit or by item. The principal author of the Facility Self-Assessment was the Chief Psychiatrist. During the 5/9/13 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 Monitoring Team's prior reviews, two primary assessment 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 results of the above-referenced interviews with the author of the Facility Self-Assessment and the Program Compliance Monitor for Psychiatry indicated the following: ▪ The audit tools the Facility utilized to conduct its Facility Self-Assessment were the specific instruments developed for Section J by the DADS State Office; ▪ The audit tools provided useful information that the Facility could use to improve its compliance with the Settlement Agreement; ▪ The audit tools primarily assessed the presence or absence of specific items related to the Settlement Agreement. A concern was that the quality of psychiatric services often was not assessed; ▪ The self-assessment process was based on adequate sample sizes, as the goal was to review 24 percent of the records of individuals receiving psychotropic medications every year. The sample sizes in the current Facility Self-Assessment did not reflect this, as the new system had only been put into place in February 2013; ▪ The audit tools had instructions to ensure consistency in the monitoring and the validity of the results, as they were directly derived from the Settlement Agreement. The criteria utilized in the audit tool were primarily of a yes versus no or present versus absent nature. For example the tool did not identify quality factors such as what type of information should be available to formulate a psychiatric diagnosis for a specific individual, but rather focused on whether the diagnosis was present in those areas where it was required. ▪ The staff members responsible for completing the audit tools were all members of the Psychiatry Department, which included the Psychiatrists, Psychiatric Nurses, and the Psychiatry Assistants. Although there was no formal process for assessing a staff member's competence to perform the

	audit, all of these Psychiatry Department Team members were well versed regarding the issues involved. The Psychiatry Assistants attended and coordinated the logistics for all of the Psychiatry Clinics on their caseload and, thus, were familiar with the items referred to in the Settlement Agreement; ▪ Although adequate inter-rater reliability had not yet been achieved, the Psychiatry Team, working in conjunction with the Program Compliance Monitor, had a system in place to continuously improve the quality of the audit process and the inter-rater reliability scores. This was accomplished via a monthly meeting, during which the Program Compliance Monitor would meet with the Psychiatry Team and provide feedback on the results of the inter-rater reliability scores; ▪ The primary methodology that the Facility used to augment the auditing of individual records was their utilization of databases and spreadsheets that tracked the overall completion rates for all individuals receiving psychotropic medication. These included spreadsheets to track the overall completion rates of the CPEs and the annual CPE Addendums in the form of the PTPs, the MOSES/DISCUS completion rates, and the polypharmacy statistics. Other disciplines also maintained relevant databases, such as the Dental Desensitization Tacking Spreadsheet maintained by the Dental Department, and the MOSES/DISCUS tracking performed by the Pharm.D.; and ▪ The Facility presented their data in a useful manner. A detailed description of the number of individual records reviewed, as well as the specific items that were scored accompanied the Facility assessment for each provision of Section J. This was followed by a Results section, which described both the positive and negative findings. The final section was the self-rating, which provided both the Facility's conclusion regarding compliance, and a detailed rationale for that finding. There was agreement between the ratings for 12 of the 15 provisions. The provisions for which the three ratings were divergent, and the reason for that difference, were as follows: ▪ Section J.3: The Facility's finding of substantial compliance did not factor in an analysis of the Chemical Restraint data. ▪ Section J.10: The Facility Assessment did not take into account the reference in this provision that indicates the risk-versus-benefit material also should be incorporated into the ISP. ▪ Section J.15: The Facility's criteria regarding how much information would be required in the Neurology Notes to constitute the clinical coordination of the individuals' care with Psychiatry was less rigorous than that utilized by the Monitoring Team. The observation that the Facility utilized a different subset of records each month should, over time, strengthen the reliability of their results. The efforts to continually reassess for inter-rater reliability should also contribute to the overall reliability of the self-assessment process in the future.
	Summary of Monitor's Assessment: At the time of the Monitoring Team's current review, ABSSLC employed one full-time Psychiatrist, one full-time advanced Nurse Practitioner (with prescribing privileges); one full-time locum tenens Psychiatrist, and one Consulting Psychiatrist who was at the Facility for two consecutive weeks each month. One Psychiatric Nurse and two Psychiatry Assistants supported

	the Psychiatrists. 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 this number of Psychiatrists should be adequate, even taking into account the fact that the current contract for the locum tenens Psychiatrist would end on 5/10/13. 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 Psychiatry Department had also developed a Psychiatric Treatment Plan (PTP), which was to serve as both an annual compilation of material for the individuals' ISPs and the annual update to the CPE. These 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 prescribed psychotropic medication. During the prior six months, a member of the Psychiatry Department had been able to attend the ISP of 92 of the 96 (96%) individuals receiving psychotropic medications who also had an ISP within this timeframe. There continued to be incremental progress with the development of Desensitization Plans for dental procedures, but there was not any substantial advance with regard to the development of Desensitization Plans for medical procedures. In the Monitoring Team's prior reviews, the importance of making sure that the information required in Sections J.8, J.9, and J.10 also were represented in the ISP, had been stressed. The Facility had acted on these recommendations, which was reflected in the current reviews. Observation of the Psychiatric Clinics of the three current psychiatric providers 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 these Quarterly Psychiatric Reviews was detailed and fully completed for each individual. The extensive risk-versus-benefit documentation that had appeared in the Quarterly Review documentation at the time of the Monitoring Team's prior review had been moved to the Annual PTP. The material that provided the justification for the individuals' psychiatric diagnosis also had been moved from the Quarterly Review to the PTP, as well as the differentiation of the behaviors that were symptoms of the psychiatric disorder. This section of the PTP also contained the derivation of the target behaviors of the psychotropic medication as being present on a behavioral basis or as the direct manifestation of the psychiatric disorder, or represented as an overlap of both of these factors. Progress in decreasing the rates of polypharmacy at ABSSLC continued. 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 considerable progress in assembling the necessary documentation

	to justify the efficacy of the psychotropic medications. At the time of the Monitoring Team's prior review, a plan had been approved to have all of the individuals followed by both Psychiatry and Neurology reviewed in a distinct Neurology-Psychiatry Clinic, which would provide improved coordination of clinical care by both specialties. This did not occur, because the Facility had not been able to devise a mechanism to have the individuals who were followed by both disciplines, in a separate clinic. Coordination remained a challenge, using this or another viable alternative. Thus, in summary, the Facility had made significant progress in a number of areas. However, the impact of some of these positive initiatives was not fully reflected in the Monitoring Team's current review, due to the time lag before the new procedures were fully assimilated into the ongoing clinical processes and the documentation appearing in the individual records. This observation was particularly relevant to the inclusion of the materials related to Section J.8, Section J.9, and Section J.10 into the annual ISP documentation. If the Facility continues to focus on these areas, 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 Disability/ Developmental Disability (ID/DD) 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. Murray had been at ABSSLC for two years. Dr. John Crowley continued as a Consulting Psychiatrist for 96 hours per month. As discussed in the Monitoring Team's previous reports, the American Board of Psychiatry certified Dr. Crowley in both Adult Psychiatry and Child and Adolescent Psychiatry. He initially began working at ABSSLC as a Consultant approximately five years ago. Dr. Crowley worked as the Child Psychiatrist for the adolescents living at the Facility and his caseload quickly expanded to adults as well. At the time of the Monitoring Team's prior review, Stephen Milstead, who had functioned as a Psychiatry Nurse at ABSSLC, had received his Master of Science in Nursing degree from the University of Texas San Antonio, and had also passed the credentialing examination to practice as a Psychiatry Nurse Practitioner with prescribing privileges. The licensure process had been completed as well. Mr. Milstead's primary exposure	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		regarding clinical work with individuals who have developmental disabilities had been limited. However, his collaborating Psychiatrist was Dr. Murray, who had extensive experience with this population. Dr. Barry Rosson began working at ABSSLC as a locum tenens Psychiatrist in January 2013. His time commitment ranged from two to three weeks per month. Dr. Rosson was Board Certified in both Psychiatry and Neurology. His original focus was on completing the CPEs, but had expanded to include the provision of direct psychiatric care to the individuals who resided in two residential homes. Dr. Rosson's clinical experience with individuals ID/DD primarily had occurred during three of the approximately six years he worked on the Specialty Service at Austin State Hospital. This service provided care to both geriatric patients and individuals with ID/DD. His training and expertise in neurology was obviously valuable in his clinical work, although he did not provide neurological treatment at ABSSLC. The Facility remained in substantial compliance with this provision.	
J2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall ensure that no individual shall receive psychotropic medication without having been evaluated and diagnosed, in a clinically justifiable manner, by a board-certified or board-eligible psychiatrist.	As noted above, at the time of the Monitoring Team's review, the Psychiatrists who diagnosed and treated the individuals who resided at ABSSLC were all Board Certified in Adult Psychiatry by the American Board of Psychiatry and Neurology. The Psychiatrists had prior experience in the diagnosis and treatment of psychiatric disorders in individuals with ID/DD. The documents, in the individual records that provided the most complete description of the psychiatric evaluation process required by this provision of the Settlement Agreement were: a) the Psychiatric Quarterly Reviews; b) the Psychiatric Treatment Plan (PTP - previously referred to as PPMTP), which functioned as a Treatment Plan for psychotropic medication; and c) the CPE. At the time of the Monitoring Team's prior review, the newly formatted psychiatric Quarterly Review Forms contained sections that discussed: ▪ The diagnosis, including the Diagnostic and Statistical Manual of Mental Disorders (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	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		medication was prescribed to address; and ▪ An empirically based risk-versus- benefit analysis for each prescribed medication. The only significant changes, subsequent to the last Monitoring Team review, were moving the risk-versus-benefit analysis and the justification for the psychiatric diagnosis, as well as the derivation of the target behaviors of the psychotropic medication, to the Psychiatric Treatment Plan (PTP). The Facility also added a section to the Quarterly Review documentation entitled, "Evidence of Efficacy of Psychotropic Medication." This section summarized the evidence to support the efficacy of the current psychotropic medications, and also identified those medications for which they were still seeking further evidence. This information was updated on a continuous basis. The current Quarterly Review documentation also included a section entitled, "Psych Med Concerns per Clinical Pharmacist, (date of most recent Pharm.D. Review)" in which they would address any concerns raised during the last Quarterly Review, by the Pharm.D. The annual PTP contained a comprehensive list of the symptoms related to the individuals' psychiatric diagnosis. 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 PTP was completed when treatment with a new medication was being 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 Bio-Psycho-Social-Spiritual formulation. It discussed the differential diagnosis and provided 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 their overt behavior. This was essential for differentiating between those behaviors that were derived from the psychiatric disorder, from those that were present due to environmental and/or learned factors. The Facility also was utilizing the Annual PTP as an update to the CPE, as indicated by the title, "Annual Psychiatric Treatment Plan (PTP), and Annual Psychiatric Update/Addendum to the CPE." Thus, when evaluating the records of 27 out of the 182 (15%) individuals prescribed psychotropic medication, all three of the aforementioned sources of clinical information were taken into account, because they complemented each other in the manner described above. The CPE, coupled with the PTP, provided the most comprehensive perspective of the individuals' history and current status. However, the Quarterly Psychiatric Review documents also provided documentation of the diagnostic criteria, as	

#	Provision	Assessment of Status	Compliance
		well as a description of the individual's mental status at the time of each Quarterly Review during the year. These three documents were each present in the records of all of the 27 (100%) individuals contained in the sample. ABSSLC did not use either "Deferred" – "Rule Out – R/O" or "NOS" qualifiers when establishing an individual's psychiatric diagnosis. In the interval since the Monitoring Team's last review, the Facility had begun to maintain a list of individuals for whom there had been a change in diagnosis, and the rationale for that change. The Monitoring Team's review of that document indicated the rationale for these changes was reasonable. 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. The finding of substantial compliance for this provision derived from the observation that there was sufficient documentation to support the working psychiatric diagnosis for all (100%) of the individuals in the sample identified above. The document that one would usually consult first to identify the individual's psychiatric diagnosis would be the Quarterly Review Documentation. As noted with regard to Section J.13, these documents had been completed Quarterly as specified in a timely manner for all (100%) of the 27 individuals in the sample. The other source would be the CPEs and/or the PTP, which served as the annual update to the CPE. The information reviewed for Section J.6 indicated that either a CPE or a PTP had been completed for each of the 27 individuals (100%) within the prior year and that the Diagnosis contained in those documents was consistent with the Diagnosis in the most recent Quarterly Review material.	
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 27 individuals' prescribed psychotropic medication did not reveal any evidence that psychotropic medication was being overtly used for the convenience of the staff, or as a form of punishment. During the course of the onsite review, a member of the Monitoring Team was able to directly observe approximately 27 percent of the 182 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, adequate justification was found to support the psychiatric diagnoses for all (100%) of the individuals in the sample. The 27 records reviewed included an active Positive Behavior Support Plan for each	Noncompliance

#	Provision	Assessment of Status	Compliance
		individual prescribed psychotropic medication. However, the Monitoring Team's initial reviews indicated that the behaviors identified as the "target behaviors" of the psychotropic medication were also often identified in the Functional Analysis and related PBSP 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, these medications were potentially 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 substantial progress in this area, although there continued to be related deficits. The current status of this finding is discussed in greater detail below with regard to Sections J.9 and J.13 of the Settlement Agreement. 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 could also 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 potentially 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 samples of chemical restraint data were reviewed: **INDIVIDUAL # / DATE / TIME / MEDICATION AND DOSAGE / ROUTE OF ADMINISTRATION** Individual #304 (A) / 3/29/13 / 2120 / Thorazine 100mg / By mouth (PO) Individual #323 (A) / 3/20/13 / 1658 / Zyprexa 10mg / IM Individual #323 (B) / 3/19/13 / 1635 / Zyprexa 10mg / IM Individual #304 (B) / 3/8/13 / 0850 / Zyprexa 10mg / IM Individual #397 / 3/6/13 / 0935 / Ativan 2mg / IM The individual restraint data was reviewed for the presence and quality of the six documentation components that the Facility utilized to record the events preceding, during, and following the administration of chemical restraint. As noted above, there were two episodes of restraints for Individual #304 and Individual #323. Accordingly, the first one of these listed on the chart will be referred to as (A) and the second as (B). These sections and the results of this review are as follows:	

#	Provision	Assessment of Status	Compliance
		1. The information contained in the section of the form following the primary prompt to: "Describe events leading to behavior that resulted in restraint" was reviewed. Directly above the field for the response, appeared a more detailed statement to: "Describe the individual's environment, actions, and interactions with others in the time before you began taking steps to avoid the use of restraint." This section of the documentation was present for all five of these individuals. However, the documentation for two of these individuals only described the overt behavior that necessitated the restraint, and not the "events" precipitating this behavior for two of these individuals (Individual #304 (A) and Individual #397). For example, the material contained in this section for Individual #304 (A) indicated only: "SIB, Property Destruction, Aggression with staff and residents." The material for Individual #397 indicated that the individual was aggressive to staff and threatening to "hurt" her. Individual #397 was being hostile with several staff as well. This information for Individual #323 (A) was simply left blank. The corresponding documentation for Individual #323 (B) and Individual #304 (B) adequately described the antecedent events. Thus, the documentation was completed correctly for only two of the five (40%) episodes. This finding was consistent with the interview with the Director of Behavioral Services that occurred during the course of the Monitoring Team's prior and current onsite reviews. Specifically, he expressed concern as to whether or not 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. The results of the review of this section of the documentation are discussed below. 2. The section that followed the prompt to describe: "Interventions attempted to avoid restraint" was also reviewed. This section, which consisted of a brief checklist of eight options, plus "Other," had been completed for all five (100%) of these episodes. 3. The portion of the documentation in which the physiological post-restraint monitoring was recorded was completed for five (100%) of the individuals in this sample. 4. The face-to-face post-restraint debriefing was not present in the documentation for three episodes: Individual #304 (A), Individual #397, and Individual #323 (A). It was completed for only two (40%) episodes: Individual #323 (B) and Individual #304 (B). 5. The Facility had developed a form entitled "Administration of Chemical Restraint: Consult Review." This document addressed a number of key steps regarding the administration of the chemical restraint process, and was present in the documentation for the following four (80%) episodes: Individual #323 (A), Individual #304 (A), Individual #323 (B), and Individual #397. It was not present	

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		for Individual #304 (B). 6. The Chemical Restraint Clinical Review Form provided a section for the Pharmacist and the Psychiatrist to comment on the clinical justification for the restraint, along with the associated risks. This section of the Chemical Restraint packets was left blank for Individual #304 (A), Individual #323 (A), and Individual #397. These forms were completely missing in the packets for Individual #304 (B) and Individual #323 (B). Therefore, these essential elements of the documentation needed to verify the appropriate utilization of the involuntary administration of chemical restraint were completed for none of the five (0%) individuals in this sample. Thus, it was not possible to definitively determine 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 psychotropic medication was being utilized as a punishment or for the convenience of staff. During the Monitoring Team's onsite interview with the Director of Behavioral Services, the packet for Individual #323 (A) was reviewed to ensure the material in the packet was correct. Specifically, the information contained in the packet was crosschecked with the material in the database, which was accessed via computer. The exercise revealed that for this set of documentation, the material included in the information provided to the Monitoring Team as part of the Pre-document Request was complete. During an onsite meeting, a member of the Monitoring Team discussed a recent audit of the Chemical Restraint data performed by the Pharm. D. The discussion of this audit suggested that the results were significantly more positive than the Monitoring Team's assessment. At the time of the onsite review, because the Monitoring Team had not completed its review of the data, the discrepancies had not been identified and, therefore, were not discussed with the Pharm. D. However, the specific information regarding the results of the current review is contained above, so that the Facility can further investigate the reasons for the different results obtained in the two reviews. The Facility remained in noncompliance with this provision. 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 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 persistent issue of the dual description of the target behaviors of the psychotropic medication also being described as primarily related to behavioral issues in some of the records.	

#	Provision	Assessment of Status	Compliance
J4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, if pre-treatment sedation is to be used for routine medical or dental care for an individual, the ISP for that individual shall include treatments or strategies to minimize or eliminate the need for pre-treatment sedation. The pre-treatment sedation shall be coordinated with other medications, supports and services including as appropriate psychiatric, pharmacy and medical services, and shall be monitored and assessed, including for side effects.	The Dental Department was coordinating the implementation of the Behavioral Desensitization Plans for dental 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 general anesthesia and pre-treatment oral sedation were required to accomplish successful dental appointments. The summary data that the Dental Department prepared for this review indicated that from 10/1/12 through 4/15/13, there had been 1,510 visits to the Dental Clinic, of which 1,469 (97%) had been accomplished without any oral or general sedation. During this time period, there were 11 (0.7%) dental appointments for which the individual received oral pre-treatment sedation, and 30 (2%) for whom general anesthesia was utilized. Review of the report related to the specific utilization of pre-treatment sedation for dental and medical procedures from 10/1/12 through 3/31/13 indicated that the orders were primarily for Halcion 0.5mg or Ativan in a range of 1 milligram (mg) to 2mg. 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 Consultant who administered the general anesthesia performed the detailed physiological monitoring for the procedure. 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 was released to the residence at the discretion of the Infirmary 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 procedures. Although the Facility did not provide this information in a format to allow easy calculation of total numbers, a review of the raw data related to the utilization of pre-treatment sedation for medical procedures (from 10/1/12 to 3/31/13) indicated that the vast majority of pre-treatment sedation at ABSSLC was utilized for medical appointments.	Noncompliance

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>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 5/6/13, 68 individuals had been evaluated, and there were 21 “formal written plans,” as well as 21 “written strategies.” The term “written strategies” is meant to encompass those less formal interpersonal interventions that the members of the Dental Department utilized to make individuals more comfortable with participating in a dental appointment. Examples of this might include interventions such as playing the individual’s favorite music or scheduling the appointments at specific times that were more apt to lead to success. It also should be noted that the department utilized other such informal techniques that were not part of written plans. The Monitoring Team has taken these numbers and descriptors from 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. Although the Facility had put a great deal of effort into the development of Pre-Treatment Sedation Plans for dental procedures, only 42 written plans/strategies were currently in the process of development and implementation. In addition, the initiative to develop similar plans for medical procedures was less well developed, even though there were many more individuals who required pre-treatment sedation for medical procedures. The development of a database for medical procedures that is similar to that used to track both the need for and the development of Pre-treatment Desensitization plans for dental procedures would assist in this process. Accordingly, the Facility was found to be in noncompliance with this provision of the Settlement Agreement.</td><td></td></tr>
<tr><td>J5</td><td>Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall employ or contract with a sufficient number of full-time equivalent board certified or board eligible psychiatrists to ensure the provision of services necessary for implementation of</td><td>At the time of the May 2013 onsite review, 182 individuals were prescribed psychotropic medication at ABSSLC, and this number continued to decline. For example, the Monitoring Team previously reported the following:

<table><tr><th>Number of Individuals Prescribed Psychotropic Medications</th><th>Date</th></tr><tr><td>225</td><td>August, 2010</td></tr></table></td><td>Substantial Compliance</td></tr>
</table>

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>this section of the Agreement.</td><td>
<table>
<tr><td>222</td><td>February, 2011</td></tr>
<tr><td>219</td><td>August, 2011</td></tr>
<tr><td>199</td><td>February, 2012</td></tr>
<tr><td>189</td><td>August 2012</td></tr>
</table>
The Psychiatry Department currently had one full-time Psychiatrist and one full-time advanced Nurse Practitioner with prescribing privileges. In addition, the Facility continued to employ a Consulting Psychiatrist, who was present at the Facility for two consecutive four-day weeks per month. There was also one full-time locum tenens Psychiatrist, but his contract was scheduled to end on May 5, 2013. During the Monitoring Team's onsite review, this psychiatrist indicated he was open to the idea of returning to the Facility for another locum tenens assignment, but had no immediate plans to do so.
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 staff members had created an administrative infrastructure that optimized the time of the Psychiatrists.
At the time of the Monitoring Team's previous review, it was recommended that the Facility perform an analysis of the number of psychiatrists necessary to provide direct clinical care to the individuals prescribed psychotropic medication, and fulfill all of the requirements of the Settlement Agreement. In response to this, the Chief Psychiatrist prepared a detailed one-page document dated 4/1/13 that fulfilled the above recommendation. This analysis took into account the time required to carry out the following functions (note: these calculations used tildes (~) throughout to denote "approximately"):
<table>
<tr><th>ANNUAL TIME NEEDED PER INDIVIDUAL:
(~) 24 HOURS/YEAR</th><th>~3 FULL WORK DAYS/
INDIVIDUAL/YEAR</th></tr>
<tr><td>CPE or Annual Update/PTP/ISP documentation:</td><td>Six to 14 hours</td></tr>
<tr><td>ISP participation:</td><td>One to three hours</td></tr>
<tr><td>Psychiatry Clinic:
(4 Quarterlies per year at 15-60 minutes)</td><td>One to four hours</td></tr>
<tr><td>PRN/Emergency Needs/IDTs/Polypharmacy:</td><td>One to 12 hours</td></tr>
<tr><td>MOSES/DISCUS/QDDR/labs</td><td>One to two hours</td></tr>
<tr><td>Family/Guardian/LAR/HRC (non-ISP/IDT) discussions:</td><td>One to two hours</td></tr>
<tr><td>Total</td><td>11 to 37 hours/year</td></tr>
</table>
</td><td></td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		(median: 24 hours) **NUMBER OF "WORK DAYS PER YEAR:** **~235 WORK DAYS PER YEAR ON AVERAGE** (365 days/year) minus (~104 weekend days) minus (~12 holidays) minus (~14 vacation days) = 235 "work days" (~235 work days/year) divided by (~3 work days per individual/year) = 75 or **75 INDIVIDUALS PER FTE** These calculations led to the following conclusion: <u>"Rule of Thumb:" One psychiatric provider FTE per 70 to 80 Individuals served on average.</u> Based on averages, psychiatric caseloads: 70 to 80 desirable 81 to 90 manageable 91 to 100 uncomfortable (for many providers) 100+ untenable (for most providers) The document included the following conclusion: "Discussion: Currently at AbSSLC, 183 Individuals are served by psychiatry. Necessary FTEs = 2.44 (183/75). In August/September 2012, when the population served was 190, ~2.53 FTEs were supported. AbSSLC psychiatry provides 2.61 FTEs with 2 full-time and 1 contract provider (since August 2012). AbSSLC has exceeded needed FTEs (before including the time provided by Dr. Rosson, locum tenens).... Dr. Crowley (contractor) works 96 hours/month = 12 "work days"/month = 144 days/year. His time contribution: (144 work days per year) (235 total work days per year) = 0.61 FTEs." The conclusions reached by this analysis appeared to be reasonable, and the Facility had the staffing identified as necessary through the analysis. The Facility was found to be in substantial compliance with this section of the Settlement Agreement.	
J6	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement procedures for psychiatric assessment, diagnosis,	The Facility had developed an initiative to complete a thorough CPE for each individual receiving psychotropic medication, which they believed would meet the standards set forth in the Settlement Agreement. They also had developed a Psychiatric Treatment Plan, which was designed to serve as an annual update to the CPE. The PTP evolved from the PPMTP, and was designed to serve as a comprehensive Treatment Plan for the individual's psychotropic medication as well as an annual update for the CPE and would	Noncompliance

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	and case formulation, consistent with current, generally accepted professional standards of care, as described in Appendix B.	form the basis for the discussion of the individual's psychiatric status at the annual ISP meeting. It was completed in conjunction with the preparation for the annual ISP. The review of the medical records of 27 individuals (15 percent of the 182 individuals prescribed psychotropic medication) identified that a CPE had been completed within the prior year and/or an annual updated PTP had been completed within the past year that met both the quality and timeliness criteria for all of the 27 (100%) individuals in the sample. Specifically, the CPEs exactly followed the outline contained in Appendix B of the Settlement Agreement, and the material in those sections was responsive to the headings in the outline. The PTP was four pages in length and contained the following major section headings: ▪ IDT Members Participating in Preliminary Interdisciplinary Formulation and Planning For ISP ▪ Briefly Summarize Initial Section of the Psychiatric Quarterly Reviews for the Past Year ▪ Behaviors of Concern for Past Year ▪ Evidence For Efficacy (Effectiveness) of Current Psychiatric Medications ▪ Assessment ▪ Discussion of Pending PBSP with Overlap Rationale ▪ Risk Versus Benefit Analysis for Psychiatric Medications (Results Listed Under Each Medication) ▪ Alternative Treatments Discussed ▪ Information for Draft Intradisciplinary Formulation and Planning To Be Discussed and Finalized in ISP Meeting ▪ Treatment Recommendations ▪ Psychiatric Medication Review Frequency, Responsibility and Where to Find in Active Record ▪ Explain Plan to Reduce Polypharmacy, if Present ▪ Non-Pharmacological Treatments and Supports to Minimize the Need for Psychiatric Medication There were also sub-headings below the major heading, which prompted the addition of relevant information. The Facility's internal compilation of individuals with completed CPEs, including the corresponding data for PTPs that served as annual CPE updates, indicated that from 5/1/12 through 4/30/13, these documents had been completed for 153 (84%) of the 182 individuals prescribed psychotropic medication. The Facility's current plan was to update the CPEs in conjunction with the individuals' annual ISP reviews. Thus, based on the success rate the Psychiatry Department had in completing these updates over the past several months, it is anticipated that all of the individuals receiving psychotropic medication will have this documentation completed before the Monitoring Team's next review. However, at this time, the Facility was found to be in	

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		noncompliance with this section of the Settlement Agreement, as the overall completion rate was 84 percent.	
J7	Commencing within six months of the Effective Date hereof and with full implementation within two years, as part of the comprehensive functional assessment process, each Facility shall use the Reiss Screen for Maladaptive Behavior to screen each individual upon admission, and each individual residing at the Facility on the Effective Date hereof, for possible psychiatric disorders, except that individuals who have a current psychiatric assessment need not be screened. The Facility shall ensure that identified individuals, including all individuals admitted with a psychiatric diagnosis or prescribed psychotropic medication, receive a comprehensive psychiatric assessment and diagnosis (if a psychiatric diagnosis is warranted) in a clinically justifiable manner.	The spreadsheets produced in conjunction with the Monitoring Team's initial reviews 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. 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. Specifically, this spreadsheet covered the time period from 7/15/12 through 5/6/13. The individuals who had been administered the Reiss Screening instrument within the timeframe described above were as follows: <u>Individual #142</u>: Reiss Screen administered 7/18/12 (Total Reiss Score = 13) This individual's mother/guardian had declined a psychiatric evaluation or services in the past. However, consent for such an evaluation recently was obtained. As a result, on 3/27/13, a Psychiatric Consultation was performed, and a Comprehensive Psychiatric Evaluation was pending. <u>Individual #377</u>: Reiss Screen administered 7/19/12 (Total Reiss Score = 0) This Reiss evaluation was performed, because there were concerns that the individual might be displaying symptoms of depression. <u>Individual #86</u>: Reiss Screen administered 8/5/12 (Total Reiss Score = 3) The Treatment Team was concerned that the Individual was having difficulty with sleep. <u>Individual #172</u>: Reiss Screen administered 1/31/13 (Total Reiss Score = 0.5) The Team had concerns about the origin of aggressive and self-injurious behavior. <u>Individual #19</u>: Reiss Screen administered 1/20/13 (Total Reiss Score =15)	Substantial Compliance

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		This individual received psychiatric services in the past, but had been tapered off of psychiatric medications. Due to the elevated score on the Reiss, on 1/25/13, a Psychiatric Consult was performed. As a result of this consultation, it was determined that the current issues were situational in nature, and no further assessment was needed. Individual #80: Reiss Screen administered 11/29/12 (Total Reiss Score = 3.5) Reiss Screen administered 3/5/13 (Total Reiss Score = 4.5) The Team had persistent concerns about agitation, even though the Reiss Screen was below the clinical cut-off score. Accordingly, a CPE was performed on 3/20/13. As a result of this, the individual was started on psychotropic medication and had been followed in the Psychiatry Clinic since that time. Individual #255: Reiss Screen administered 3/28/13 (Total Reiss Score = 1) This individual was newly admitted and was not receiving psychotropic medication. Individual #233: Reiss Screen administered 4/17/13(Total Reiss Score = 0) This individual was newly admitted and was not receiving psychotropic medication. At the time of the Monitoring Team's prior review, it had been recommended that the Facility 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. 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. The Psychiatry Department had responded to this recommendation by maintaining a comprehensive spreadsheet to track any change in status or other reasons that would prompt the administration of the Reiss Screen, the date of administration, the action taken as a result of the Reiss score, and/or if it was elevated above the clinical cut-off score. This data indicated that the Reiss Screen was being utilized when an individual's team developed concerns about a change in an individual's clinical status. However, there was no formal written policy that would specify under what circumstance an individual should be considered for a Reiss evaluation. The review of the data and the results of the evaluations indicated that the Psychiatry and Psychology departments were doing these evaluations in situations where it was appropriate to do so, but a statement cannot made as to whether or not they were being performed in all such situations. There was also evidence that the Psychiatry Department assessed those individuals who had elevated	

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		scores. The elevated score for Individual #19 did not result in a CPE. However, this individual was well known to the Psychiatry Department because of prior treatment that had been successfully discontinued. The Psychiatric Consultation performed as a result of this score was sufficient to answer the clinical questions raised by the elevated score. The Consultation revealed that the reasons for obtaining the Reiss and the elevated score at that time were situational in nature and had since resolved. The Facility was found to be in substantial compliance with this provision, because there was evidence of ongoing monitoring of the status of the individuals who were not receiving psychotropic medication that could lead to the administration of the Reis Screen, as well as the administration of the instrument to all newly-admitted individuals who were not receiving psychotropic medication. There was also evidence indicating that an elevated score would prompt the performance of a Psychiatric Consultation, which would then be followed by a CPE, depending on the results of the Consultation. The circumstances described above with regard to Individual #19 were reasonable and compelling with regard to the rationale for not proceeding with a formal CPE for this individual. However, the Facility should be aware that the specific language of the Settlement Agreement does not account for this situation. Thus, in the future, to maintain substantial compliance, they will need to present either an equally compelling explanation for not any instances in which a CPE is not performed in response to an elevated score on the Reiss or perform a CPE.	
J8	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall develop and implement a system to integrate pharmacological treatments with behavioral and other interventions through combined assessment and case formulation.	The integration between Psychiatry and Psychology Services was apparent in the interviews with the four psychiatric providers, as well as the interview with the Director of Psychology Services. These interactions also were visible in the observation of the Psychiatry Clinics, where it was apparent that the Psychologist had a central role in both the conduct of the meeting, and the analysis of the behavioral data upon which key decisions related to changes in the psychotropic medications were based. The observations of the Psychiatry Clinics and the related documents 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. In	Noncompliance

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		summary, this review indicated that this subject was discussed adequately in the Psychiatric sections of the records of all 27 individuals (100%). However, taking into account the material in the psychology sections of the record reduced this figure to 20 of the 27 records (74%). The reason being that the material in the psychology section for seven of the 27 individuals (26%) was different from that in the psychiatry section and did not consider all of the factors that had been discussed in that section. Section J.8 also contained 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 the 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 Monitoring Team's prior review, the members of the Psychiatry Department 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 27 individuals in this sample. This review indicated that a member of the Psychiatry Department had attended a recent individual ISP meeting for 12 of the 27 (44%) individuals in this sample. The specific records that contained this documentation were those of: Individual #320, Individual #478, Individual #460, Individual #87, Individual #451, Individual #397, Individual #180, Individual #525, Individual #355, Individual #518, Individual #139, and Individual #324. At the time of the Monitoring Team's prior review, it was recommended that the documentation related to these meetings should reflect both the Psychiatrists' contribution to the meetings, and also contain a reference to the primary components of the psychiatric medication treatment plan. The documentation contained in nine of the 27 (33%) individual records reviewed contained an adequate discussion of the psychiatric aspects of the individuals' treatment, as specified in Sections J.8, J.9, and J.10 of the Settlement Agreement. The specific records which contained this information were those of Individual #300, Individual #397, Individual #478, Individual #460, Individual #180, Individual #405, Individual #525, Individual #87, and Individual #461. A member of the Psychiatry Department team also	

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		attended these meetings, with the exception of Individual #405, for whom the information had been supplied by Psychiatry in advance of the meeting. The specific documentation related to the individuals' psychiatric disorder that was contained in these ISPs ranged in length from approximately one and a half pages to over two pages. The subject matter that was discussed in this section included the following topics: The psychiatric diagnosis with supporting symptoms and the "interdisciplinary formulation," which included the derivation of the target behaviors of the psychiatric medications as well as any overlap with the target behaviors described in the PPSP; the medical factors which could influence the individual's behavioral presentation; the relevant information from the most recent Quarterly Review documentation, including information on the efficacy of the prescribed medication as well as the presence of any side effects including the results of the most recent MOSES and Discus evaluations; and a discussion of the risk versus benefit considerations and a subsection entitled "Determination of least restrictive and most positive interventions," which included the pros and cons of alternate possible forms of intervention other than psychotropic medication. The concluding paragraph described the conclusions of the IDT related to the above considerations. Beginning in January 2013, the Psychiatry Department had begun to track the attendance of a member of their team at the ISP meetings. This documentation indicated that a member of the team had attended 92 of the 96 (96%) individual ISP meetings that occurred in this timeframe. This frequency of attendance differed from that found in the sample described above, because the timeframe for the ISPs of individuals in the sample spanned the prior year, and it was only beginning in January of this year that the Psychiatry Department increased their efforts to attend these meetings. The Facility remained in noncompliance with this provision, primarily due to the deficits in the documentation found in 67 percent of the ISPs contained in the sample. However, this represented a significant improvement, as in the Monitoring Team's prior reviews, adequate documentation had not been found in any of the records reviewed. This observation also indicated that the Department had created a mechanism for including this documentation into the ISP document, which needs to be effectively replicated in the future.	
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,	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 found in the sample of 27 records of individuals receiving psychotropic medication. The Psychiatrist relied heavily upon the data related to the frequency of those behaviors 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	Noncompliance

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	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.	had been identified in the Monitoring Team's previous reports, related to the degree to which behaviors 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 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 evolved into the PTP. The issue of the differentiation of the behaviors related to the psychiatric diagnosis, as opposed to being related to a purely behavioral etiology, as well as the discussion of those behaviors that were co-determined, was reviewed in a distinct section of the Psychiatric Treatment Plan. This section provided a checklist related to any overlap that 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 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 Initiation (PMI) form served as an addendum to the PTP when a new medication was started for an individual already receiving psychiatric services. The identification of the primary symptoms of the individual's psychiatric disorder, which was contained in the PTP, 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 27 records contained in this sample indicated that these areas were completed in all (100%) of the documents, in a timely manner that was responsive to the prompts. This discussion in these records represented an adequate differentiation of the behaviors or rationale for their co-existence on a behavioral basis and as a symptom of the psychiatric disorder. The interaction of the biological and behavioral-based aspects of the individual's presentation was also discussed in the Bio-Psycho-Social-Spiritual formulation section of	

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		the CPEs. That information summarized the material 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 Monitoring Team's current and prior reviews indicated the discussions upon which the documentation in the Psychiatry Quarterly Reviews and PTP were based occurred in the context of the individual Psychiatry Clinics and represented contributions from all of the disciplines present, including the direct support professionals. The Psychology documentation did not contain a discrete section that discussed this issue, but the language of the PBSPs had been modified so 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. These references appeared throughout the PBSPs, where appropriate. The review of the sample of records for 27 individuals receiving psychotropic medication identified 20 (74%) individuals 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 #320, Individual #518, Individual #462, Individual #323, Individual #94, Individual #478, Individual #355, Individual #168, Individual #534, Individual #4, Individual #363, Individual #405, Individual #397, Individual #170, Individual #278, Individual #517, Individual #87, Individual #304, and Individual #460. The individuals' records that were identified as containing a dual reference to maladaptive behaviors were those of: Individual #530, Individual #324, Individual #510, Individual #525, Individual #529, Individual #180, and Individual #139. As noted previously, the documentation in the Psychiatry section of the record discussed this issue effectively in all of the 27 (100%) records. The deficits in the seven (26%) individual records referenced above consisted of a lack of discussion of this issue in the Psychology section of the records. This omission was in marked contrast to the material in the other 20 records, in which there was a thorough discussion of this subject. 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 they would receive the behavioral supports that were appropriate to address the problem. The contributions of this process to the determination of the least	

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		intrusive interventions are obvious. As noted above with regard to Section J.8, the ISP documentation contained in 18 of the 27 (67%) records was not adequate to show that teams had conducted the necessary review this provision of the Settlement Agreement required. However, the documentation contained in the other nine of the 27 (33%) records provided an adequate discussion that addressed the following topics, which were referred to in the Settlement Agreement: ▪ 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 ▪ When a team determined the use of psychotropic medication was necessary, the ISPs also specified the non-pharmacological treatments, interventions, or supports to address signs and symptoms in order to minimize the need for psychotropic medication to the degree possible. Thus, although the progress of the Psychiatry Department in addressing these issues through the methods described above was significant, the Facility remained in noncompliance with this provision. This was due to the continued deficits in the coordination of the documentation contained in the Psychiatry and Psychology Departments with regard to the derivation of the behaviors identified as the targets of the psychotropic medication. In addition, the deficits in the ISP documentation identified in Section J.8 are also relevant to this provision.	
J10	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, before the non-emergency administration of psychotropic medication, the IDT, including the psychiatrist, primary care physician, and nurse, shall determine whether the harmful effects of the individual's mental illness outweigh the possible harmful effects of psychotropic medication and whether reasonable alternative treatment strategies are likely to be less effective or potentially more dangerous than	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 reviews also indicated 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 identified as the targets of the psychotropic medication. The Facility responded to the recommendations related to these observations by developing a more specific system for documenting the risk-versus-benefit considerations. The Facility's method 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	Noncompliance

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	the medications.	individual's psychiatric illness, if it was not treated. 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 efficiently. The Monitoring Team's current review found that there was an adequate discussion of the risk-versus-benefit analysis in each of the 27 (100%) individual records in the sample. Supporting documentation for these decisions was contained in the Quarterly Psychiatric Review, as well as the PTP, which had evolved from the PPMTP. The Quarterly Psychiatry Review form contained specific sections related to: ▪ The evidence that would support the efficacy (benefit) of the current psychotropic medication; ▪ A checklist of commonly experienced side effects, including a space for "other" and a global rating of severity; ▪ The most recent MOSES and DISCUS scores; and ▪ A section to address any questions or comments raised by the last Quarterly Pharm.D. review. A number of subjects previously discussed in the Quarterly Review forms had been moved to the PTP. A significant amount of the information in the four-page PTP document was devoted to defining the risk-versus-benefit considerations for each of the individual's prescribed psychotropic medications. These sections of the PTP recorded the results of the assessment of both the potential and realized risks of each medication, as well as the documented benefits realized from the use of those medications that had been added more recently. The potential benefits were discussed, as well as the length of time that might be required for the individual to experience those benefits. These sections of the PTP also included a review of alternate treatment approaches that had been considered. Observations of the Psychiatry Clinics during the Monitoring Team's onsite review indicated that there was an active discussion of these issues during the Quarterly Review, in which many of the IDT members participated. The discussions between the Psychiatry team and members of the HRC during the Monitoring Team's prior reviews indicated that there had been some confusion regarding the implementation of the new risk-versus-benefit analysis system. This confusion was not observed during either the HRC Meetings on 8/22/12 or 5/8/13. The 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	

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		Meeting. The Chief Psychiatrist attended both of these meetings. As noted above, this review found that there was adequate documentation in the entire sample of 27 (100%) individual records. The Facility had developed a system, which ensured a thorough review of both the efficacy (benefits) and side effects (risks) of each of the individuals prescribed psychotropic medications, and was consistently implementing those methods. Although the Facility had developed an effective method for documenting the risk-versus-benefit considerations involved in the use of psychotropic medication, this information had not yet been integrated into the ISP process, as mandated by the requirements of this provision, which stipulates that it must be approved by the IDT. However, as indicated in the discussion of Section J.8, 33 percent of the ISP documents contained in the individual records were found to have an adequate discussion of this and the other aspects of the individuals' psychiatric care as mandated by the Settlement Agreement. The integration of the relevant material considering the risk-versus-benefit considerations related to the use of psychotropic medication into the ISP process needs to be expanded. Accordingly, although good progress had been made, the Facility was found to be in noncompliance with this provision.	
J11	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall develop and implement a Facility- level review system to monitor at least monthly the prescriptions of two or more psychotropic medications from the same general class (e.g., two antipsychotics) to the same individual, and the prescription of three or more psychotropic medications, regardless of class, to the same individual, to ensure that the use of such medications is clinically justified, and that medications that are not clinically justified are eliminated.	ABSSLC had continued its policy of reviewing every individual whose psychotropic medication regimens met the criteria for polypharmacy on a monthly basis. The "Monthly Psychiatric Polypharmacy Committee 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, the Psychiatric Nurse Practitioner, 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. The one exception to this was that those individuals who were in the stable polypharmacy group (SP) were reviewed quarterly. On 5/8/13, a member of the Monitoring Team observed the May meeting of this Committee. The meeting included a 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 5/8/13 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 50 (27%) of the 182 individuals prescribed 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	Substantial Compliance

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		contained this information did not include the total number of individuals prescribed psychotropic medication until August of that year. Tabular representation of that data is as follows:	

DEFINITIONS OF POLYPHARMACY	8/10	5/13
Number of individuals receiving two or more medications from the same class	16	10
Number of individuals receiving three or more medications regardless of class or indication	108	46
Total number of individuals on polypharmacy	108	50*
Total number of individuals receiving psychotropic medication	224	182
Percentage of individuals receiving psychotropic medication whose medication regimen met the criteria for polypharmacy	48%	27%

*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, as these individuals are only counted once.

This section of the Settlement Agreement also states that it is necessary "to ensure that the use of such medications is clinically justified, and that medications that are not clinically justified are eliminated." Thus, this section also relates to the documentation that all prescribed medications could be empirically demonstrated to be effective.

During the earlier observations of the Polypharmacy Committee meetings, 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. At the time of the Monitoring Team's prior review, 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). As of the conclusion of the 8/21/12 Polypharmacy Committee 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 medications for 19 of the 45 (42%) individuals prescribed medication regimens that met the criteria for polypharmacy. For the remaining 58 percent, the Facility was 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 Monitoring Team's onsite review in August 2012, there was an extensive discussion between a member of the Monitoring Team and the members of the Polypharmacy

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		Committee regarding the type of evidence that would generally be required to substantiate efficacy. At the time of the 5/8/13 meeting, the Facility had determined that there were 27 individuals in the SP group, and 23 individuals in the AP group. However, the latter number also included seven individuals who had been admitted to the Facility in recently. The first of these individuals was admitted in November 2011, and the other six had been admitted since the Monitoring Team's previous review. All of these seven individuals were in the AP group and were receiving three or more psychotropic medications at the time of admission. Three of these individuals also met the criteria for intra-class polypharmacy. The total number of medications that these individuals were receiving at the time of admission ranged from three to seven. Specifically, two were on three mediations, three were on five medications, and two were on seven. Both of the individuals who were admitted on seven medications were currently receiving only three. Two that were on five medications were admitted since 3/1/13, and were still receiving five mediations, but the one that was admitted earlier had now been reduced to four mediations. 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 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 individuals in the AP group. The historical data the Psychiatry Department had assembled to support their contention that the use of these medications could be empirically justified was discussed at the time of the meeting, and since then, a member of the Monitoring Team has further reviewed it. This evidence was specific to the individual, and usually consisted of the documentation of significant improvement following the initiation of a specific medication, and/or behavioral data related to a prior attempt to decrease the medication that led the Team to reinstate treatment with the medication at the dosage proven to be therapeutic. The data related to the determination of efficacy was also carried forward and continuously updated in the Quarterly Review documentation. The data compiled was found to be of a sufficient quality and detail to be considered justification for their continued use for all of the individuals that were described in the written material contained in the minutes of the Polypharmacy Committee. As will be discussed later with regard to Section J.13, the efficacy of the prescribed psychotropic medications for all of the individuals contained in the sample of 27 individuals (100%) was also found to be	

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		sufficient. The individuals the Facility had placed in the AP grouping had more complex psychiatric presentations and also had historically been prescribed more psychotropic medications. This group also contained some individuals who had active tapering schedules for some medications, but the medication had not yet reached the point that it could be discontinued. The current AP group consisted of 23 individuals. However, this also included the seven individuals who had been admitted to the Facility on multiple medications. The removal of these seven individuals from the active group, in order to place them into a separate monitoring group that had yet to be justified, reduced the number of individuals prescribed polypharmacy to 16 of the 182 (9%) individuals prescribed psychotropic medication. The current finding of substantial compliance for this provision primarily related to the observation that the Facility had reduced the rate of unjustified polypharmacy to nine percent, and was continuing to make progress in either reducing the medications of the remaining 16 individuals and/or compiling the necessary data to support efficacy. For individuals in the Stable Polypharmacy group, the data the Facility maintained was sufficient to show the justification for the polypharmacy. It is essential that the Facility continue to 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 that 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 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 requires systemic, quarterly monitoring for the emergence of motor side effects related to the utilization of antipsychotic medication with the Dyskinesia Identification System: Condensed User Scale, and the monitoring of more general systemic side effects related to psychotropic medication with the Monitoring of Side Effects Scale every six months per the Health Care Guidelines. 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 the nurse completed the exam, and the documentation was reviewed and signed by the prescribing physician. The review of the sample of records for 27 individuals prescribed psychotropic	Substantial Compliance

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		medication showed that the MOSES evaluation was current (completed within the last six months) and had been performed at least every six months for the prior year, was present for all of the 27 (100%) individuals. The records of 26 of the 27 (96%) individuals contained documentation that the prescribing physician had reviewed the MOSES evaluation in a timely manner, which had been defined as 14 calendar days. The individual whose MOSES documentation was not reviewed in a timely manner (latency between dates) was that of Individual #460 (10/31/12 to 11/27/12). 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 27 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 prior 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 Facility's rationale is 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 who require 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 of the individuals in the sample. Thus, the DISCUS had been performed as specified for all of the 27 (100%) individuals 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 three individuals whose records indicated 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 #460 (12/11/12 to 12/31/12); Individual #534 (10/31/12 to 11/27/12); and Individual #168, for whom the 12/17/12 evaluation did not contain the signature of the prescriber who reviewed the document. Thus, the prescribing physician reviewed the DISCUS in a timely manner for 24 of the 27 (89%) individuals. The DISCUS and MOSES also are necessary to monitor for the side effects of Reglan,	

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		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 18 individuals receiving Reglan who were not also prescribed a psychotropic medication. The following sample of six individuals (33 percent of the 18 individuals who fit the above criteria) was selected, including: Individual #296, Individual #162, Individual #265, Individual #117, Individual #333, and Individual #385. Review of the records of these individuals related to the MOSES indicated that the examination had been performed at least every six months for all six (100%) individuals. 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 six (100%) individuals. With regard to the completion of the DISCUS for the individuals in the sample, these evaluations were completed as specified for all of the six (100%). Once completed, the prescribing physician had reviewed the DISCUS evaluations in a timely manner for all six (100%) individuals in the sample. During the Monitoring Team's initial 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 had 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 Monitoring Team's previous review and the 5/7/13 Psychiatry Clinic, a member of the Monitoring Team discussed the process with a nurse who had completed the MOSES and DISCUS evaluations. She indicated that linking the evaluations to the Quarterly Psychiatry Reviews had been helpful, because she had to prepare other documentation for these reviews, and that 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 the Monitoring Team's previous review, a 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	

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		to that video. During the Monitoring Team's current onsite review, a request was made for this documentation, and the Facility provided a detailed three-page spreadsheet, which described the training materials, and the scoring methods for assessing competence. 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 included the review of every MOSES and DISCUS evaluation performed at ABSSLC from 3/12 to 2/13. The spreadsheet that reported this data provided monthly results and quarterly summaries. The results of the quarterly summaries from 3/12 to 2/13 were as follows: ▪ 3/12 to 5/12 = 74 percent; ▪ 6/12 to 8/12 = 91 percent; ▪ 9/12 to 11/12 = 88 percent; and ▪ 12/12 to 2/13 = 90 percent. This data was consistent with the results of the Monitoring Team's current review in terms of both the significant improvement and the current status. 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 was found to be in substantial compliance with this provision. The methods that the Facility implemented to improve both the timely administration of the MOSES/DISCUS, as well as the review of these documents had been successful. Specifically, the results from the Monitoring Team's current review of the 27 records of the 182 individuals who were prescribed psychotropic medication indicated that the MOSES was completed as specified for 100 percent of the individuals and had been reviewed in a timely manner for 96 percent. The corresponding review for the DISCUS indicated that it had been performed as specified for 100 percent of individuals and reviewed in a timely manner for 89 percent. The MOSES and DISCUS monitoring for the individuals receiving Reglan was 100 percent complete for both the timely administration and the prescribing physician's review of these evaluations.	
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	This provision of the Settlement Agreement addresses processes that are essential for the appropriate use of psychotropic medication for individuals with ID/DD. The first of these relates to the integrity of the psychiatric diagnosis, as indicated by the following terminology: "The Treatment Plan for the psychotropic medication identifies a clinically justified diagnosis or a specific behavioral-pharmacological hypothesis." The review of records of a sample of 27 (15%) of the 182 individuals receiving psychotropic medication indicated that adequate documentation to support the psychiatric diagnosis of record could be identified for all (100%) of the individuals. However, an adequate discussion of this material only appeared in the ISP documentation for nine of the 27	Noncompliance

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	justifiable diagnosis or a specific behavioral-pharmacological hypothesis; the expected timeline for the therapeutic effects of the medication to occur; the objective psychiatric symptoms or behavioral characteristics that will be monitored to assess the treatment's efficacy, by whom, when, and how this monitoring will occur, and shall provide ongoing monitoring of the psychiatric treatment identified in the treatment plan, as often as necessary, based on the individual's current status and/or changing needs, but no less often than quarterly.	individuals in the sample (33%). This issue and the references to the specific records that contained this information are discussed with regard to Section J.8. The narrative contained in relation to Section J.8 also discusses the specific content of the material that was covered in the ISP documentation that met the quality standards of the Settlement Agreement. This material addressed the items that are also described in this provision, such as the justification for the psychiatric diagnosis, the expected effects of the medications, as well as the symptoms and or behaviors that would be monitored to assess the efficacy of the medication. The other factors that are referenced in this provision, such as the ongoing monitoring of these symptoms or behaviors, is discussed in the quarterly documentation that also was summarized in those ISPs that have been identified as meeting the quality standards of the Settlement Agreement. This subject is also discussed in more detail with regard to Section J.2 and Section J.6. The criteria for this section also address the need to identify "the objective psychiatric symptoms or behavioral characteristics that will be monitored to assess the treatments' efficacy." These "symptoms or behavioral characteristics" were referred to in 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 is discussed in detail with regard to Section J.9. This important issue was addressed in the Psychiatry section in each of the records of the 27 individuals selected for review. It also was reviewed in a comprehensive manner in the Psychology section of 20 of the 27 (74%) individuals, as detailed in Section J.9. However, in the remaining seven (26%) there was no discussion of the impact of the individual's psychiatric diagnosis on their behavioral status, leading to the observation that the target behaviors of the psychotropic medications were also described in the Psychology section as being present on an operant basis and/or related to environmental factors. The objective symptoms of the psychiatric disorder and the related behavioral characteristics were detailed in each of the Quarterly Psychiatric Review notes contained in this sample, as well as those that were observed during the course of the Monitoring Team's onsite review. The Psychologist led this aspect of the discussion during the meeting, but there was active input from all of the professional disciplines 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. The format of the meetings was not strictly formalized, but generally followed the outline of the two-page Psychiatric Quarterly Review notes, which the Psychiatrist completed	

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		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. 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 to pre-set allocations 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. The Facility also had the capability to perform urgent evaluations. On 5/7/13, a member of the Monitoring Team was able to observe the clinical evaluations performed by the Consulting Psychiatrist in the home of Individual #405 and Individual #397. Both of these individuals had undergone psychotic decompensations. The evaluations were thorough, and the findings were clearly communicated to both the Unit Nursing staff and the direct support professionals who worked with the individuals. These discussions also indicated that the Consulting Psychiatrist had previously been contacted by telephone during the hours when he was not at the Facility with regard to Individual #405, and had been responsive to these calls. The Quarterly review documentation was structured to provide clinical information on the following subjects in the order that follows: A narrative description of the individual's history since the last review; the objective behavioral data related to the frequency of the direct symptoms of the psychiatric disorder and/or the behaviors that were derived from those symptoms, which was presented in tabular form; the derivation of the target behaviors; the current psychotropic medications and dosages; the data related to dates of any changes in those medications; the empirical evidence related to the efficacy of those medications; the past psychotropic medications; a listing of the non-psychotropic prescribed medications; recent medical events; date of last Seizure and Neuro consult, if applicable; most recent relevant laboratory data including medication blood levels, if applicable; nutritional assessment; vital signs and weight including Body Mass Index; type of diet; allergies to medications; the results of the most recent MOSES and DISCUS evaluations; the results/comments of the last quarterly review by the Pharm. D. including the response to those comments; a description of any current medication side effects; the recommendations from the most recent Polypharmacy Committee meeting; mental status evaluation conducted at the time of the meeting; the psychiatric diagnosis and the primary identified symptoms of that disorder including the Global	

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		Assessment of Functioning; a description of the individual's medical diagnoses; suggested psychotropic medication for behavioral emergencies, if relevant; a section in which to discuss any changes to the individual's psychiatric medications; and a space for any additional comments. This documentation was routinely completed for all of the individuals in the sample of 27 individuals (100%). The information related to the timelines with which the effects from any changes related to the prescription of new psychotropic medications could be expected to occur, as well as the extensive risk versus benefit discussion that previously appeared in the Quarterly Review documentation had been moved to the Psychiatric Treatment Plan which was currently performed yearly in conjunction with the ISP. The contents and structure of this document is described in detail with regard to Section J.6 This section also addresses the question of the efficacy of the prescribed psychotropic medication. As indicated in the discussion of Section J.11, the Facility has developed a system to empirically determine the efficacy of each individual's psychotropic medication, and then eliminate those whose efficacy could not be substantiated. This information was also contained in a separate section of the Quarterly Review documentation, and was continuously updated. The Facility's overall success in eliminating unnecessary polypharmacy is described with regard to Section J.11. The final requirement of this provision is related to the frequency with which the Psychiatrist reviews individuals prescribed psychotropic medication. The current review of the sample of records indicated that Quarterly Reviews were performed as specified in this provision for all of the 27 (100%) individual records reviewed. Documentation was also present to show that the Psychiatrist had directly observed the individual in conjunction with the Quarterly Review for the entire sample of 27 (100%) individuals. The Psychiatry Department had made progress with several of the components specified in this section of the Settlement Agreement. Much of this progress was related to the Quarterly Review documentation and the Annual PTP for those individuals prescribed psychotropic medication, as discussed in detail with regard to Sections J.2 and Section J.10. However, the Facility remained in noncompliance with this provision due to the deficits related to the dual descriptions of behaviors as being both targets of the psychotropic medication and present on a behavioral basis in 26 percent of the 27 records reviewed.	
J14	Commencing within six months of the Effective Date hereof and with full implementation in one year,	The review of the Rights/Consents sections of the medical records for the sample of 27 individuals indicated that 17 (63%) individuals had a guardian. Those individuals without a guardian relied on the Facility Director to review the material concerning risk-	Noncompliance

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	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.	versus-benefit considerations related to the utilization of psychotropic medication, and then provide the necessary consent. As indicated with regard to Section J.10 of the Settlement Agreement, the risk-versus-benefit analysis contained in the Psychiatry section of the record demonstrated that 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 the medication was made. If the guardian could not be directly contacted 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 determine if the guardian might have had concerns, but did not express them to the medical team. The QDDP was the member of 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. Following the verbal consent, the approval process proceeded to the next HRC Meeting. Following their approval, the Medical Records Department would send out the detailed side effect information as well as an explanatory cover letter to obtain the final written consent. On 5/8/13, 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 earlier reports described difficulties the Committee was experiencing in understanding and reviewing the risk-versus-benefit analysis. The Chief Psychiatrist had been periodically attending the HRC meetings over the past six months and attended the meeting on 5/8/13. 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 previously had been performed in conjunction with their approval of the PBSP. Following the Monitoring Team's February 2012 review, the process of reviewing the psychotropic medications separately from the PBSP had been fully implemented. Overall, this appeared to be a positive change that provided for a more detailed analysis of the risk-versus-benefit considerations related to	

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		the use of each specific psychotropic medication. The Monitoring Team's current review also found signed consents in the sample of 27 (100%) records of individuals receiving psychotropic medication. The direct observations of the Human Rights Committee review of the use of psychotropic medications during both the Monitoring Team's current and prior reviews, as well as the documentation from those meetings, indicated that the Facility had a functioning system to obtain Informed Consent for the use of psychotropic medication at ABSSLC. The Monitoring Team found that the Facility remained in noncompliance with this provision, which was consistent with the finding in the most recent Facility Self-Assessment, where it was noted that there continued to be problems with the identification of the "associated risk of medications" and "the limitations on use of medications." The latter point is an important consideration as currently the Facility's consent process allowed for the use of individual medications with no restrictions on the dosage range of medication that can be prescribed for the individual or the specific indications for which it can be used. These parameters are integral aspects of the informed consent process as indicated by the language in this provision that states that the informed consent "shall include any limitations on the use of the medications." The Facility should ascertain if a simplified version of this individual-specific information could also be provided to the guardian/LAR, in addition to the more general side effect information that is already supplied. It would also be useful if the process of obtaining verbal consent, which is described above in the third paragraph of this section, could be documented in a log or a similar written record. The Facility should also address the issue of reasonable limitations on the use of the medications including information on the dosage range that will be used and if that dosage range adheres to the accepted FDA Guidelines.	
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	At the time of the Monitoring Team's prior review, ABSSLC 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 the Monitoring Team's onsite review. Based on report, the individuals with a psychiatric disorder as well as a neurological disorder were not routinely scheduled for appointments during separate time periods from those who did not have a psychiatric	Noncompliance

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	disorder.	diagnosis. At the time of the Monitoring Team's prior review, 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. In the months following the Monitoring Team's last review, the Psychiatrist had stopped attending the Neurology Clinics because of the amount of time required, and the fact that most of this time was devoted to the review of individuals who were not also followed by Psychiatry. During the Monitoring Team's prior reviews, the Facility had indicated that if, in the future, more Neurology consultation time was required, the contract could be expanded. At the time of the current review, this had occurred. Specifically, a new Consulting Neurologist had been contracted to perform one Neurology Clinic per month to augment the two Clinics per month the other neurologist continued to perform. 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. 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 was also assessed. Documentation that the individual had been seen in a Neurology Clinic during the past year was present in 16 of the 27 (59%) individuals. The documentation that the Neurology Clinic had occurred appeared in the Psychiatric Quarterly Review Notes for all of the 16 (100%) individuals in this sub-sample. The Neurology Notes also referenced the psychotropic medications for all 16 (100%) individuals. 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 identification of the individual's psychotropic medication in the Neurology note is essential to ensure that the Neurologist is aware of these medications and can account for any possible interactions with the prescribed anticonvulsant medications. The presence of this information is not sufficient to constitute the joint "coordination" of the psychiatric and neurological medications as specified in the Settlement Agreement, because this requires the discussion of other aspects of the individual's clinical presentation.	

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		The review of the correspondence between the Chief Psychiatrist and other members of the medical staff indicated that, following the time of the Monitoring Team's prior review, the Psychiatry Department had pursued approval to institute a separate Neurology Clinic for those individuals jointly followed by both Neurology and Psychiatry. The purpose of a joint Neurology-Psychiatry Clinic would be to 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. However, based on interview with the Chief Psychiatrist, this plan was not possible to implement. The reasons for this appeared to be primarily logistical in nature, as the existing Neurology Clinic was organized to bring all of the individuals from a specific home that were due to see the Neurologist at the same time, to make it possible for the direct support professionals and the nurse to provide information to the Neurologist. The individuals who Psychiatry also followed were interspersed throughout these large groups, making it impossible to develop a separate Neurology-Psychiatry Clinic within the current system. The Facility remained in noncompliance with this provision, due 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 was often either not present or very brief. During the course of the Monitoring Team's onsite review, the Psychiatry Department indicated that the addition of the new Consulting Psychiatrist, who would be performing an additional Neurology Clinic each month, might make it possible to create a separate, combined Neurology-Psychiatry Clinic that would enable the Psychiatrist to directly interact with the Neurologist in a manner that is efficient for both of them. Another component of this plan would be to identify those individuals who were actively being monitored by both Psychiatry and Neurology, which would decrease the number of individuals who would need to be seen. ABSSLC had a large number of individuals residing at the Facility who had seizure disorders. The language of this provision of the Settlement Agreement is specific in stating the Psychiatrist and the Neurologist coordinate the use of medications "when they are prescribed to treat both seizures and a mental health disorder." At the time of the onsite review, the list of individuals prescribed anticonvulsant medication for psychiatric purposes identified 49 individuals. However, it is likely that many of these individuals did not have a comorbid seizure disorder, as anticonvulsants are primarily used in Psychiatry as mood stabilizers. Many of the individuals followed in the Neurology Clinic and also followed by Psychiatry, had a stable seizure disorder that was being treated with an anticonvulsant medication that was not also used for psychiatric purposes. Accordingly, the Facility's efforts to meet the	

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		requirements of this provision of the Settlement Agreement may become more manageable if they focus on the specific individuals who meet the criteria identified in this provision.	

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

1. The documentation contained in the Chemical Restraint forms that involve the oral administration or intramuscular injection of a psychotropic medication during crisis situations should be fully completed. (Section J.3)
2. 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. This process could be facilitated by developing a database for medical procedures that is similar to that used to decrease the reliance of pre-treatment sedation for dental procedures. (Section J.4)
3. 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 risk-versus-benefit determination, and the least intrusive intervention, as specified in the Settlement Agreement. In this regard, the Facility use as models the ISPs identified in Section J.8 that were found to have fulfilled the requirements of the Settlement Agreement (Section J.8, Section J.9, and Section J.10)
4. The Facility should explore the possibility of incorporating a simplified version of their risk-versus-benefit determinations into the material that is provided to the guardian as part of the Informed Consent process. In addition, they should consider developing a verbal consent log or other written documentation that would be used to record the dates of the verbal conversations with the guardians related to the initial verbal consents to use psychotropic medications. As part of the consent process, the Facility also should develop reasonable limitations on the use of the psychotropic medications as described in the Settlement Agreement. (Section J.14)
5. The Psychiatry Department should consider developing a distinct Neurology-Psychiatry Clinic devoted to the individuals prescribed medications treating both a seizure disorder and a psychiatric disorder, and/or improve the quality of the information that is contained in the Neurology Consultations concerning the individuals' psychiatric status. (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 5/6/13; o Section K Presentation Book; o Organizational Chart for Department of Behavioral Services, dated 5/13; o Chart of Associate Psychologists and progress in obtaining board certification, dated 3/4/13; o Vitae: Kathy Theiss; o Draft Policy: Behavioral Health Service Department, Number 008.3; o Psychology Procedure: Training Staff on Behavior Support Plans, revised 4/1/13; o Behavioral Crisis Response Procedure, undated; o Behavioral Crisis Debriefing form, undated; o Functional Assessment guidelines/template, revised 3/24/13; o Psychology Procedures: Psychological Evaluations and Updates, revised 3/24/13; o Detailed Instructions for Submission to Behavior Support Committee, revised 9/12; o Psychology Procedure: Behavior Services Peer Review, dated 3/24/13; o Psychological Evaluation/Update template, revised 3/24/13; o Procedure for Teaching Individuals About Sexual Behavior, dated 3/11/13; o Department of Behavioral Services meeting minutes from 11/5/12 through 3/22/13; o Behavior Support Committees description, dated 1/3/13; o Completed BSC templates for assessments and/or plans for: Individual #87, Individual #440, Individual #199, Individual #163, Individual #126, Individual #115, Individual #180, Individual #74, Individual #220, Individual #390, Individual #26, Individual #300, Individual #478, Individual #422, Individual #6, Individual #147, Individual #464, Individual #76, Individual #218, Individual #108, Individual #229, Individual #239, Individual #196, Individual #481, Individual #197, Individual #441, Individual #42, Individual #89, Individual #425, Individual #127, Individual #168, Individual #97, Individual #268, Individual #153, Individual #24, and Individual #200; o External Peer Review meeting minutes from 11/9/12, 12/14/12, 1/18/13, 2/8/13, 3/6/13, and 4/10/13; o Interdisciplinary Peer review, notes regarding identified individuals, undated; o List of Individuals Admitted since 9/1/12; o Psychology Monthly Progress Notes from 12/12 to 2/13 for: Individual #87, Individual #126, Individual #220, Individual #168, Individual #97, Individual #24, Individual #465, Individual #182, and Individual #414; o Psychology Monthly Progress Notes from 1/13 to 3/13 for: Individual #280, Individual #517, Individual #61, Individual #315, Individual #355, Individual #287, and Individual #211; o Psychology Monthly Progress Notes from 2/13 to 4/13 for: Individual #26, Individual

	#489, Individual #505, Individual #545, Individual #89, Individual #285, Individual #273, Individual #430, Individual #215, Individual #222, Individual #525, Individual #37, and Individual #324; o Psychology Monthly Progress Notes for: Individual #123 (4/13), Individual #46 (11/12, 1/13, 2/13), Individual #397 (2/13, 3/13), Individual #527 (11/12, 12/12, 2/13), and Individual #80 (3/13, 4/13); o PBSP Data Sheets for: Individual #87, Individual #126, Individual #280, Individual #123, Individual #517, Individual #61, Individual #220, Individual #26, Individual #478, Individual #489, Individual #239, Individual #505, Individual #545, Individual #197, Individual #315, Individual #89, Individual #355, Individual #97, Individual #168, Individual #24, Individual #465, Individual #285, Individual #46, Individual #273, Individual #430, Individual #287, Individual #215, Individual #222, Individual #397, Individual #525, Individual #37, Individual #527, Individual #324, Individual #211, Individual #80, Individual #182, Individual #414, and Individual #399; o Data sheets for target problem behaviors for the period of 5/6/13 to 5/9/13: Individual #23, Individual #123, Individual #42, Individual #456, Individual #222, and Individual #80; o Abbreviated Behavioral Assessment for: Individual #87, Individual #280, Individual #220, Individual #26, Individual #478, Individual #239, Individual #505, Individual #545, Individual #89, Individual #97, Individual #168, Individual #24, Individual #465, Individual #273, Individual #430, Individual #287, Individual #222, Individual #525, Individual #37, Individual #527, Individual #211, and Individual #182; o Behavioral Assessment for: Individual #123, Individual #517, Individual #61, Individual #489, Individual #315, Individual #355, Individual #46, Individual #215, Individual #397, and Individual #414; o Brief Behavioral Assessment for Individual #285 and Individual #80; o Human Rights Committee meeting minutes, from 10/2/12 through 3/26/13; o Abbreviated Functional Assessment for new admissions: Individual #239, Individual #248, Individual #222, and Individual #211; o Behavior Protocol for new admissions: Individual #239, Individual #256, Individual #248, Individual #222, and Individual #211; o Reiss Screen and Inventory for Client and Agency Planning (ICAP) summary for new admission: Individual #255; o Counseling Referral Form, dated 10/19/12; o Lists of individuals receiving counseling from the ABSSLC counselor and from the two contract counselors; o Treatment Plan, Psychotherapy Progress Notes (12/12 to 2/13), and ISP Action Plan for Counseling Services for: Individual #87, Individual #517, Individual #478, Individual #99, Individual #430, and Individual #447; o Individual Treatment Plan (counseling) for: Individual #184, Individual #92, Individual #231, and Individual #405; o Progress Note (counseling) for: Individual #184, Individual #92, and Individual #231;

	○ List of Individuals with Behavior Support Plans; ○ Behavior Support Plan for: Individual #87, Individual #126, Individual #280, Individual #123, Individual #517, Individual #61, Individual #220, Individual #26, Individual #478, Individual #489, Individual #505, Individual #545, Individual #197, Individual #315, Individual #89, Individual #355, Individual #168, Individual #97, Individual #24, Individual #465, Individual #285, Individual #46, Individual #273, Individual #430, Individual #287, Individual #215, Individual #222, Individual #397, Individual #525, Individual #37, Individual #527, Individual #324, Individual #211, Individual #182, Individual #414, and Individual #399; ○ Behavior Coach Weekly Schedule, from 5/12/13 to 5/19/13; ○ List of Individuals with Behavior Support Checklists; and ○ Behavior Support Checklists for: Individual #164, Individual #263, Individual #120, Individual #505, Individual #187, Individual #537, Individual #369, and Individual #103. ▪ **Interviews with**: ○ Direct Support Professionals, on 5/6/13; ○ Candia Hallford, Vocational Services Director, on 5/7/13; ○ Kristin Wyrick, QDDP Coordinator, Jeff Branch, Director of Active Treatment, Jolene Willis, Assistant Director of Programs, and Linda Lothringer, DADS SSLC Director of Compliance, on 5/7/13; ○ Shae Butts, Human Rights Officer, on 5/7/13; ○ Jeff Branch, Active Treatment Coordinator, Kristin Wyrick, QDDP Coordinator, and Jolene Willis, Assistant Director of Programs, on 5/8/13; ○ Ron Manns, Director of Behavioral Services, and Dr. George Zukotynski, DADS Coordinator of Behavioral Services, on 5/8/13; and ○ Erin Lomasney, Associate Psychologist/Counselor, on 5/8/13. ▪ **Observations of**: ○ Residence 5961, Residence 5962, Residence 5971, Residence 5972, Residence 6330, Residence 6350, Residence 6360, Residence 6370, 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, and Activity Center 6700; ○ Workshop 1, Workshop 2, and Workshop 3; ○ 5th Street Diner; ○ Human Rights Committee meeting, on 5/7/13; ○ ISP meeting for Individual #241, on 5/8/13; ○ Behavior Support Committee meeting, on 5/8/13; and ○ Restraint Reduction Committee meeting, on 5/9/13.
	Facility Self-Assessment: The Facility provided the Monitoring Team with a copy of its Self-Assessment, dated 4/22/13. The monitoring tool used to assess progress was not included in the Presentation Book.

	Based on a review of the Facility Self-Assessment and interviews with staff: ▪ The Director of Behavioral Services completed monitoring of all Section K components. Additionally, the Associate Psychologist responsible for counseling services completed an audit of referrals and treatment plans for a four-month period. ▪ Department staff rosters and census data were used to assess compliance for Sections K.1, K.2, and K.13. These were adequate tools for determining progress. ▪ In Section K.4, the sample size was identified as 10% of the psychology monthly progress notes over a four-month period. The actual number of progress notes reviewed was not indicated. An analysis of eight indicators was completed with compliance data provided. ▪ The information presented in Section K.5 indicated that all functional assessments completed over a five-month period had been reviewed by the Director of Behavioral Services. The number of assessments was not identified. Although eight indicators were identified within the rubric used to monitor these assessments, compliance data for each indicator was not presented. Over a three-month period, the Director of Behavioral Services and the Associate Psychologist responsible for the assessment monitored a total of 34 assessments. Although an average monthly score was provided, information related to compliance on each indicator was not. The average discrepancy in points scored on the rubric was noted, inter-rater reliability across reviewers for each of the indicators was not identified. ▪ While the Self-Assessment indicated that the Director of Behavioral Services reviewed all behavior support plans presented to the Behavior Support Committee, the number of plans reviewed to determine timely submission and implementation were not identified. Similar to Section K.5, there was a reference to inter-rater reliability in Section K.9. The plan author and the Director of Behavioral Services, using the same rubric, reviewed a total of 33 behavior support plans. Average monthly scores on the rubric were presented with the difference between reviewers noted. Again, this did not allow for an understanding of inter-rater reliability on specific plans or with regard to specific indicators. ▪ Psychology Monthly Progress Notes (identified above) and staff training databases were used to assess compliance in Sections K.10, K.11, and K.12. Outcome data was summarized and clearly presented. ▪ The Facility rated itself as being in compliance with the following sub-sections of Section K: o Section K.2: This was consistent with the Monitoring Team's findings. The Director of Behavioral Services met the requirements outlined in the Settlement Agreement. o Section K.3: This was not consistent with the Monitoring Team's findings. The opportunity for ongoing review of challenging cases remained infrequent. External and interdisciplinary peer review committees met once a month with limitations on the number of cases that could be reviewed. Guidelines for dissemination and implementation of recommended revisions to plans were not clearly identified. Lastly, participating members of the internal and interdisciplinary peer review committees were not noted in meeting minutes. 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. The Department of Behavioral Services was now staffed with eight Board Certified Behavior Analysts (BCBAs), including the Director, Clinical Supervisor, and six Associate Psychologists. Support for training and supervision was ongoing. The Behavior Support Committee continued to meet weekly to review functional behavior assessments, behavior support plans, and crisis intervention plans. The Facility continued with efforts to ensure that these supports were prepared in time for the individual's annual meeting. The External Peer Review Committee and a newly formed Interdisciplinary Peer Review Committee each met monthly to review challenging cases. Due to time constraints, review was limited to one to three cases. Follow-up to recommendations made through the peer review process remained an area in which focused effort was needed. Monitoring of data collection and program implementation continued with recently initiated review of videotapes to help assess data reliability and treatment integrity. Training on plans was enhanced through the introduction of Behavior Support Checklists and the use of Behavior Coaches to provide supervision and support to staff. Further support was provided to staff with the introduction of a protocol for recruiting support during behavioral crises. Improvements were found in a review of functional assessments and behavior support plans. The staff were focusing more on descriptive assessment and in some cases were completing a structured, functional analysis. There was greater evidence of individualized reinforcement systems and expanded identification of replacement behavior. However, work was needed in a number of areas, including but not limited to ensuring BSPs included operational definition of functionally equivalent replacement behavior, increased training opportunities for replacement behavior, and expanded prevention strategies.

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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	At the time of the Monitoring Team's visit, the Department of Behavioral Services was staffed with a BCBA Director, an additional BCBA (identified by the director as the department's Clinical Supervisor), and 18 Associate Psychologists, six of whom had obtained board certification as behavior analysts. Of the remaining 12 Associate Psychologists, three had completed all coursework and supervision requirements, two had completed all coursework, two were enrolled in coursework, and five were not currently enrolled. The Director and Clinical Supervisor provided onsite weekly supervision, required for certification. Additionally, a study group was meeting weekly to help staff prepare for the certification exam. Although significant progress had been made, the Facility remained out of compliance with this provision because the professionals in the Behavioral Services Department were not yet demonstrably competent in applied behavior analysis as evidenced by the	Noncompliance

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	individuals, to minimize regression and loss of skills, and to ensure reasonable safety, security, and freedom from undue use of restraint.	absence of professional certification, and continuing concerns with the quality of behavioral programming. 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 in past reports, 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 continued to provide supervision to Associate Psychology staff who were pursuing board certification as behavior analysts. The Facility remained in substantial compliance with this provision of the Settlement Agreement.	Substantial Compliance
K3	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall establish a peer-based system to review the quality of PBSPs.	Since the last visit, the Facility had developed a description of the various peer review committees. These are reviewed below: ▪ The Behavior Support Committee continued to serve as the internal peer review mechanism. In February, membership was restricted to the Director of Behavioral Services and BCBA staff who participated on a rotating basis. This committee continued to meet weekly. Templates were used to review behavioral assessments, behavior support plans, and crisis intervention plans. ▪ External Peer Review was conducted monthly via conference call with staff from three other facilities (Austin, Corpus Christi, and Lubbock). ▪ An Interdisciplinary Peer Review committee was initiated in 3/13. Membership included the Chief Psychiatrist, the Medical Director, the Pharmacy Director, the Nurse Educator, and a speech and language pathologist. This committee was established to review cases in which the individual was experiencing increased behavioral difficulties. A request was made for the weekly meeting minutes of the Behavior Support Committee for the six-month period prior to the Monitoring Team's visit. The Facility provided copies of completed templates for assessments and plans that were presented during this time frame. Templates related to documents presented to the BSC between 9/12 and 3/13 for 36 individuals were reviewed. This review is summarized below. ▪ The associate psychologist responsible for the assessment or plan was not identified in any of the completed BSC reviews (0%). ▪ The date of the individual's ISP was identified in 35 of the BSC template reviews. ▪ The date of the Functional Behavior Assessment and/or Behavior Support Plan was identified in 30 of the BSC template reviews. ▪ Feedback was provided in all of the BSC template reviews (100%). In the future it would be helpful to identify a due date when revisions to an assessment or plan are recommended by the BSC.	Noncompliance

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		▪ Seventeen BSC template reviews noted whether or not approval by the Human Rights Committee was necessary. This was a helpful piece of information for the individual's psychologist. ▪ The BSC continued to review assessments and plans as these were developed or revised in preparation for the individual's annual team meeting. As noted in the Behavioral Health Service Department draft policy, the plan moving forward was to provide internal peer review for Behavior Support Plans with low treatment efficacy or for high-risk individuals. At this point in time, the BSC provided annual reviews only. While this information was helpful in reviewing the work of the BSC, there was no documentation provided that indicated the staff who were present at the meetings. In the future, the Facility should provide information that lists the date of the meeting, the participating staff, and agenda items with the responsible psychologist identified. A small sample of completed templates would be sufficient for review. A review was completed of the minutes from six External Peer Review meetings held between 11/12 and 4/13. The following summarizes the findings: ▪ In four of the six meetings (67%), staff from all four Facilities were present. On 2/8/13, three Facilities participated, and on 3/6/13 only two Facilities participated. ABSSLC staff participated and presented one case at every meeting. ▪ The meeting held on 3/6/13 reflected a review of the cases presented at the three previous meetings. Only the follow-up from the meeting held on 1/18/13 reflected the implementation of recommendations made by the committee. ▪ While the minutes from each case conference included an outline of issues discussed and accompanying recommendations, the minutes from 4/10/13 reflected a particularly robust discussion regarding possible variables affecting Individual #304. ▪ It remained unclear how recommendations were disseminated to the individual's interdisciplinary team or how these were addressed. The Facility should consider developing a protocol for responding to the recommendations made by the External Peer Review Committee. The Monitoring Team was provided six case reviews identified as having been presented to the Interdisciplinary Peer Review. These were not dated, and no record of the staff who participated in the review was submitted. Further, it was not clear whether the individual's psychologist or QDDP staff attended this meeting. Additionally, it would be valuable to include staff from the individual's home, because Direct Support Professionals are essential members of the Interdisciplinary Team. Again, the format for disseminating this information to the individual's interdisciplinary team and addressing	

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		recommendations was not clear. The Facility is commended for maintaining regular meetings of the Behavior Support Committee and the External Peer Review Committee, and for initiating a mechanism to address individual cases in which the targeted problem behaviors are not improving or are worsening. Implementation of ongoing review of difficult cases by the BSC would also be beneficial. Over the next six months, the Facility should record the participants who should include the plan authors and those that supervise implementation of the plans, the cases reviewed, and follow-up to recommendations made. While the Facility has taken important steps in developing effective internal and external peer review, it will be necessary to develop and document a mechanism for disseminating and implementing recommendations made by peer review committees or justifications for not following the recommendations of both internal and external peer review groups. Finally, while not a requirement of the Settlement Agreement, the suggestion remains to invite direct support professionals and other members of the Department of Behavioral Services to participate in these reviews as they serve as an excellent resource for training and mentoring. At this time, the Facility remained out of compliance with this requirement of the Settlement Agreement.	
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.	A total of 102 Psychology Monthly Progress Notes were reviewed representing 35 individuals. The time period ranged from 12/12 to 2/13 for 10 individuals, 1/13 to 3/13 for seven individuals, and 2/13 to 4/13 for 13 individuals. Non-consecutive monthly reports were reviewed for two individuals, two monthly reports were reviewed for two individuals, and one monthly report was reviewed for one individual. The format for these progress notes was consistent across individuals and remained similar to that described in previous reports. A summary of the Monitoring Team's findings is provided below: ▪ Graphs of an individual's target problem behaviors were presented in the progress reports for all individuals who required them (100%). The progress notes for Individual #80 did not include graphs, because he did not yet have a PBSP. He was still being monitored with a Behavior Protocol. ▪ In the progress notes for the 34 individuals in which graphs were displayed (100%), monthly totals were provided. General labels (i.e., frequency, month) were applied to the vertical and horizontal axes, respectively, in the progress notes for 33 of the 34 individuals (97%). One to two months of progress notes for four individuals included weekly display of data. However, the following issues were identified with regard to the graphs: o The progress notes for Individual #414 included graphs in which the vertical axis was labeled "percent of interval." The length of the interval and the number of intervals were not identified. Additional concerns regarding the data collection system used to track his self-	Noncompliance

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		injurious behavior are addressed below. o The documents used to track problem behavior for four individuals were identified as partial interval data sheets. These were Individual #517, Individual #97, Individual #287, and Individual #527. The instructions advised staff to record the occurrence or nonoccurrence of identified problem behaviors within half hour intervals of time during the first and second shifts. As such, the recorded data did not represent a frequency of occurrence, rather it represented a percentage of 32, half-hour blocks of time during which the behavior was observed. The graphs for these individuals should be labeled accordingly. o When using ABC data sheets, the staff were advised to record the duration of behavioral episodes. For Individual #126, his disruptive behavior was noted to have lasted for eight hours. Similarly, Individual #239 was noted to have engaged in self-injurious behavior for one to two hours. Graphic display of frequency of occurrence did not reflect extended episodes of problem behavior and might minimize the severity of the problem. ▪ For 23 individuals (66%), at least one progress note included graphic display of replacement behavior. ▪ Progress on counseling services was provided in the progress notes for five of seven individuals (71%) who participated in this service. It is important to include progress in counseling when completing the monthly psychology progress note. ▪ For all the 34 individuals in the sample who had a PBSP (100%), there were criteria identified for determining progress on targeted problem behavior. However, consistently progress criteria were not included for psychiatric symptoms that were being tracked or for replacement behaviors. ▪ While 30 of the 36 Behavior Support Plans reviewed in Section K.9 included criteria for revising the plan, the progress notes for only two individuals (i.e., Individual #126 and Individual #545) included this information. Plans were to be re-evaluated and possibly revised following three consecutive months without progress. The Director of Behavioral Services indicated that he wanted to change this criterion to a 50% increase in targeted problem behavior(s) or a 50% decrease in replacement behavior(s). This change had not occurred at the time of the Monitoring Team's visit. ▪ As noted in the Monitoring Team's last report, all of the progress notes (100%) included information regarding monitoring of the BSP implementation reported in text, graphic display, or both. Specific indicators included: a) staff knowledge of BSP components assessed through interview; b) Planned Activity Check regarding engagement; c) inter-observer agreement related to data recording; and d) assessment of plan implementation or treatment integrity. As reviewed	

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		with regard to Section K.11 below, videotaped monitoring of these last two indicators only recently had been introduced. While this is a helpful review, staff should clearly outline the steps taken to assess each of these measures and the training that was provided when scores were not at an acceptable level. ▪ In the progress notes for 26 individuals (74%), the PLACHECK score was defined as "…engagement for the individual and those immediately around him." It is unclear why engagement of others would be reported in an individual's progress report. The tool used to record engagement allows for a review of an individual's engagement during the observation period. It would appear that this would be a more appropriate measure to include in the report. ▪ For 32 of the 35 individuals in the sample (91%), every progress note was signed and dated. For the remaining three individuals, two of the three monthly progress notes were signed and dated. Data sheets used to track problem behavior identified in an individual's PBSP were reviewed for 38 individuals. The findings are summarized below: ▪ For 17 of the 38 individuals (45%), staff recorded data using an Antecedent-Behavior-Consequence (ABC) Form. As noted previously, although this allows for the recording of information related to the location of the event, the current activity, the immediate antecedent, and the immediate consequence, this form does not require staff to record the absence of the behavior. As a result, it is difficult to determine whether no behavior problems were exhibited or whether staff had not recorded the event. ▪ A scatterplot-simple frequency data sheet was used to record targeted problem behaviors for 11 of the individuals in this sample (29%). Concerns raised in the past remain current. There were often instances of missing data, yet the total frequency of occurrence for that day had been recorded. Further, there were data sheets in which lines were drawn across multiple hours or entire shifts, suggesting that staff were not recording data in the moment, but rather were relying on recall to record this information. ▪ The documentation provided for six individuals (16%) indicated that a combination of data sheets were used to track identified problem behavior. ▪ For four individuals (11%), data was collected using a partial interval recording. This required the staff to record the presence or absence of the target behavior(s) within designated intervals of time. This can be an effective method of recording, however, intervals are usually of short duration. In each case the identified interval was 30 minutes in duration. o Particular concerns were raised when reviewing the data sheet for Individual #414. Staff were told to observe the individual for five minutes every two hours. They were then to record whether or not self-injury had occurred. This would likely result in a significant under-	

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		recording of this problem behavior. Further concerns were raised when reviewing other documents for this individual. His Behavior Assessment included a report of self-injury occurring approximately 72 times per hour and his PBSP suggested that his rate of self-injury appeared to be "…grossly under documented." Steps should be taken as soon as possible to resolve this problem with accurate data collection. As noted in previous reports, during the week of the onsite review, the Monitoring Team occasionally observed problem behaviors. The data sheets for six individuals were reviewed. For two of the six individuals (33%), the data sheets reflected the occurrence of the observed behavior within a 10-minute time period. Specific information related to the remaining four individuals is provided below: ▪ Individual #80 was observed in his home on 5/6/13 at approximately 3:07 p.m. He hit his head at least six times. His data sheet reflected no occurrences of self-injury at this time. ▪ Individual #23 was observed in his home on 5/6/13 at approximately 3:30 p.m. He was seated by the door repeatedly hitting his chin with his hand. The note from the Facility indicated that his behavior support plan had been discontinued on 4/18/13. The presence of this behavior would suggest the need for a plan. ▪ Individual #222 was observed in the activity center on 5/6/13 at approximately 3:35 p.m. She displayed five hits to her head. These were not recorded on her data sheet. ▪ Individual #456 was observed in his home at approximately 8:47 a.m. on 5/9/13. He displayed repeated hits to his head. Although the staff member told him to stop and offered to get him a racket, there was no record of this behavior on his data sheet. Although the Behavioral Services Department had initiated steps to assess the accuracy of data collection, it remained apparent that clinical decisions were being made based upon data that is very likely inaccurate and unreliable. Psychology staff should work closely with direct support professionals to ensure that data collections systems are manageable and completed with high integrity. Continued training, oversight, and assessment of inter-observer agreement will be necessary. Based on observation and review of documents, the Facility remained out of compliance with this section of the Settlement Agreement.	
K5	Commencing within six months of the Effective Date hereof and with full implementation in 18 months, each Facility shall develop and implement standard psychological	A total of 34 Functional Behavioral Assessments were reviewed. These were presented under various titles, including Abbreviated Functional Assessment (22 individuals), Behavioral Assessment (10 individuals), and Brief Behavioral Assessment (two individuals). The assessment completed for Individual #239 was excluded from the analysis that follows, because no problem behaviors had been observed since his	Noncompliance

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	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.	admission to the Facility. Also excluded from the analysis was the brief assessment completed for Individual #80. The staff conducted a structured functional analysis with somewhat inconclusive results. A summary of findings for the remaining 32 assessments is presented below: ▪ All of the assessments (100%) included in the analysis identified both indirect and descriptive methods of determining behavioral function. As noted in previous reports, indirect instruments included the Questions About Behavioral Functioning, the Functional Analysis Screening Tool, and/or the Functional Assessment Interview. Formal observations were noted in 28 of the 32 assessments (88%), but the quality of the observations and resulting information varied across the reports. The assessments for Individual #465 and Individual #527 included clear descriptions of observations conducted across different environments. This allowed for a better understanding of the findings presented in the reports. ▪ Six of the 32 assessments reviewed the results of a structured functional analysis in which different conditions were systematically presented. This formal testing of different hypotheses can often result in a clearer understanding of the antecedent conditions and maintaining consequences to problem behavior. Although not required by the Settlement Agreement, this was a promising and commendable practice. ▪ Seventeen of the 32 assessments included an analysis of conditional probability in which situations are determined that will likely result in problem behavior. Many were completed through a review of Antecedent-Behavior-Consequence (ABC) data sheets, while some were completed through structured observation. Such analysis can result in better identification of the variables that are maintaining the problem behavior. Again, this is not a requirement of the Settlement Agreement. ▪ All of the assessments (100%) identified setting events, antecedent stimuli, and consequences to problem behavior. Summaries of variables likely maintaining the problem behavior also were provided. Where appropriate, biological variables were identified. ▪ Replacement behaviors were identified in 31 of the 32 assessments (97%). Where identified, these behaviors were functionally equivalent in 26 of 32 (81%) cases. There was a noticeable increase in the identification of appropriate communicative responses to allow a delay or break from activities. Staff also should examine the use of choice and the introduction of greater variety in the activities offered to individuals. ▪ Included in 26 of the 32 assessments (81%) were graphs depicting measures of staff knowledge of BSPs, integrity of treatment application, individual engagement, and data reliability. These data remained difficult to interpret as the four measures vary markedly. A brief narrative explaining the process used	

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		to collect these measures might prove very helpful. In the narrative regarding Sections K.4 and K.10 of this report, there is further discussion regarding the monitoring of these different measures. ▪ Preference assessments were identified in all of the reports (100%). There was a marked improvement in methodology with less reliance on staff report and a greater focus on individual report or observed response to stimulus presentation. For 14 individuals, a structured assessment of preference was conducted through observation of the individual when items/activities were presented. Similarly, 14 individuals were interviewed to help identify their preferences. Finally, preferences for four individuals were identified through staff interview. ▪ Twenty-eight of the 32 assessments (88%) were signed and dated. The responsible psychologist was identified in two of the remaining four reports. Of the signed and dated reports, four were signed within one month of the date of the report, eight were signed between one to two months following the date of the report, and 14 were signed over two months after the date of the report. The assessment for Individual #46 was signed over two years after the report date. Though signed and dated, the assessment for Individual #182 did not clearly identify the date the report was written. ▪ In 23 of the 32 assessments (72%), the report had been completed prior to, or in one case, on the same day as the scheduled Individual Support Plan meeting. It was unclear why some of the assessments were completed off the ISP cycle. In the future, staff should note whether the assessment was completed in response to a lack of progress, worsening of problem behavior, or emergence of new problem behavior. It would be helpful for all assessments to include both the report date and the meeting date as this was included in only 15 of these assessments. Cross-checking of documentation was necessary to identify all assessments completed prior to the individual's ISP. Three assessments were completed one to two months following the ISP, and two were completed more than two months following the ISP date. Two assessments were completed between 11 and 12 months before the individual's meeting. It is suggested that more current information should be provided when developing a hypothesis regarding behavioral function. One assessment was not dated. ▪ Although the reports for three individuals were current with the identified ISP date, the ISP date was from the previous year. Annual meetings had been held for Individual #517, Individual #355, and Individual #397 between 12/12 and 2/13. Their functional assessments should have been updated accordingly. As noted in the updated psychology procedures, staff were expected to complete or update the functional behavior assessment 10 days prior to the individual's annual meeting. If updated, the staff member needed to ensure that new observations were	

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		conducted, recent data and specific events were reviewed, and current preferences were identified. This should result in enhanced assessments of behavioral function and should lead to better behavior support plans. Feedback related to specific reports is provided below. ▪ Several reports referenced assessments or events that occurred after the date of the report. The completion of rating scales, formal observations, and/or preference assessments that post-dated the report were referenced in the assessments for Individual #505, Individual #89, Individual #355, Individual #24, Individual #285, Individual #273, Individual #430, Individual #215, and Individual #527. It is essential that all reports be dated accurately. ▪ Individual #123 and Individual #525 were noted to have a severe visual impairment. It would be appropriate to recommend a consult from an orientation and mobility specialist if one had not recently been conducted. ▪ A potential discriminative stimulus for the challenging behavior demonstrated by Individual #280 was boredom, described as "…an internal event and difficult to observe." As the majority of his reported problems occurred at workshop, an appropriate recommendation would be to explore a variety of jobs that might prove more interesting to the individual. This was not suggested in the assessment. ▪ Obtaining attention was the hypothesized function of the problem behaviors Individual #545 displayed, yet the identified replacement behavior was his learning to wait when asked. It would appear that a more appropriate replacement would be to teach him an appropriate communicative response that would result in attention. ▪ One of the hypotheses identified in the assessment for Individual #315 was that she displayed hand-mouthing to indicate discomfort during medical procedures. There were no recommendations made to address her discomfort. ▪ The assessment for Individual #355 suggested that his identified adaptive behavior functioning level of moderate retardation remained accurate following an evaluation completed in 2008. However, as noted in his Psychology Monthly Progress Reports, this young man was reported to be graduating from high school after having completed course work in inclusive or "mainstream" classes without support. It would appear that this is an inaccurate assessment of his adaptive behavior. ▪ Staff are commended for completing a structured preference assessment with Individual #97. However, it was unclear why a bible and magazine were included as potential items of interest as this woman was legally blind, and no modifications were noted to make these written materials accessible to her. ▪ In the report provided for Individual #285, there were conflicting statements regarding the frequency of his pica behavior. One statement suggested there	

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<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>was an increase in this behavior, while the first statement in the paragraph that followed suggested there was a decrease in this behavior. The graph depicted a stable pattern with zero occurrences of the response. Reports should be carefully proofed to ensure that the information is accurate.
▪ The report for Individual #46 indicated that she was required to stand while at work. It was also noted that she was requesting the bathroom more frequently to escape standing. It was unclear if her job required that she stand or if the decision was made to require this position to reduce the problem behavior of swallowing air. If it was the latter, it is suggested that this constitutes a rights restriction, because prolonged periods of standing might be very uncomfortable.
▪ The conditional probability analysis reported for Individual #182 suggested that aggression occurred most often in demand situations. As escape was the likely function of this behavior, a means to teach her to delay participation in an activity and/or the simple provision of a choice of activities should have been included as a replacement behavior or preventative strategy, respectively.

Screening for psychopathology continued to be completed either through the psychiatric clinic's completion of a psychiatric assessment or through utilization of the Reiss Screen for Maladaptive Behavior to determine a need for 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. Psychology staff completed emotional assessments for identified individuals as necessary.

The Facility remained out of compliance with this provision due to issues related to the quality of the behavioral assessment. Staff are encouraged to place greater emphasis on information gained through thorough descriptive assessment, identify functionally equivalent replacement behaviors, and expand recommendations to address the array of setting events and antecedent stimuli that were identified as likely maintaining the problem behavior. All assessments should be dated and signed.</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 19 of the 34 assessments reviewed for Section K.5 (i.e., the functional/behavioral assessments). 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 #123</td><td>10/11/88</td><td>Individual #24</td><td>2/1/90</td></tr>
<tr><td>Individual #517</td><td>7/21/98</td><td>Individual #285</td><td>6/20/90</td></tr>
<tr><td>Individual #61</td><td>9/16/85</td><td>Individual #46</td><td>5/9/89</td></tr>
</table></td><td>Noncompliance</td></tr>
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Individual #220	7/5/96	Individual #273	5/22/89
Individual #26	11/21/01	Individual #430	3/26/96
Individual #478	12/1/91	Individual #215	2/10/88
Individual #489	5/9/07	Individual #397	6/22/95
Individual #315	2/15/90	Individual #527	2/8/89
Individual #89	2/1/90	Individual #414	1/10/86
Individual #355	9/11/08		

For all but two of these individuals, the most recent psychological assessment was between 11 and 27 years old. This clearly did not reflect current clinical data.

Records for 41 individuals were requested for review of Sections K and S of this report. Although a psychological evaluation was clearly listed in the document request, a current evaluation was not provided for any of the individuals. For the 29 individuals whose records were requested on site, a note was enclosed indicating that there "…was no psychological evaluation available at this time." A request was also made for a copy of the document used to track the completion of standardized assessment of cognitive abilities and adaptive behavior. The Facility indicated that this had not yet been developed.

Due to these reasons, the Facility remained out of compliance with this provision of the Settlement Agreement.

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.	A total of nine individuals were admitted to the Facility between 9/7/12 and 4/23/13. Psychological assessments were requested for each of these individuals. A summary of findings is provided below: ▪ Individual #239: An Abbreviated Functional Assessment and a Behavior Protocol were developed within 30 days of admission and prior to admission, respectively. Although pica behavior was identified in the protocol, this was not addressed in the assessment. Standardized assessments of cognitive abilities and adaptive behavior were not reviewed. ▪ Individual #255: The only documentation provided was a Reiss Screen report completed approximately two months after admission, and an ICAP summary completed just over one month after admission. Standardized assessments of cognitive abilities and adaptive behavior were not identified. ▪ Individual #256: A Behavior Protocol was developed for this individual prior to her admission. There was no evidence of a functional behavioral assessment or standardized assessment of cognitive abilities and adaptive behavior. ▪ Individual #248: An Abbreviated Functional Assessment was completed within 30 days of admission for this individual. Graphs depicted daily occurrences of	Noncompliance

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		two of the three behaviors identified prior to admission. There was no data presented for tantrum behavior. Information regarding a preference assessment conducted after the date of the report was included. A Behavior Protocol was not provided. ▪ Individual #233: There was no evidence of a functional behavior assessment or behavior protocol. ▪ Individual #222: An Abbreviated Functional Assessment and a Behavior Protocol were developed within 30 days of admission and upon admission, respectively. Information regarding the individual's cognitive abilities and adaptive behavior was referenced from a DMR report dated 7/13/11. ▪ Individual #288 and Individual #298: No information was provided regarding these individuals. Admission to the Facility occurred a few weeks prior to the Monitoring Team's visit. It is possible that their psychological evaluations had not yet been completed. ▪ Additional document requests were submitted while the Monitoring Team was on-site. Included in the information provided for Individual #239, Individual #255, Individual #222, Individual #233, and Individual #211 was the following note: "No psychological evaluation available at this time." In sum, while the Abbreviated Functional Assessment and the Behavior Protocol provided for the individuals identified above reviewed important introductory information, this did not provide information based upon standardized assessment of cognitive abilities and adaptive behavior. In addition, as noted with regard to Section K.6, the Facility did not provide current psychological assessments for individuals in response to the Monitoring Team's requests, and the Facility indicated it was not able to provide summary data on the completion of standardized assessment of cognitive abilities and adaptive behavior. As a result, the Facility was found to be out of compliance with this requirement of the Settlement Agreement.	
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.	ABSSLC provided a list of 26 individuals who participated in counseling services offered by one of the Facility's Associate Psychologists. Sixteen individuals received individual counseling services, nine participated in group services, and one individual participated in both individual and group counseling. The Treatment Plan, Psychotherapy Progress Notes (12/12 to 2/13), and ISP Action Plan for Counseling Services were reviewed for six individuals. A summary of findings is provided below: ▪ Three individuals received individual counseling and three participated in group counseling. ▪ Two individuals (33%) began receiving counseling within one month of their referral date. Counseling was delayed more than 30 days from referral for the other four individuals. ▪ All of the individuals (100%) had identified goals and objectives that stated the	Noncompliance

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		observable behavior in measurable terms. The individual was expected to exhibit the behavior one to four times during the counseling session. To meet the objective, the individual was expected to sustain the behavior for between three and 10 consecutive counseling sessions. ▪ In every treatment plan (100%), references to published papers, texts, or curricula were included. ▪ All of the treatment plans (100%) were signed and dated, 3/26/13. ▪ Progress notes included the goal and objective, a description of the intervention, recorded data, and a brief narrative. The individual's participation in scheduled sessions was also noted. Each of the progress notes only provided room to record the individual's performance on one trial of the identified objective. As discussed with the counselor, data sheets should allow for a recording of the individual's performance on each of the trials identified in the objective. ▪ All the progress notes (100%) were signed and dated. ▪ The ISP Action Plans provided a review of the goals and objectives, a description of the plans for generalization, and review criterion. This last section indicated that counseling services would be reviewed by the individual's Team following a specific number of consecutive refusals to attend or a specific number of consecutive months without progress. For each of these six individuals, generalization of skills was addressed through inclusion of similar goals/techniques in his/her BSP. Individual #517 was also going to have a training skill developed that would be implemented by staff at the activity center. The counselor and home psychologist were to monitor the generalization of skills. ▪ Missed appointments remained a concern. For the six individuals, participation ranged between 25% and 91%, with a mean participation rate of 54.5%. Reasons identified included refusal, staff error, medical, weather, problem behavior at home, session cancelled, or no explanation. It would be advisable to develop a plan to improve participation in counseling services, particularly when the identified issue is staff error or individual refusal. The Facility's counselor clearly had made an effort to develop observable and measurable objectives for counseling services, and had initiated plans for generalization of learned skills. As noted in the Behavioral Health Services Department draft policy, it might prove helpful to include review of counseling plans in the internal peer review process. As most individuals meet once weekly with the counselor, it might prove beneficial to conduct as many training trials as possible during scheduled sessions. Additionally, it would be helpful for the counselor to assess generalization of these skills outside of the counseling environment. It will be important for the counselor to be closely involved with training staff on components of the individual's BSP to ensure that generalization plans are implemented with a high degree of integrity. As the individual's	

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		verbal report was most often the measure of counseling efficacy, it will be important to also assess the individual's observed response in difficult situations. Two independent practitioners also provided services to 10 individuals, one of whom also met weekly with the on campus counselor. Each independent counselor provided treatment plans for two individuals. Progress notes for three of these individuals were also provided. These plans and progress notes did not reflect the same level of specificity noted above. Goals were not written in observable and measureable terms and objective data was not collected to assess progress. There were no plans for generalization. To be found in compliance, it will be necessary for all counselors to meet the requirements outlined in the Settlement Agreement. The Associate Psychologist with whom the Monitoring Team spoke asked about establishing a profile or description of individuals who would benefit from counseling services. A clearer outline of necessary skills might better guide the interdisciplinary teams as they make referrals to counseling services. As reported by the Associate Psychologist, occasionally a team recommends counseling when other efforts to produce positive change have been unsuccessful. In her experience, the individual who is referred might not be able to benefit from counseling due to limited communication skills or some other issue. This is a matter that might be effectively resolved through the established peer review processes. As efforts to address the requirements of this provision of the Settlement Agreement just recently had been initiated, compliance will be evident when these changes are well established and extended to the independent practitioners. At this time, the Facility remained out of compliance with Section K.8.	
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	As indicated on a list the Facility provided, a total of 226 individuals residing at the Facility were provided the services of a Behavior Support Plan. A review was completed of 36 BSPs, representing 16% of this group. Individual specific BSPs are identified in the documents reviewed section above. A summary of findings is presented below: ▪ The current ISP date (i.e., within the last 12 month period) was identified in 24 of the 36 plans (67%). It should be noted that seven of these 36 plans (19%) identified an older ISP date. ▪ Twenty-seven of the plans (75%) indicated the date of plan implementation. ▪ All of the plans (100%) included a rationale for the BSP. This provided a review of the hypothesized function of the targeted problem behavior(s). Eleven of the plans (31%) included the date the functional behavior assessment was completed. ▪ Thirty-five of the 36 plans (97%) included an adequate operational definition of the targeted problem behavior(s). There was a concern regarding the plan for	Noncompliance

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	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.	Individual #97 as the definition of disruptive behavior did not include "…striking herself against objects." As this poses a risk to the individual, it should be addressed in her plan. Noteworthy in at least three plans (i.e., Individual #315 and Individual #215, and Individual #527) was the inclusion of non-examples of the targeted problem behaviors. This sometimes enhances the clarity of the operational definition. ▪ Twenty-five of the plans (69%) included operational definitions of replacement behavior(s). ▪ Twenty-six of the plans (72%) identified functionally equivalent replacement behaviors. ▪ Twenty-six (72%) of the plans included adequate preventative strategies that addressed motivating operations, setting events, and/or antecedent conditions. ▪ Eighteen of the plans (50%) identified adequate schedules of training for developing replacement behaviors. ▪ Twenty of the plans (56%) included baseline or comparison data with the dates of data collection identified. Due to the problems identified with partial interval recording reported with regard to Sections K.4 and K.5 above, staff should carefully check the way in which data is described to ensure that it matches the method used to track problem behavior. For example, the baseline or comparison data for Individual #287 was presented as frequency of occurrence per month, but her data sheet described a partial interval recording system. ▪ Thirty-two of the plans (89%) included expected treatment outcomes presented in observable and measurable terms. Three plans did not identify a clear time frame (e.g., frequency per month for a number of consecutive months) for determining progress. Rather than identifying a reduction in the rate of self-injury, the plan for Individual #414 identified treatment outcome as zero injuries related to self-injury. ▪ Data collection methods were clearly identified in 31 of the plans (86%). ▪ Twenty-one of the 36 plans (58%) were signed, eight plans were signed and dated (22%), and the author was identified in the remaining seven plans (19%). In the future, staff should sign and date all plans. Feedback regarding individual plans is provided below. ▪ Strategies designed to prevent the occurrence of targeted problem behavior varied across plans. For example: o The plan for Individual #61 included thoughtful consideration of allowing time for her to fully wake up in the morning and following naps. Staff were advised to not place excessive demands on her at these times. o Individual #478 and Individual #525 were both reported to display problem behaviors during "check and change" activities that required	

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		the use of a lift. Although staff were advised to sing to Individual #525, it is suggested that more deliberate pairing of preferred items/activities at these times might be helpful. o Staff were to observe Individual #355 if he engaged in leisure activities in "…confined spaces such as in closets or behind bushes." It remained unclear why leisure activities would occur in either of these environments. ▪ Replacement behaviors also varied across plans with regard to their functional equivalence to the target behavior(s), the degree of effort required to engage in these behaviors, and the scheduled training opportunities. For example: o It was encouraging that Individual #517 was learning some self-management strategies. He was to wear a watch that would cue him every 30 minutes to initiate a request with a staff member. o Individual #220 was learning to choose an activity. As described, the individual would reach for an object/activity when presented with a choice of two. While this would be an acceptable communication for choice, he was then required to imitate the verbal label of the object/activity. This increased the effort of the replacement behavior and might impede progress. Further, this was to be taught only once per shift. o Individual #89 was learning to request a break to escape demands or loud environments. The training description indicated that staff should ask her if she would like a break once she displayed the target behavior. If she did not respond, staff would walk away while explaining that they would return in a few minutes. If she did respond, the delay in presenting the task a second time was slightly longer. Either way, she received a break from the task, therefore her learning the identified replacement behavior might be compromised. o Individual #24 was to learn the sign for "later" as a means of delaying demands. This was concerning for two reasons. First, she was described as one who could speak in short phrases. It was unclear why sign language would be identified as the communicative choice. Second, similar to the situation described above, she would escape the demand regardless of whether or not she displayed the replacement behavior. o Similarly, Individual #215 was to be given a break whether or not he requested one following presentation of a task. o The replacement behavior for Individual #273 was to "express her feelings." While this might be an appropriate goal, it was unclear how this was equivalent to her aggression that was hypothesized to function as a means of escape. o Individual #489 was to be encouraged to use her "stress management	

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		box" at appropriate times. This might prove difficult, because it was also reported that this box was to be kept in a cabinet. ▪ There was greater evidence of token or point systems in place to reinforce the absence of problem behavior or the display of appropriate, alternative behavior. For example: o Individual #87 was earning points for the absence of targeted problem behavior. o Individual #197 and Individual #211 could exchange their points for a preferred item/activity at a designated time each day if targeted problem behaviors had not occurred. o Individual #26 was to earn an extra "punch" on his token card if he reported accurately regarding "check and change" activities. o Individual #397 could access a can of soda if he did not display targeted problem behaviors while at work. ▪ Several plans included consequences that might result in a strengthening of the targeted problem behavior. For example: o Individual #87 was to be "encouraged" to go to a quieter area such as her room when she displayed aggression or inappropriate sexual behavior. As she had a personal device located in her bedroom, she might find this consequence very satisfying. o Individual #430 had targeted problem behaviors of self-injury and property destruction, both of which were identified as escape motivated. Contingent upon self-injury, he was to be told to stop and then be offered a break. It would appear that this procedure might inadvertently reinforce the target behavior. o Individual #168 had a targeted problem behavior of placing his hands in his pants. The hypothesized function was automatic reinforcement, however, the consequence was to "pivot." It is unclear how staff withdrawing their attention would effectively reduce this behavior. In sum, behavior support plans should be written to ensure inclusion of the following: a) the ISP date and the date the support plan was implemented; b) dates of necessary consents; c) operational definitions of both targeted problem behavior(s) and replacement behavior(s); d) hypothesized function of targeted problem behavior(s); e) comprehensive preventative strategies; f) clear strategies for teaching replacement behavior(s); g) sufficient opportunities for teaching replacement behavior(s); h) enriched schedules of reinforcement using individual-specific reinforcers; i) clear guidelines for responding to targeted problem behavior(s); and j) accurate descriptions of data collection systems. With only four exceptions, due to holidays or the absence of the Human Rights Officer	

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		(HRO), the Human Rights Committee (HRC) met weekly between 10/2/12 and 3/26/13. Minutes from 22 meetings were reviewed. The following provides a breakdown of the members in attendance during this period: Human Right Officer (100%), non-affiliated member (82%), parent member (73%), resident member (64%), medical personnel (100%), and psychologist (100%). As explained by the HRO, meetings could only be held if a non-affiliated or parent member was present. The meeting minutes reflected compliance to this standard. Although the Chief Psychiatrist was present at only one of these meetings, the HRO continued to reference an individual's psychiatry folder when the issue before the committee was related to medication management. The psychologist for the individual continued to present plans usually via conference call. The Associate Psychologist who provided counseling services was the standing member who attended each of the HRC meetings. The minutes reflected a good summary of the topic discussed and action taken. Discussion was delayed when key professional staff (e.g., Associate Psychologist) were unavailable. As indicated in the minutes, a total of 24 issues were tabled due to the need for further information, the unavailability of the psychologist, the absence of a psychiatry folder, or conflicting information over the period reviewed. In 15 of the 24 cases, there was evidence that the matter was discussed and approved at a follow-up meeting of the HRC. It is possible that the remaining nine cases were discussed at a later meeting of the HRC for which minutes were not reviewed. As suggested to the HRO, it might prove helpful to indicate an expected follow-up date when matters are tabled or when approval is denied. Meeting minutes reflected approval of 16 BSPs and approval pending guardian consent for 14 BSPs. Additionally, five Crisis Intervention Plans were approved and five were approved pending guardian approval. Based upon the review of behavior support plans, the Facility remained out of compliance with this provision of the Settlement Agreement.	
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	Over the three to four-month period before the Monitoring Team's visit, the behavioral services staff had begun using videotaped documentation to assess treatment integrity, data reliability, and individual engagement (PLACHECK). Occurrences of problem behavior were identified through a review of data collection sheets and then 30 minutes of video were reviewed. Psychologists and Psychology Assistants were responsible for completing this assessment of staff performance and individual engagement. Interviews with direct support professionals took place at another time. This assessment focused on the residential areas, but plans were to extend this to the workshops and activity centers in the future. As outlined in the Psychology Procedures, dated 4/1/13, the expectation was that a reliability check of the Psychology Assistant's assessment of treatment integrity would be completed each month by the supervising psychologist, with the department director completing four reliability checks each month. Staff knowledge of individual BSPs was documented in the narrative of 85 of the 102	Noncompliance

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	medications.	Psychology Monthly Progress Reports referenced in Section K.4. Correct responding to 10 interview questions ranged from 40% to 100% with a mean of 85.53%. Department policy indicated that staff would be retrained if they scored less than 90% when responding to the interview questions. When asked by the Monitoring Team during the onsite visit, staff consistently reported that the BSPs were clearly written and understandable. As knowledge of a plan does not always translate to correct implementation, measures of treatment integrity were also reviewed. Included in the narrative of 53 of the 102 Psychology Monthly Progress Reports referenced in Section K.4 were descriptions of the monitoring of treatment integrity completed through review of videotapes. Treatment integrity ranged from 0% to 100%. In 57%, or eight of the 14 instances where integrity scores were less than 100%, there was an indication that retraining had occurred. It was not clear whether the retraining was conducted only with the staff member observed via videotape or with all staff. It was also unclear when the retraining occurred. Particularly concerning was that no training was documented even when integrity scores were 0%. While the use of videotaped records is an effective and creative way for behavioral services staff to assess events that they may not otherwise be present to observe, it does not allow for immediate feedback to staff regarding their performance. The benefit of collecting real time measures of treatment integrity is the ability to discuss and review the staff member's performance in the moment. Unless the Psychologist/Psychology Assistant and the direct support professional view the tape together, there is little opportunity for this type of training and supervision. That being said, this remains an effective use of the technology already in place at the Facility. Ongoing efforts to improve this initiative and to observe staff as they work with individuals are recommended. Due to continued difficulties with staff implementation of individual BSPs, the Facility remains out of compliance with this provision of the Settlement Agreement. Many of the concerns regarding data used to determine the efficacy of treatment have been addressed in other sections of this report. Specifically, such discussion is included with regard to Sections K.4, K.8, and K.9. Concerns remained about the accurate recording of observed problem behaviors, the current system used to assess inter-observer agreement, and the reporting of documented target behavior. Other concerns noted in previous reports are repeated below. With the exception of a few monthly progress reports that provided one to two months of weekly data, the majority of graphs continued to display total monthly occurrence of targeted behaviors. Axes were labeled (broadly), and data points and paths were displayed. Labels were not always appropriate to the data. "Call out boxes" were used to depict changes in medication, change of residential placement, illness, introduction of a	

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		new or updated BSP, and other events. 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 of 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, assessment of inter-observer agreement and treatment integrity was only recently introduced, 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.	A review of 36 Behavior Support Plans was completed in Section K.9 of this report. The plans were written clearly. When direct support professionals were asked about their understanding of these plans, they consistently indicated that they could follow the plans without difficulty. Further, they indicated that Behavioral Services staff were available and responsive should questions arise.	Substantial Compliance
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.	Since the Monitoring Team's last visit, the Department of Behavioral Services had identified and hired Behavior Coaches to assist with training of all Direct Support Professionals. As identified in the coaching schedule for the week of 5/12/13 to 5/19/13, a total of 11 Behavior Coaches were divided into five groups with each responsible for four residences. These Behavior Coaches were trained by the psychologist to competently implement individual behavior support plans. The Behavior Coaches then helped provide training and support to the staff working in the residences. This process had been established in December with full implementation by March. A second development was the introduction of Behavior Support Checklists. At the time of the visit, checklists based on individual BSPs had been developed for 47 individuals. Checklists were reviewed for eight individuals. For each individual, checklists had been designed to review the following four components of the BSP: prevention, replacement behavior, responding (consequence following occurrence of the targeted behavior), and documentation. The staff were trained via role-play or on-the-job (entitled opportunity), their performance was noted as correct/incorrect, and any need for retraining was noted. In general, the checklists were clearly written. One exception was identified on the replacement behavior checklist for Individual #263. Instructions to teach the sign for help were as follows: "This is the sign for I need help. You can ask me to help you. Do the sign." These appeared to be very wordy instructions that might only confuse the	Noncompliance

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		individual (to be determined by the success or failure of the training efforts). It might be better to simply prompt the sign for help at appropriate times and in appropriate contexts. Prompting could then be systematically faded as the individual begins to display the sign. Beginning in April 2013, psychologists were expected to have developed checklists for each BSP presented to the Behavior Support Committee. Overall, the introduction of checklists to train staff on individual BSPs was a very promising development. In addition to teaching staff how to respond when problem behavior occurred, it was particularly noteworthy that there was an equal emphasis on their learning prevention strategies and techniques to teach replacement behaviors. While not directly related to staff training, the Facility had introduced a Behavioral Crisis Response Procedure in February. When an individual continued to display problem behavior for a prolonged period of time in spite of staff efforts to address the problem, staff could place a call to request assistance. In response, a Behavioral Crisis Group would be notified to provide assistance. Members included staff from the Department of Behavioral Services, Residential Campus Coordinators, Unit Directors, and Administrators. The individual's psychologist completed follow-up Behavioral Crisis Debriefing with the involved staff. This allowed for additional training and problem solving. When asked whether this procedure had proven helpful, most staff responded favorably. As noted previously, the Facility is commended for the steps taken to address competency-based training of all staff. With continued efforts to develop and train staff on Skills Checklists for all BSPs, there should be a corresponding improvement in treatment integrity and efficacy. With these steps only recently initiated and not yet fully implemented, the Facility remained out of compliance with this provision of the Settlement Agreement. However, the Monitoring Team looks forward to assessing full implementation of these processes during the next review.	
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 393. With 18 Associate Psychologists with identified caseloads, the Facility met the criterion of one professional for every 30 individuals. As noted with Section K.1, only six of these were BCBAs, although others were working towards certification. With 11 Psychology Assistants, the requirement for one support person for every two psychologists was also met. Additionally, the department employed 11 Behavior Coaches to assist with staff training. As noted in the past, not all those served at the Facility have positive behavior support	Noncompliance

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		plans. However, a ratio of one professional to every 30 individuals served is still required per the Settlement Agreement. As noted in the last report and repeated here, 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 of 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 Behavioral Services Department were not yet demonstrably competent in applied behavior analysis as required by the Settlement Agreement. This was evidenced by the absence of certification, as well as by issues related to the quality of the programming observed at the Facility.	

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 ensure that all minutes from peer review committees include the date of the meeting, a record of participants, the cases reviewed, and the presenting psychologist. Further, it will be necessary to develop and document a consistent method for providing ongoing review of challenging cases, and a mechanism for disseminating and implementing recommendations made by peer review committees. (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) ensure that reports of Planned Activity Checks reference the individual's engagement and not that of a group of individuals; 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 graphic display and data recording systems; and g) ensure that all reports are signed and dated. (Section K.4).
5. Data collection systems should be developed to ensure that accurate data is collected on identified target behaviors. The Facility should ensure that the data collected is an accurate reflection of the severity or intensity of the problem behavior. 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. If this is assessed through review of videotapes, psychology staff should ensure timely follow-up and discussion with the staff member. (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.10)
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. Structured assessment of preferences is also recommended. (Section K.5)
10. 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)
11. The State and the Facility should develop and implement a policy that provides clear guidelines for the completion of formal assessment of cognitive abilities and adaptive behavior. Psychological evaluations should be conducted at a minimum of once every five years. Measures of adaptive behavior are recommended annually. (Section K.6 and Section K.7)
12. The Facility should include review of counseling plans in the internal peer review process. As most individuals meet once weekly with the counselor, it might also prove beneficial to conduct as many training trials as possible during scheduled sessions. Additionally, it would be helpful for the counselor to assess generalization of these skills outside of the counseling environment. It will be important for the counselor to be closely involved with training staff on components of the individual's BSP related to counseling to ensure that generalization plans are implemented with a high degree of integrity. As the individual's verbal report was most often the measure of counseling efficacy, it will be important to also assess the individual's observed response in difficult situations. (Section K.8).
13. It will be necessary to have independent counselors meet the requirements of the Settlement Agreement. (Section K.8).
14. The Facility and State should develop clear guidelines regarding appropriate candidates for counseling services. (Section K.8)
15. The Facility should ensure that information regarding the date of completion of the functional assessment along with a brief description of assessment activities be included in an individual's behavior support plan. (Section K.9)
16. 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. The hierarchy of treatments outlined in the draft Behavioral Health Service Department policy should prove helpful to staff; and
    e. All plans should be signed, indicating the author and any supervisory staff who provided review, and dated. (Section K.9).
17. 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, Planned Activity Checks, and inter-observer agreement data should be viewed as important measures of different events. Although videotaped monitoring can be an effective means to ensure data reliability and treatment integrity, staff must take measures to ensure timely feedback to staff. When there are identified problems with either data recording or treatment implementation, retraining of staff should occur in a constructive and timely manner. (Sections K.10, K.11, and K.12).
18. It will be important for Associate Psychology staff to conduct frequent training and supervision with Behavior Coaches to ensure that the

training and support they provide to direct support professionals is accurate, comprehensive, and effective. (Section K.12)

19. The Facility should develop a system to assess the efficacy of and staff satisfaction with the Behavioral Crisis Response Procedure. (Section K.12)
20. Assessment of compliance on each indicator identified in the sub-sections of Section K should be reported in the Self-Assessment. QA staff or others from outside the department should complete inter-rater reliability measures. (Facility Self-Assessment)

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, titles, and degrees; o Name and CV of Medical Director, if new since the last visit; o Name and degrees of all primary care providers that were new to the Facility since the Monitoring Team's last review; o Number of individuals on each PCP's caseload; o Employees listed under Medical Department completing CPR training certification with dates of completion, and dates of expiration; o Copy of any in-service for PCP training on ICD and DSM diagnostic criteria in the last six months; o Since the Monitoring Team's last on-site review, copy of Continuing Medical Education (CME) for each primary care provider, list of CME credits according to topics reviewed, list per PCP of total CME credits during this time period (separate out/remove CME credits not earned since the last on-site review); o Copy of any clinical guidelines developed and implemented since 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 (e.g., morning medical meetings, etc.) copy of all minutes, handouts, logs form Infirmary, hospitalizations, and 24-hour reports discussed, for 15 days prior to 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, and separate reports/data of external medical peer review audits from internal medical peer review audits; o List of individuals who died since the Monitoring Team's last visit. For each individual, submitted information included 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 the following: Individual #362, Individual #351, Individual #257, Individual #457, Individual #109, Individual #346, Individual #407, Individual #186, and Individual #259; o Mortality Reviews (i.e., clinical, administrative, and nursing reports) since Monitoring Team's last visit; o Corrective actions related to Mortality Reviews (include 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 the following individuals: Individual #164, Individual #296, Individual #540, Individual #184, Individual #105, Individual #300, Individual #528, Individual #454, Individual #394, Individual #276, Individual #224, Individual #521, Individual #194, Individual #107, Individual #268, Individual #524, Individual #18, Individual #88, Individual #405, Individual #353, and Individual #64; o Specialty clinic schedule per month for past six months: including the list of appointments made, the list of appointments completed, the list of appointments refused by the individual, the list of appointments missed for other reasons than refusals, the list of missed appointments (refusals) for which follow-up appointments were made, the list of missed appointments (non-refusals) for which follow-up appointments were made, the list of refused appointments for which a follow-up visit was completed, the list of missed appointments (other than refusals) for which a follow-up visit was completed, and the list of missed appointments for all reasons still outstanding; o List of all outside consultations for medical purposes for the past six months, categorized by specialty: including the list of appointments made, the list of appointments completed, the list of appointments refused by the individual, the list of appointments missed for other reasons than refusals, the list of missed appointments (refusals) for which follow-up appointments were made, the list of missed appointments (non-refusals) for which follow-up appointments were made, the list of refused appointments for which a follow-up visit was completed, the list of missed appointments (other than refusals) for which a follow-up visit was completed, and the list of missed appointments for all reasons still outstanding; o List of individuals: ▪ With tracheostomies; ▪ With fractures, date of fracture, type of fracture (i.e., compound, simple, stress, etc.), bone fractured (location); ▪ With injuries requiring visit to ER or hospitalization since the Monitoring Team's last on-site review; ▪ With pica or ingesting inedible object, date of ingestion, object ingested, whether taken to ER or hospitalized, since the Monitoring Team's last on-site review; o Policies or procedures for medical screening and routine evaluations; o For those over 50, date of last colonoscopy, identification of reason for colonoscopy (i.e., 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 listed if not up-to-date (e.g., guardian refusal, etc.); 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 (include calcium, Vitamin D, IV bisphosphonate, etc.), date of last DEXA

	scan or statement if not completed, 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 (e.g., 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 (e.g., specific medications, etc.) of osteopenia/osteoporosis; o For each individual with osteopenia/osteoporosis, any active record document for calculation of daily calcium intake (based on diet, average percentage of meal ingestion, feeding formula, etc.); o For individuals with Down's syndrome, date of last thyroid test; o For those going to the 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 record 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 (in order to allow completion of recommendations): Individual #230, Individual #530, Individual #289, Individual #394, Individual #411, Individual #443, Individual #465, Individual #403, Individual #285, and Individual #468; 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 record 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 (in order to allow completion of recommendations): Individual #7, Individual #253, Individual #403, Individual #33, Individual #385, Individual #353, Individual #181, Individual #408, Individual #165, 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 Summary report or trend analysis of infectious disease/communicable disease last two quarters; o Avatar pneumonia tracking forms for past six months; o For those with diagnosis of pneumonia in last six months and taking food/liquid by mouth, type of liquid (amount of thickening), and type of texture of solid food ordered, and last swallow study; o Absolute numbers of new cases (prior year, by month) for the following: a) pneumonia, b) decubitus ulcers, c) UTIs, and d) 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: a) malignancy,

	b) cardiovascular disease, c) diabetes mellitus, d) sepsis, e) bowel obstruction or bowel perforation, and f) 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, diagnosis (type of seizure), and medication regimen; o For past six months, for five individuals, documentation of seizure management (e.g., neurologist's notes): Individual #176, Individual #343, Individual #238, Individual #414, and Individual #519; o List of individuals seen by neurologist with dates on which appointments were completed and reason, since the 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 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 Vagal 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, and Felbamate); o Any tracking of data for individuals who have transitioned to the community since the 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, seven, 45, and 90-day post-move monitoring reports. For these three individuals, copy of Community Living Discharge Plan (CLDP), most recent ISP, BSP, and subsequent addendums, most recent annual medical exam and most recent nursing assessment for: Individual #163, Individual #48, and Individual #200; 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 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 medical meetings for period of 30-60 days prior to the Monitoring Team's visit, 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, including consents, HRC approval, relevant assessments, ISP entries, any general discussion record, action plan, and integrated progress note entries. Information submitted for the following individuals: Individual #480, Individual #318, Individual #97, Individual #211, and Individual #304; o Ten most recent PNMT recommendations with physician orders; o ISPAs addressing missed appointments or refusals for the past three months (for mammograms and colonoscopies); o List of missed medical appointments with reasons for the past six months; o Presentation Book for Section L; o DADS Preventive Health Care Guidelines, SSLCs, dated August 30, 2011; o For women aged 21 to 65, list of individuals with date of last pelvic exam (including whether attempted but unsuccessful), date of last pap smear with determination of adequate reading, sufficient sample, etc., (including whether attempted but unsuccessful), and individuals for whom a pap smear was not indicated (including reason), if pelvic not done, documentation of the reason/indication, and if pap smear not done documentation of the reason/indication. For those with a history of hysterectomy, the reason for the hysterectomy; 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, MRIs, ultrasound reports, hospital discharge summaries for past one year, ER reports for past one year, consults and procedure reports past one year, DNR forms if applicable, physician orders for past one year, most recent ISP and subsequent addendums, most recent BSP, and the past three medical quarterly reviews: Individual #119, Individual #413, Individual #311, Individual #97, Individual #524, Individual #465, Individual #493, Individual #386, and Individual #14; o For each PCP, copy of two most recently completed quarterly medical reviews from each assigned residence; o For the self-assessment process, a list of monitoring/audit tools used; for each tool, identification of the total number of the eligible population to be sampled, identification of the number of the sample, a determination of how the sample was chosen and the frequency of data collection, the staff that completed the audit/monitor survey and whether any inter-reliability data was obtained/analyzed for the audit/ monitoring review; o For the self-assessment process, list of databases utilized (other than audit information)

	including title of each database/record/table with date range of each database, with indication of frequency of data collection if applicable; o Minutes of the medical morning meeting during the Monitoring Team's visit 5/7/12, 5/8/12, and 5/9/12; and o Leadership Council/QA/QI Agenda 5/6/13, QI Infection Control Handouts, Quarterly Dental Presentation Handout. ▪ **Interviews with**: o Richard Chengson, MD, Medical Director; o Edward Craig, MD, Settlement Agreement Compliance Physician; o Elizabeth Greer, RN, Medical Program Compliance Monitor; and o Krista Hamilton, Infection Control Nurse. ▪ **Observations of**: o Individual #119, Individual #429, Individual #122, Individual #162, Individual #7, Individual #361, Individual #75, Individual #452, Individual #91, Individual #212, Individual #53, Individual #492, Individual #253, Individual #359, Individual #270, Individual #497, Individual #385, Individual #353, Individual #54, Individual #233, and Individual #468; o Lunch and Learn medical staff meeting, on 5/9/13; and o Morning Medical Meetings 5/7/13, 5/8/13, and 5/9/13.
	Facility Self-Assessment: For Section L 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: External and Internal General Medical and Medical Management Audit. The Medical Department had not created and implemented any additional internal audits. o These 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. o The monitoring tools included appropriate methodologies, such as record reviews. o The Self-Assessment identified the sample(s) sizes, and this sometimes included 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). These sample size(s) were not always adequate to consider them representative samples. Although the general medical audit had a sufficient sample size, the medical management audit was problematic. Whether the eligible population was large (osteoporosis) or small (diabetes mellitus), a sample size of three was completed. There was no review of sample size based on the size of the eligible population for that diagnosis. o The monitoring/audit tools had adequate instructions/guidelines to ensure consistency in monitoring and the validity of the results. This was a new revision added to the audits.

	o The following staff/positions were responsible for completing the audit tools: external physicians and PCP peers. o The staff responsible for conducting the audits/monitoring had clinical/programmatic experience in the relevant area(s). o Adequate inter-rater reliability had not been established between the various Facility staff responsible for the completion of the tools. The QA Department determined there was a problem with obtaining this information from the database, but provided no further information. ▪ The Facility used some other relevant data sources to show whether or not the intended outcomes of the Settlement Agreement were being reached, such as annual medical summary tracking, and quarterly medical summary tracking. The quality of the data maintained in the few databases appeared to be complete and accurate. Examples of databases/data sources that were not considered included preventive care services, mammograms and osteoporosis treatment, ER visits or hospitalizations, and morning medical meeting closures, etc. ▪ The Facility did not consistently present data in a meaningful/useful way. For instance, the osteoporosis data was not all in one database. Specifically, the Facility's Self-Assessment: o Did appear to present information clearly, but the data was limited in scope. o Presented findings consistently based on specific, measurable indicators. o Did not consistently measure the quality as well as presence of items. ▪ The Facility rated itself as being in compliance with none of the sub-sections of Section L. This was consistent with the Monitoring Team's findings. ▪ The Facility data identified areas in need of improvement. For those areas of need, the Facility Self-Assessment provided some limited analysis of the information, identifying, for example, the need for further focus on timely assessments. However, the scope of the analyses was limited.
	Summary of Monitor's Assessment: The Facility now had a dedicated position for Settlement Agreement Compliance Physician. With the staff member in this position working with the Medical Program Compliance Nurse, a number of progress steps had occurred in a short time span. It is important to note that the Compliance Physician did not have a caseload, and was able to concentrate efforts on development, implementation, and monitoring of new projects. The morning medical meeting had become a forum for critical thinking, in part due to the Compliance Physician's constant teaching of clinical problem-solving. All PCPs had participated in this approach in regards to new hospital admissions and discharges, Infirmary admissions, and on-call concerns. Other disciplines also attended the morning meeting. The annual medical assessments had been revised to incorporate updated plans of care for specific diagnoses, and included more details about the medication list, including indications and doses. The quarterly medical review template had been revised to focus on changes in the prior three months, and templates were available to assist the PCPs in reviewing the clinical care post-hospitalization. There had been in-services most weeks on clinical indicators and clinical pathways.

	As these changes had only been in place for the past three months, considerable challenges remained. The morning meeting needed to expand into a more managed system, with the group referring some concerns to the IDTs for review and ISPA development, reviewing consult reports at the meeting, and assigning follow-up items and open record reviews to members with timelines for completion. There should be a tracking system to closure of these many concerns. The mortality review process required monitoring to ensure recommendations had value, and they were tracked to completion. A PNMT member would add value to the Clinical Death Review Committee. The QA Department needed to review how it tracked the corrective action plans, and needed to present data in a user-friendly format. The Facility remained in noncompliance with Section L, but there was the potential for rapid progress, based on positive steps already implemented.

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L1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall ensure that the individuals it serves receive routine, preventive, and emergency medical care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	Given that this paragraph of the Settlement Agreement includes a number of requirements, this section of the report includes a number of different 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 DNR Orders. <u>Staffing and Administration</u> For the census of 393 individuals as of 5/6/13, there were six PCPs responsible for this population. The Medical Director had a caseload of 22 individuals. Other PCPs had caseloads ranging from 70 to 83 individuals. The week of the Monitoring Team's visit, the department had no vacancies. Two of the PCPs were contract physicians. The remaining PCPs were State-employed physicians and physician extenders. A list was submitted indicating those members of the Medical Department that remained current in CPR certification. The list was dated April 2013. Of the six primary care providers in the department only three were listed. The two contract physicians and one State-employed physician were not listed. Of the three State-employed PCPs listed, three out of three (100%) were current in CPR. Additionally, the State-employed Settlement Agreement Compliance Physician was certified. The reason for not listing the other three PCPs was not determined. Of the six PCPs in the Medical Department, a list of CME credits completed since the Monitoring Team's last visit was submitted for four of six (67%) PCPs. This varied from	Noncompliance

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		three hours to 24 hours. The topics that were covered included: annual wellness visit, obesity counseling, colorectal screening, rheumatology update, managing migraines, pain management, diabetes mellitus, cancer screening, depression, the acute abdomen, celiac disease, prevention of kidney disease, heart failure, chronic obstructive pulmonary disease (COPD), lipid disorders, pap smear update, Methicillin-resistant Staphylococcus aureus (MRSA) skin infections, prostate-specific antigen (PSA) testing, Clostridium difficile (C-diff) treatment, newer antithrombotic agents, and peripheral vascular disease. 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 the Facility. The majority of the topics that were covered included areas of importance to primary care and the individuals residing at ABSSLC. There were no topics specific or unique to the intellectual disability/developmental disability (ID/DD) population. <u>Physician Participation In Team Process</u> To assist the PCPs in preparing for the morning medical meeting, as well as to ensure a clinical review of events prior to an acute illness requiring hospitalization, a template/form was developed entitled "Post ER/Hospital Transfer Medical Chart Review Progress Record," dated 4/24/13. Subsections that the PCP was to complete included instructions/guidance for standardization of content. Subsections included past medical history specific to hospitalizations within past six months, including discharge diagnosis and final diagnosis; summary of review of progress notes for seven to 14 days prior to transfer to hospital; review of ER/hospitalization diagnostic test results and treatment; review of recent changes in orders at ABSSLC as well as at hospital; and clinical areas needing focus by the PCP. An example was submitted, but it is in the early phase of implementation. However, cases the PCPs discussed/presented at the morning medical meeting reflected many of these components, and led to quality clinical discussions of further evaluations, plans, assistance from other departments, etc. It is recommended that, once this form is implemented, a monitoring tool be created to sample compliance with the quality of the completion of the document and the improvement of care/treatment of the individuals. Additionally, on 3/19/13, a "Client Report Template" was revised to assist the PCPs in obtaining and reviewing essential clinical aspects of on-call and Infirmary cases in preparation for the morning medical meeting discussions. For the three morning medical meetings observed, there was a signed attendance roster in three of three (100%) meetings. Departments represented at the morning medical meeting on a daily basis included: all PCPs when scheduled to work that day, the Settlement Agreement Compliance Physician, Dental Department, Medical Compliance Nurse, Infirmary Charge Nurse, Habilitation Therapy Services, Pharmacy Department, QDDP Department, Unit Director representative, Direct Support Professional	

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		representative, and Hospital Liaison Nurse. Departments represented at the morning medical meeting on a weekly or periodic basis included: psychiatry (two meetings) and psychology (one meeting). For the three morning medical meetings observed, there were zero admissions to the hospital, and eight admissions to the Infirmary (i.e., Individual #245, Individual #499, Individual #465, Individual #84, Individual #187, Individual #236, Individual #544, and Individual #264). Based on the Monitoring Team's observations and review of documentation (as noted with regard to Section G.1, the Monitoring Team requested documentation of morning meeting minutes for the week prior to the onsite review, but the Facility did not provide them, so these findings are based on observations and the resulting minutes): ▪ **Critical review of hospitalizations with IDT follow-up with ISPA:** During the Monitoring Team's review, no individuals were currently hospitalized. As a result, there were no opportunities for critical clinical questions to be raised followed by a request for the IDT to meet to review the case for preventive measures, with subsequent development of an ISPA. ▪ **Critical review of Infirmary admissions with IDT follow-up with ISPA:** For zero of five (0%) individuals with acute illness Infirmary admissions were critical clinical questions raised that resulted in a request for the IDT to meet to review the case for preventive measures, with subsequent development of an ISPA. It was noted there were an additional three admissions to the Infirmary for elective surgery procedure preparation and post-operative care. ▪ **Critical review for post-hospitalization/ER visits with IDT follow-up with ISPA:** There was one Infirmary admission post-hospitalization and one Infirmary admission post-ER visit. Critical clinical questions were raised followed by discussion. For these two, there was no request for the IDT to meet to review the case for preventive measures, with subsequent development of an ISPA, as indicated. One individual had new onset respiratory distress, and a medical work-up was underway. There was no request for the IDT to meet to review preventive measures, environmental concerns, whether there were triggers of aspiration at mealtime, etc., information that would be documented in an ISPA. The other individual was found to have a slow pulse, and there was no further work-up or monitoring noted. There was no information that an IDT had met to discuss the new condition, and develop an ISPA to instruct direct support professionals and other staff on observations to be made, or to review the medication list to determine potential side effects of drugs. ▪ **Need for additional preventive steps discussed or prior ones reviewed**: For nine of nine (100%) Infirmary admissions, discussions during the morning	

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		medical meeting included additional steps to be taken to treat the individual early in the illness to prevent an ER visit, hospitalization, or Infirmary admission; a discussion of differential diagnosis or other critical clinical rationale; or discussion that additional steps were determined not to be clinically indicated. ▪ **Assignment of follow-up to meeting participant:** For seven of the nine Infirmary Admissions, unresolved issues were identified. For four of these seven (57%) individuals, identification of the issues needing closure was followed by assignment of the concern for further review by one or more morning medical meeting attendees. Timelines were not identified. ▪ **Formal record review:** There were no hospitalized individuals for which there was a need to request that there be a formal record review to determine preceding events, monitoring intensity, etc., before the onset of acute illness. ▪ **Assignment of open book/record review:** There was one individual with possible aspiration pneumonia. The PCP had begun a record review for the prior seven to 14 days of the illness. There was clinical discussion of the differential diagnosis, including medication side effects. However, there was no assignment to review the active record for monitoring of nursing or direct support professional care, positioning documentation, feeding concerns, early warning signs that could have been assessed and reported to the PCP, or discussion of involvement of the PNMT, which might have added important clinical information. ▪ **Closure discussions**: There were four prior concerns with follow-up, which were presented at the morning medical meetings. At the start of the Monitoring Team's onsite observations of the morning medical meetings, there was no information concerning the number of outstanding concerns needing closure from the prior week or prior month. ▪ **Requested ISPAs reviewed:** There were no brief summaries of ISPAs that had been assigned to IDTs in responding to concerns referred by the medical morning meeting group. There was one ISPA, which became part of the minutes, but there appeared to be no discussion of it at the morning medical meeting. ▪ **Infection control updates:** For the three morning medical meetings, there was discussion of infection control updates at one or more meetings, but there was no documentation of this information in the minutes. ▪ **Summaries of completed consultations:** For the three medical morning meeting minutes, there were no summaries presented of completed consultations from the prior day(s). ▪ **Dental Department updates**: The Dental Department provided brief updates/information during one of three morning medical meetings, in response to a follow-up from an Infirmary admission that was post-hospitalization. It would not necessarily be expected that such discussions would occur daily. ▪ **PT/OT/Speech and PNMT updates:** The PT, OT, Speech, and PNMT did not present updates during the three morning medical meetings observed, because	

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		they were scheduled on a different day of the week. It would not necessarily be expected that such discussions would occur daily. ▪ **Skin integrity updates:** Skin integrity reports/updates were provided at zero of three morning medical meetings. It would not necessarily be expected that such discussions would occur daily. There was discussion of two individuals with decubiti. One was presented by the Psychology Department, with behavioral data shared with the morning medical meeting participants. There was interdisciplinary discussion, but the minutes did not reflect an assignment of follow-up tasks or timelines for review at the morning medical meeting. ▪ **Discussion of significant weight change:** There was a discussion of one individual with significant weight loss at two morning medical meetings. ▪ **Hospital Liaison Nurse updates:** The hospital nurse liaison attended three of three (100%) morning medical meetings, but there were no hospitalizations to report. ▪ **On-call PCP participation:** For the three morning medical meetings observed (100%), the on-call PCP (from the prior evening) participated in presenting the cases in three meetings. The strengths noted at the medical morning meetings included the following: ▪ There was demonstration that the PCPs knew the clinical backgrounds of the individual, had completed record reviews, and had plans in place for continuing care. ▪ Critical evaluation and discussion was evident with each acute care case, whether from the Infirmary or from an on-call report. ▪ At times, there was substantial interdisciplinary discussion. In one case, the psychologist reviewed specific data. Weakness and concerns included: ▪ The morning medical meeting did not include a brief review of important consults that returned the prior day. ▪ Although there were good discussions, a formal follow-up process would ensure information was gathered and concerns resolved. There was no request for IDTs to review specific aspects of care and develop an ISPA in response to concerns. For instance, although there was a good discussion about preventing further hypothermia in an individual, there appeared to be no formal request for the IDT to respond to this concern, develop an ISPA, and have the morning medical meeting review the contents to ensure it answered the concerns. ▪ There was no formal assignment of tasks and timelines for presentation back to the morning medical committee. For example, an individual returned from the ER with bradycardia, but the minutes did not indicate plans for evaluation, and no timeframe was requested for follow-up at the medical morning meeting. For the	

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		individual with a history of current and prior decubiti, there was no probing to determine the last time that pressure mapping of the seating had been completed, and whether that needed review, or the condition of the wheelchair being used. No assignments were made to determine this information. ▪ The minutes of the medical morning meeting did not reflect some of the important discussions and contributions from other team members. ▪ There was no information provided that tracked concerns needing closure. In response to a request for documents concerning evidence of closure of issues identified at morning medical meetings, there was only one statement in the folder: "Closure list [has] been suspended process under revision." There was no further explanation. It is essential that items requiring closure be followed through to conclusion. In addition, tracking the number of concerns referred to IDTs or specific members of IDTs, the number of ISPAs reviewed at the morning medical meeting, the number of consult reports reviewed, the number of assigned tasks, the number of assigned tasks with closure, the number of open record reviews by PCPs, the number of open record reviews by nursing/residential staff, etc. would provide a measure of the activity, as well as evidence of timely response and integrated care. Additionally, there was the concern that the meetings were lengthy. The attendance at the morning meeting represented many disciplines, along with all the PCPs with full caseloads. This needed to be considered when the meetings began to go over an hour in length. The current time commitment from other departments might not be sustainable once the meeting goes beyond an hour. Further, the teaching component had had marked positive impact on the critical clinical discussion, but this might be best continued with the PCPs during the "Lunch and Learn" meetings held twice each week. The need to expand the morning meetings to review recent consultations, determine assignment of tasks to IDT for ISPA development or other specific IDT members, and review completed ISPAs are critical areas that need further development, and ample time would be available if the teaching component was moved to the PCP-only meetings. <u>Routine Care</u> A list of dates of the last two annual medical assessments and physical exams were submitted. Individuals newly admitted within the prior six months were omitted from this list. There was one entry, which was a database error. A total of 393 individuals were listed with current and prior annual medical assessments. Of these, 319 of 393 (81%) of the recent annual medical assessments were completed within 365 days of the prior assessment. For 21 individuals, a copy of the most recent annual medical summary and physical examination evaluation, as well as the prior annual medical summary and physical	

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		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 the 21 individuals, compliance was 19 out of 21 (90%). This suggested the most recent annual medical assessments were being completed in a timely manner. ▪ For the 21 most recent annual medical assessments, there was an interval history included as part of the document in 21 of 21 (100%) reviews. ▪ For the 21 most recent annual medical assessments, the major active problems listed had plans of care in 21 of 21 (100%) assessments. ▪ For the 21 most recent annual medical assessments, 19 (90%) addressed smoking history. ▪ Family history was adequate/helpful in nine of 21 (43%). ▪ A discussion of readiness/requirements for transition to the community was included in 19 of 21 (90%). A systematic approach should be developed to ensure family histories are updated and complete, and clear documentation is provided if family histories are not available. Criteria should be developed to standardize documentation of/approaches to attempt to obtain family history, including the role of the QDDP or other departments in providing family contact information. As part of the monitoring review process, the Monitoring Team selected the medical records of nine 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 a listing of risk ratings per individuals. Individuals with several high-risk indicators were selected. Documents reviewed included the preventive care flow sheet, physician orders for the prior year, integrated progress notes for the prior year, the most recent three quarterly medical reviews, most recent BSP, last annual ISP and subsequent addendums, labs, x-rays/ Computed Tomography (CT) scans, MRI scans, ultrasound scans, other radiographic test results for the prior year, the integrated risk rating form, the most recent health care management plan/risk action plan/ integrated health care plan, the most recent annual medical assessment and physical exam, DNR forms if applicable, 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 nine medical records reviewed: ▪ Eight of nine (89%) annual medical assessments had been completed in the prior 365 days.	

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		▪ Active problem lists appeared to be thorough in five of nine (56%). ▪ Nine of nine (100%) had information about smoking and/or substance abuse history. ▪ A family history was documented (or attempts at obtaining this information) in six of nine (67%) records. ▪ Seven of nine (78%) had information discussing requirements for transition. ▪ The DG-1 forms were reviewed. Of the nine records reviewed, eight (89%) DG-1s were submitted. Of these eight, three (38%) had updated significant diagnoses. These nine medical records also were reviewed to determine whether the physician IPN note used the SOAP format. In nine of nine (100%), the SOAP format was used, and included date and time on the IPNs. *Quarterly Medical Reviews* For any one quarter of the year, one would anticipate one annual assessment for 25% of the individuals and a quarterly medical review for 75% of the individuals. For the past year, for each active record, one would expect one annual assessment and three quarterly medical reviews. For the nine active records reviewed, one would expect 27 quarterly medical reviews. Submitted were 14 quarterly medical reviews, for a compliance rate of 52 percent. It was noted that there was only one quarterly medical review submitted for 2013. The Facility submitted a list of the dates of the quarterly medical reviews completed over the prior six-month time period. There were 390 names listed for the last two quarterly medical reviews, which was spread over a nine-month window of time or greater. For 390 names, one would estimate that 25% of these would have an annual medical evaluation to replace a quarterly medical review each quarter of the year. From this estimation, one would anticipate that a total of 390 x 0.75 = 292.5 quarterly medical reviews should occur per quarter, or 585 in two quarters. The list of quarterly reviews was categorized by quarter of the calendar year in which they were completed. Ninety-three were completed from October through December 2012. One hundred thirty four were completed from January through March 2013. For the two quarters, this was 134 + 93 = 227. This was a compliance of 39 percent. It was noted that this calculation did not account for those that were no longer at the Facility due to transfer, transition, or those who might have been admitted in the prior six months, etc. Contents of the quarterly medical review of 36 medical records were reviewed for completeness: ▪ A template format was used by all PCPs. The template was utilized/completed in 36 of 36 (100%) quarterly medical reviews. ▪ Thirty-six of 36 (100%) included the date of the quarterly review completion.	

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		▪ Thirty-six of 36 (100%) included the signature of the PCP. ▪ Major diagnoses were listed in 36 of 36 (100%) medical quarterly reviews. ▪ The last three monthly weights or equivalent information were recorded in 36 of 36 (100%) medical quarterly reviews. ▪ There were brief comments/entries listing numbers of seizures (if applicable) in 16 of 16 (100%) medical quarterly reviews. ▪ When a seizure disorder was present, the date of the most recent seizure was documented in 16 of 16 (100%) medical quarterly reviews. ▪ There was documentation of changes in medication in three medical quarterly reviews. It could not be determined if others had medication changes that were not documented on this form. ▪ Important/abnormal labs and drug levels/radiographic test results were documented in 15 of 36 medical quarterly reviews. ▪ For seven individuals, there was documentation of ER visits or hospitalizations. ▪ There was documentation of consultations in 33 of 36 medical quarterly reviews. It was noted that much of the quarterly review including pasting and copying the long active problem list. A revised template was submitted, in which that section would be replaced with a component entitled "significant chronic conditions." The quarterly medical review is meant to be a brief summary of changes in the past three months, and listing the most important diagnoses being treated would provide the needed background without the lengthy listing of every diagnosis. Focus should be on changes, and the three quarterlies when completed accurately, would allow parts of the annual medical assessment to be completed by reviewing the contents of these three quarterlies. The revised template also included prompts to be completed for specific clinical details if there was a seizure disorder, urinary tract infection (UTI), or diabetes mellitus. *Access to Specialists* The total number of appointments completed off-site, based on submitted information was 470. The total number of appointments scheduled was not provided. The number of off-site visits completed for the following specialist appointments was submitted: ▪ Cardiology – 79; ▪ Dermatology – five; ▪ Endocrinology – 19; ▪ Gastroenterology – 77; ▪ Genetics – one; ▪ Hematology – 52; ▪ Infectious disease – five; ▪ Internal medicine – eight; ▪ Nephrology – five; ▪ Neurology – 11;	

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		▪ Neurosurgery – six; ▪ Ophthalmology – 25; ▪ Ophthalmology Plastic surgery – one; ▪ Optometry – two; ▪ Orthopedics – 27; ▪ Leddy Braces – four; ▪ Otolaryngology – 19; ▪ Pain management - four ▪ Pediatrics – one; ▪ Podiatry – four; ▪ Pulmonology – eight; ▪ Retina specialist – one; ▪ Rheumatology – 14; ▪ Sleep study – two; ▪ General surgery – 17; ▪ Urology – four; and ▪ Wound care – 69. Information was provided for missed community, specialty appointments. In some cases, it was not clear whether the specialty appointment was off-site or on campus. From a document entitled "ABSSLC Consultations by Specialty – Refuse/Missed/Still outstanding 9/2/12 - 3/30/13," the following number of missed appointments were documented per specialty: ▪ Audiology - three appointments; ▪ Cardiology - 12 appointments; ▪ Endocrinology - one appointment; ▪ Gastroenterology - eight appointments; ▪ Hematology/Oncology - five appointments; ▪ Neurology - three appointments; ▪ Ophthalmology - four appointments; ▪ Pediatrics - one appointment; ▪ Pulmonology - one appointment; ▪ Surgery - one appointment; ▪ Urology - one appointment; and ▪ Wound care - one appointment. Of these, 18 had been rescheduled and were completed. Nine were cancelled and were not rescheduled. Fourteen remained outstanding at the time of the report. On site, several specialty clinics were held to meet the needs of the individuals from September 2012 through March 2013. Onsite clinics occurred on the following dates:	

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		▪ Allergy Clinic was held on 3/6/13. Eight appointments were scheduled and seven of eight (88%) were completed. ▪ Ear, Nose, and Throat (ENT) Clinic was held on 9/22/23, 12/13/12, and 3/6/13. Forty-seven appointments were scheduled and 38 (81%) were completed. ▪ Endocrinology Clinic was held on 9/6/12. Thirteen appointments were scheduled and 10 (77%) were completed. ▪ Optometry Clinic was held on 9/12/12, 9/26/12, 10/10/12, 10/24/12, 11/14/12, and 1/9/13. One hundred sixty three appointments were scheduled and 142 (87%) were completed. ▪ Neurology Clinic was on held 9/10/12, 9/24/12, 10/22/12, 11/12/12, 11/15/12, 11/26/12, 12/10/12, 12/19/12, 1/10/13, 1/14/13, 1/24/13, 2/11/13, 2/15/13, 2/25/13, 2/28/13, 3/11/13, 3/14/13, 3/25/13, and 3/28/13. According to a document entitled "Individuals seen by neurologist since last monitoring visit," (dated April 2013), 374 individuals completed a neurology visit. However, there was no information concerning a missed appointment rate. From a separate list of clinic appointments held 9/10/12 through 12/10/12, 190 appointments were scheduled and 148 (78%) were completed. ▪ Pap and Pelvic Clinic was held on 10/31/12, 11/28/12, 1/30/13, 2/7/3, and 3/27/13. Thirty appointments were scheduled and 22 (73%) were completed. ▪ Podiatry Clinic was held on 10/16/12, 11/20/12, 12/18/12, 1/15/13, and 3/19/13. Two hundred twenty two appointments were scheduled and 167 (75%) were completed. ▪ Vagus Nerve Stimulator (VNS) Clinic was held on 9/10/12, 9/24/12, 10/22/12, 11/12/12, 11/26/12, and 12/10/12. Thirty-nine appointments were scheduled and 34 (87%) were completed. The quality of the consultation referrals is reviewed as part of the peer review process. This is discussed in further detail with regard to Sections 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 nine out of nine (100%) records reviewed. Preventive care flow sheets were up-to-date in three out of nine (33%) records reviewed. Current vision screening was documented within the prior 12 months in six out of nine (67%) of the records reviewed, and in eight of nine (89%) within the prior 24 months. Audiological screening occurred in six out of nine records reviewed (67%) in the prior	

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		year, and in nine of nine (100%) records reviewed in the prior two years. The influenza vaccination had been given to nine of nine (100%) individuals in a timely manner during 2012. 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 nine of the nine (100%) active records reviewed. 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 was being tracked for completion), was recorded in seven of the nine (78%) active records reviewed. For one individual, there was no information. For one individual there was conflicting information written in the record. A Tetanus-Diphtheria-Pertussis (Tdap) vaccine was given to five of the nine individuals (56%). Whether it had been given to four of the nine individuals was difficult to determine. It appeared three individuals had not received a Tdap. Of concern, whether the individual had received a Tdap versus a dT was not always clear from the preventive care flow sheets/nursing assessments. It is recommended that the Infection Control Department verify which individuals received the Tdap and ensure clear documentation of verification in the preventive care flow sheets. This might require considerable historical review, because the reported Tdap administrations occurred back to 2005. A pneumococcal vaccination had been given to nine of nine individuals (100%). According to State Office guidelines, two individuals were recommended to have the zoster vaccine. Of these two, two (100%) received the vaccine. The Infection Control Meeting minutes of 10/25/12 identified several areas of activity to improve compliance with immunization recommendations. Immunization pocket guides for flu, pneumococcal, Tdap, and Zoster vaccines were distributed to PCPs and nursing staff. ABSSLC began to use the Avatar tracking system for immunizations. As of the 2/14/13 infection control quarterly review of progress, 50.1 percent of the immunization records of individuals at ABSSLC had been moved to this database. For the 2012-13 flu season, 56 percent of employees received the flu vaccine (781 of 1392 employees). One hundred percent of eligible individuals received the flu vaccine. Additionally, rapid influenza tests were available on site, as well as antiviral medication for individuals and staff exposed to the flu. The 11/14/12 P&T Committee minutes documented that the Infection Control Nurse and	

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		medical records staff were updating the "Preventive Care Flow Sheet" to include additional vaccines recently recommended by the Centers for Disease Control, including the 13 valent pneumococcal vaccine and Human Papillomavirus (HPV). The 2/13/13 P&T Committee minutes included a revised draft of the "Preventive Care Flow Sheet," which included these two additional vaccinations, but the Medical Records Committee had not approved this document. *Mammograms* 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 was outdated. A total of 155 women were identified as being over the age of 40. Of these, there were 21 women aged 70 or greater. There were four women less than 40 years of age on this list. The DADS SSLC policy "Preventive Health Care Guidelines," dated 8/30/11 was to be followed. Of the 130 eligible women, 10 (8%) had reasons not to have a mammogram (e.g., guardian refusal, inability to physically provide proper positioning for the test, etc.). Of the remaining 120 women, 49 (41%) had mammograms within the prior year. A total of 109 women had a mammogram completed in the past two years. This was a compliance rate of 91 percent. It was noted that there were 21 women aged 70 or greater. Thirteen of the 21 (62%) women age 70 or greater had a mammogram completed during either 2011 or 2012. From the sample of nine medical records reviews, there were two females between the ages of 40 and 70. Of these, one female was eligible for a yearly mammogram (no contraindication or reason for not completing a mammogram). One of one (100%) was up-to-date on mammogram testing for completion every two years. *Pap smears* From the sample of nine active records reviewed, there were three females between the ages of 21 and 65. Two of three females did not meet criteria/have risk factors that necessitated testing in the prior three years. One female met criteria for a pap smear every three years. One (100%) female had pap smears completed within the prior three years. *Colonoscopies* The Medical Department submitted a list of those individuals over the age of 50 with the date of the last colonoscopy and the reason for the colonoscopy. A total of 220 names were submitted. As the date of birth or age was not provided, it could not be determined whether any of these individuals were over the age of 75. There were no incomplete data or data entry irregularities for the 220 entries. Of these 220 individuals, 38 had completed a colonoscopy for evaluation of an active problem rather than as a preventive screen and these names were excluded. Twenty-nine of these had clinical contraindications or family/guardian refusals of consent. Nine individuals were new admissions, had just	

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		turned age 50, or were pending the procedure, which had been scheduled. Therefore, the eligible population for review was 144 individuals. Of these, 126 (88%) completed a colonoscopy within the prior 10 years, and/or had alternate testing considered acceptable as clinical equivalents. Of the nine active records reviewed, there were two individuals between the age of 50 and 75. Zero of these were currently age 50 (would not necessarily have had a colonoscopy completed at the time of the active record review). One individual was over the age of 75. Of the two individuals in the recommended age range for a colonoscopy, two of two (100%) had a colonoscopy completed in the past 10 years. *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 were requested. This information was requested, because for those with a diagnosis of osteopenia or osteoporosis, a T-score usually would be an important aspect of the work-up provided through a DEXA scan. Additionally, the T-score would be used to guide treatment (initially and at intervals) to optimally treat the individual. Follow-up DEXAs to determine T-scores are indicated at intervals (every two to three years) to determine effectiveness of treatment. Other fracture risk indicators were not reviewed. The Facility was not able to provide the requested information in one table or database report, suggesting this information was not reviewed at regular intervals by medical administration. It is recommended that information including test results and treatment of osteopenia/osteoporosis be entered into a database and updated on an ongoing basis for quarterly review by the PCPs. A total of 227 individuals were determined by the Facility to have a diagnosis of osteopenia or osteoporosis. Of these, 222 had a DEXA scan submitted. Of the 222 individuals reviewed, the T-scores were interpreted as normal bone density for seven individuals. The remaining 215 had either osteoporosis or osteopenia. A total of 201 of the 215 individuals with osteopenia and osteoporosis had a current DEXA scan report submitted (completed within the prior two years). The cut off date for the calculation was 4/1/11. Eight individuals with osteopenia had the most recent DEXA completed greater than two years prior to 4/1/13. Of these, six had the last DEXA scan greater than three years ago. Six individuals with osteoporosis had the most recent DEXA scan completed greater than two years prior to 4/1/13. One individual with osteoporosis had the most recent DEXA scan completed greater than three years ago.	

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		Eighty-two individuals had a T-score consistent with osteopenia. Twenty-seven of 82 (33%) were treated with a bisphosphonate. Fourteen of 82 (17%) were prescribed Prolia. One (1%) was prescribed Miacalcin. Eighty of 82 (98%) were treated with calcium supplementation. Fifty-nine of 82 (72%) were treated with Vitamin D supplementation. It is recommended that those with a diagnosis of osteopenia be reviewed for optimal treatment (including a review of medications for prevention of osteoporosis, as well as adequate Vitamin D supplementation) according to current guidelines. One hundred thirty-three individuals had a T-score consistent with osteoporosis. Sixty-four of 133 (48%) were treated with a bisphosphonate. Forty-eight of 133 (36%) were treated with Prolia, and two (2%) were treated with Forteo. None were treated with Miacalcin. As a total number, medication to treat osteoporosis was prescribed for 114 of 133 (86%) individuals. Calcium was prescribed in 126 of 133 (95%) individuals. Vitamin D supplementation was prescribed for 71 of 133 (53%) individuals. It is recommended that those with a diagnosis of osteoporosis be reviewed to ensure adequate treatment with medication for osteoporosis, as well as adequate supplementation with Vitamin D, according to current guidelines. It was also noted that three individuals with normal bone density were prescribed a bisphosphonate or Prolia. It is recommended that the fracture risk be reviewed for these individuals and that national standards be followed for treatment with these medications. It was not known if they had prior osteopenia/osteoporosis, which had responded to treatment. A copy of the annual nutrition assessment for each individual with osteopenia/ osteoporosis was submitted. Fifty-seven of these were reviewed for content. Fifty-one of 57 (89%) listed a diagnosis of osteopenia or osteoporosis. Thirty listed a diagnosis of Vitamin D deficiency. For 18 of 57 (32%) the amount of calcium provided through food/formula, medication, and supplements was calculated. For an additional six of 57 (11%), there was a calculation based on medication only. For 51 of 57 (89%), calcium intake was considered adequate, despite lack of calculations. Zero of 57 (0%) calculated Vitamin D intake. The assessments were multi-page, and important information could be easily missed. Additional attachments of several pages reviewed food and medication interactions. It is recommended that the nutrition assessment be revised, with calculations of both daily calcium intake and daily Vitamin D intake (including food/formula, nutritional supplements, and total amount by daily medication), with a comparison to daily requirements, and recommendations to the PCP. The current assessment did not provide important details to guide the PCPs in determining optimal doses of these important nutrients.	

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		From the sample of nine medical records reviewed, nine had a diagnosis of osteopenia or osteoporosis. Nine had completed a DEXA scan. Nine of these DEXA scans were completed in the prior three years. ▪ Of these, nine of nine (100%) had a DEXA scan /T-score recorded. ▪ Of these, nine of nine (100%) had a T-score consistent with the diagnosis of osteoporosis or osteopenia. Seven had a T-score less than -2.5. ▪ Of these, nine of nine (100%) had been prescribed supplemental calcium and vitamin D. ▪ Of these, four of nine (44%) had been prescribed additional medication to treat osteoporosis/osteopenia (i.e., bisphosphonate, Prolia, etc.). ▪ The osteoporosis clinical pathway appeared to be followed in four of nine (44%) of the individuals. A list of those with Down syndrome was submitted, along with the date of the last thyroid test. A total of 15 individuals were identified with a diagnosis of Down syndrome. Fifteen of 15 (100%) had a thyroid test completed within the prior 12 months. The Medical Department completed some in-service training on preventive care, including: ▪ On 11/30/12, Preventive Health Care Guidelines, including Primary Prevention, Secondary Prevention, Oral Health and Cancer Screening, and Breast Cancer. Seven staff attended this training. ▪ On 12/7/12, Preventive Health Care Guidelines, including Cervical Cancer Screening. Four staff attended this training. ▪ On 2/1/13, Preventive Health Care Guidelines, including Screening for Colorectal Cancer. Six staff attended this training. <u>Acute and Emergency Care</u> The active record was reviewed for 10 individuals who had most recently gone to the Emergency Room (ER) and returned. These individuals are listed in the documents reviewed section. For these 10 individuals, there were 12 ER visits. One ER visit led to a hospitalization, and was removed from this review. Eleven ER visits with return to the Facility were reviewed. For nine of the 11 ER visits, the individuals had gone to the ER from their residence. There were two ER visits for which the individuals had gone from the Infirmary to the ER. The following summarizes the results of this review, based on the submitted documentation: ▪ Information was submitted indicating that the ER was notified prior to the arrival of the individual with appropriate medical background information provided for six of 11 (55%) records. ▪ Prior to the transfer to the ER, a PCP was on site for seven of these transfers. In seven of seven (100%) records, the PCP had written an IPN that included the date and time.	

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		▪ For five of seven (71%) PCP transfer IPNs, vital signs were recorded. ▪ For seven of seven (100%) PCP transfer IPNs, reason for the transfer was documented. ▪ In seven of the seven (100%) PCP transfer IPNs, the SOAP format was utilized. ▪ A copy of the ER report was available in 11 of 11 (100%). ▪ Of the 11 ER visits, diagnostic categories included: Respiratory concerns - four, abdominal pain - one, cardiovascular disease - one, urological concerns - two, mental status change - two, and neurological concerns – one. ▪ When the individual returned to the Facility after evaluation at the ER, 11 of the 11 (100%) active records had a PCP IPN. ▪ Ten of 11 (91%) post-ER visit PCP IPNs included date and time. ▪ Six of 11 (55%) post-ER visit PCP IPNs included recording a set of vital signs. ▪ Eight of 11 (73%) post-ER visit PCP IPNs utilized a SOAP format. ▪ A summary of ER information and findings was included in 10 of 11 (91%) PCP IPNs. ▪ When returning to the Facility, zero returned to the individual's residence, and 11 returned to the Infirmary. ▪ For 10 of 11 (91%), the submitted information indicated treatment was considered timely. For one, the submitted information did not include pre–ER visit documents. For the 10 ER visits submitted with documentation, there were no perceived delays in care in transferring the individuals to the ER. Additionally, 10 active records were reviewed for those individuals admitted to the hospital. The following provide the results of this review: ▪ Ten individuals returned to the Facility. ▪ Nine of 10 (90%) had a PCP IPN post-hospitalization note within 24 hours of return. For one individual, there was a notation that an admission assessment had been completed (dictated/typed), but this document was not submitted. ▪ Of the nine post-hospital PCP IPNs submitted, five of nine (56%) included vital signs. ▪ Nine of nine (100%) submitted post-hospital PCP IPNs included date and time. ▪ Eight of nine (89%) submitted post-hospital PCP IPNs had an adequate summary of hospital events and findings. ▪ Eight of nine (89%) submitted post-hospital PCP IPNs used the SOAP format. ▪ Eight of nine (89%) active records of the hospitalized individuals included a copy of the hospital admission history and physical. ▪ Eight of nine (89%) active records included a copy of the hospital discharge summary. ▪ Ten of 10 (100%) active records included a copy of either the hospital admission history or physical, or a copy of the hospital discharge summary. ▪ Eight of the 10 (80%) included Hospital Liaison Nurse notes for the individuals	

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		(either as part of the hospitalization packet of information or as part of a separate request). Two sets of Hospital Liaison Nurse notes were for the correct individual, but not the correct hospitalization dates. ▪ For six of the 10 (60%) individuals that returned to the Facility, additional PCP IPNs were included as part of the follow-up. ▪ Of the 10 hospitalizations, major organ system reasons for the hospitalizations included the following: o Acute respiratory illness – five; o Gastrointestinal disease – two; o Sepsis – one; o Osteomyelitis from a decubitus – one; and o Elective surgery (dental) – one. ▪ Nine of 10 returned from the hospital to the Infirmary at ABSSLC. For one individual, this information could not be determined, as pages appeared to be missing. For admissions of individuals to the Infirmary over the prior six months (September 2012 through February 2013), the length of stay was determined. The length of stay varied from less than one day to 115 days. ▪ The number staying one day or less was 13. ▪ The number staying two days was nine. ▪ The number staying three days was 11. ▪ The number staying four days was nine. ▪ The number staying five days was seven. ▪ The number staying six days was nine. ▪ The number staying seven to 10 days was 12. ▪ The number staying 11 to 20 days was four. ▪ The number staying 21 to 30 days was four. ▪ The number staying 31 to 60 days was four. ▪ The number staying 61 or more days was four. The reasons for Infirmary admissions included the following categories: ▪ Cardiovascular disease - three admissions; ▪ Gastrointestinal disease - 18 admissions; ▪ Genitourinary disease - seven admissions; ▪ Respiratory disease - 21 admissions; ▪ Neurological disease - nine admissions; ▪ Other disease/hospice/surgical care/other concerns - 16 admissions; and ▪ Trauma - four admissions.	

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		Pneumonia Data was submitted which had been entered into the Avatar database. However, the information was not separately submitted for pneumonia, but was pneumonia was listed with all other reported infections. It was unclear if/why a report on pneumonia/aspiration pneumonia could not be generated, and this raised questions about whether the Facility staff had easy access to information from this database to allow necessary review and analysis. Information was extracted from an infection control report entitled "Summary Report (Overall)." Information concerning pneumonias was submitted for the time period 9/1/12 through 2/28/13. According to this database, there were 15 pneumonias during this time period. Of these 15, eight were categorized as aspiration pneumonia. There was one case in which aspiration pneumonia was diagnosed, but there was an additional entry in which a nurse indicated it was not aspiration pneumonia. It was then signed off as an Upper Respiratory Infection (URI)/flu symptoms. However, the Avatar report was available, and included that the off-campus physician provided the diagnosis of aspiration pneumonia. The chest x-ray indicated pneumonia. A modified barium swallow showed dysphagia with aspiration. An esophagogastroduodenoscopy (EGD) showed reflux. There was no information given for the reason to refute the aspiration pneumonia diagnosis. As the information appeared consistent with aspiration pneumonia, for purposes of this report, this was categorized as aspiration pneumonia. The nurse entry did not provide an alternative interpretation of the chest x-ray reading of "pneumonia present." Off-site physicians diagnosed eight of these 15 pneumonias. As part of confirmation of the diagnosis of pneumonia, the following information was provided in this database: ▪ Fourteen of 15 (93%) had a chest x-ray completed or a reading was submitted. ▪ For 14 of these 14 (100%), the chest x-ray confirmed pneumonia. ▪ According to the database, four individuals were taking by mouth (PO) nutrition at the time of the pneumonia. For four of four (100%), there was documentation of a therapeutic diet with varying textures and fluid thickenings. ▪ Ten of the 14 individuals had a feeding tube prior to the onset of the pneumonia (for one individual, no information was provided). Nine of the 10 were gastrostomy tubes (G-tubes), zero were gastro-jejunostomy tubes (G/J-tubes), and zero were jejunostomy tubes (J-tubes). One was a temporary naso-gastric tube. The pneumonia was diagnosed during the time of the naso-gastric tube placement. For those with gastrostomy tubes, eight of nine utilized an intermittent flow rate, and one utilized bolus feedings. ▪ From this Avatar data, the distribution of aspiration pneumonia and pneumonia per month were as follows:	

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Month	# Aspiration pneumonia	# Pneumonia
September 2012	0	1
October 2012	1	0
November 2012	2	0
December 2012	1	1
January 2013	2	4
February 2013	3	0
TOTAL	9	6

The Infection Control Meeting minutes of 10/25/12 documented no aspiration pneumonia cases at ABSSLC from August and September 2012. During this time, there were three cases of pneumonia identified. An infection control summary report from 9/1/12 through 2/28/13 recorded eight cases of aspiration pneumonia and six cases of pneumonia.

A separate list of pneumonia diagnoses per month indicated agreement in some months and discrepancies in other months. The document entitled "Absolute numbers of new case for the following: pneumonia" (dated April 2013) indicated the following numbers of pneumonias per month:

- September 2012 – one;
- October 2012 – four;
- November 2012 – three;
- December 2012 – two;
- January 2013 – five;
- February 2013 – three; and
- March 2013 – three.

The Medical Department provided some in-service training on health conditions or medications which might be associated with aspiration pneumonia, including:

- On 1/31/13, side effects of Aricept, risk/benefits, attended by six PCPs; and
- On 3/20/13, case presentation, attended by six PCPs.

Six individuals were diagnosed with sepsis in the past 12 months.

Trauma
During the time period from May 2012 forward, there were four fractures (document entitled "Fractures" and dated April 2013). The fracture site included the following: ankle, rib, humerus, and phalanx.

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		Chronic Conditions and Specific Diagnostic Categories *At-Risk Individuals* The following provide some examples of concerns related to the assessment and planning for individuals at risk: ▪ Individual #493 had a significant change of health status in the prior six months. On 11/14/12, there was a change of status IRRF created along with numerous ISPAs during the months of September 2012 through January 2013 (as listed below). There was documentation of inter-disciplinary discussion. Important questions were raised, but there appeared to be no clear next steps identified. It was noted that the PCP was not in attendance at most meetings. A PCP might have been able to answer some of the concerns at that time. However, there were significant concerns about an esophageal stricture with gastritis, as well as osteoporosis. It was noted that on 1/14/13, the individual had an order for nothing by mouth (NPO), but there was no further change of status IRRF to reflect that important change in health. At one time the individual was scheduled for a thoracic surgery consult, and the gastroenterology (GI) consultant did not appear to be aware that the consult had been discontinued, according to a January 2013 consultation report. The active record did not record the reasoning for discontinuing the consultation request, nor was the consultant informed at that time. Further discussion of the concern of recurrent stricture with subsequent pooling of oral secretions and aspiration could not be found. The GI specialist recommended frequent oral suctioning to prevent accumulation of secretions, but this appeared to be interpreted from a dental hygiene perspective. Vacuum tooth brushing was reduced to twice a day from five times a day (the individual had several small meals a day prior to the G-tube placement), but the active record did not indicate the PCP addressed the need for or frequency of oral suctioning as a nursing intervention to prevent pooling or secretions independent of vacuum tooth brushing (the individual was edentulous). This information might have been located elsewhere in the record (such as a PNMP), but the rationale of clinical care from the PCP was difficult to follow. The team brought up other surgical procedures, which may or may not have been indicated, but there was no PCP present to respond and provide a clinical perspective. Additionally, the ISPA of 11/1/12 reviewed the diagnosis of osteoporosis and lack of treatment. The individual was known to have hypogonadism (prior bilateral cryptorchidism and orchiectomy), but was not treated with hormonal	

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		replacement. The reason for not currently treating the secondary cause of osteoporosis could not be determined from the record review. However, the individual was no longer able to take a bisphosphonate orally or by feeding tube, and the individual was not a candidate for Prolia, according to the IDT notes. For such complex cases, an endocrinologist or other specialist would have been helpful to assist in identifying additional options, but there was no next step identified. As discussed above, it was noted the IDT met several times during this individual's health decline. ISPAs were held on 9/11/12, 9/26/12, 10/2/12, 10/14/12, 11/1/12, 11/14/12, 11/29/12, 1/3/13, 1/14/13, and 4/29/13. It was noted a PCP was only in attendance at the 9/26/12 and 10/2/12 IDT meetings. The PCP also did not attend the at-risk/IRRF meeting of 9/5/12. Given the complex medical concerns, it is recommended that the PCP attend such meetings to guide the IDT, but also that the QDDP ensure the meeting is scheduled at a time when the PCP can attend, and provide sufficient advance notice to ensure medical coverage can be arranged while the PCP attends the ISPA meeting. As mentioned, there were many questions and concerns raised, some of which could have been quickly dispelled, and some of which could have led to further actions, but the absence of the PCP appeared to reduce the quality and timeliness of the IDT's decision-making. In such complex cases, the PCP should take a leadership role in the clinical discussion and decision-making. In addition, the active problem list did not include dysphagia or GERD, and the preventive care flow sheet had not been updated in over a year. These documents are helpful to the IDT members in understanding the medical conditions of the individual, but these tools did not provide current information. ▪ Individual #465 had change of mental status with history of falling, and was found to have recurrent elevations in Dilantin level. This individual was admitted to the Infirmary in April 2013. There was no ISPA to document the IDT was aware of the work-up at that time, or discussion and development of an action plan based on the change in health status. The ISP did provide some details concerning the work-up completed for falls, such as the results of a CT of the head in the prior months, but did not add it to the information included on the IRRF. Results of the, cardiology consult and psychiatry consult/review of medications did not appear to be reported through the IRRF process. Additionally, there did not appear to be PCP guidance to the IDT in the interpretation of results and incorporating this guidance into the IRRF. For example, many of the findings on the CT report were consistent with prior findings, and not new concerns (the prior CT scan date was inaccurate as it was documented as occurring in 3/8/14). There was one potential recommendation listed in the CT report, but there was no information in	

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		the ISP or IRRF concerning discussion or follow-up by the PCP or IDT. When reviewing the fall, fracture, and seizure sections of the IRRF, this report was not summarized in any of these sections. Additionally, the last quarterly medical review was September 2012. The IDT could not depend on the quarterly medical review process to confirm important tests had been completed or test results reviewed and addressed. ▪ Individual #524 had ongoing risk concerns. This individual had a DEXA scan in May 2008, with a T-score of -2.05. The individual was not a candidate for Fosamax at the time. The individual had been prescribed calcium and Vitamin D. However, there was no further DEXA, despite a recent x-ray of the foot, which showed diffuse osteopenia. There were no other medication options discussed, and rationale could not be found for not further monitoring the osteopenia/osteoporosis. As the individual was wheelchair and bedbound, the risk was high for development of worsening osteopenia/osteoporosis. The individual had had decubiti of the sacrum/coccyx/buttocks over the past several months, with intermittent healing and then breakdown. There was pressure mapping of the mattress and the wheelchair. There was mention of an additional recliner that was used, but no information concerning optimal positioning in the recliner and whether pressure mapping had been completed on this or whether it was no longer used. On 2/6/13, a seating system assessment of the wheelchair was completed, but the submitted documents did not indicate whether or not the individual had received the new wheelchair at the time of the Monitoring Team's visit. It was noted from a 2/6/13 nursing IPN that the dressing change had not been followed and there was a lack of non-adhesive dressing when the dressing was removed and this created three open skin areas. There was an evaluation of the most physiologically appropriate range for head of bed elevation. The individual had a positioning schedule in which the individual was not to be in the wheelchair more than two hours at a time, but it was not clear who was to monitor the positioning schedule to ensure it was occurring according to schedule. Given the large number of decubiti needing constant review and dressing changes for individuals at ABSSLC, it is recommended the Nursing Department consider having one nurse focused on decubiti throughout the campus, who primarily changes dressings and teaches staff, as well as monitors quality of the dressing process. Training in decubitus care would then be focused on one assigned nursing staff rather than training all nurses on campus, which might reduce complications of dressings done incorrectly. On 6/5/12 and 1/2/13, the individual had pneumonia, both of which resolved	

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		after treatment in the Infirmary. However, the annual medical assessment indicated that "since no recent aspiration pneumonia, preventative measures seem to be working," while in the prior paragraph, the history of the 1/13 aspiration pneumonia was reviewed. The individual had a follow-up modified barium swallow study (MBS), which was normal. The individual continued to have wheezing and hypoxia, but there was no information of further assessment and role of GERD/gastroparesis in contributing to these episodes. The individual had a history of GERD and was taking a proton pump inhibitor, but there was no further information whether this was sufficient to meet the needs or whether the GERD was worsening and contributing to respiratory compromise. The individual's head-of-bed elevation had been slightly reduced by the PNMT, but this might increase the risk of reflux and aspiration. ▪ Individual #413 was hospitalized from 4/15/13 to 4/23/13 for fever and hypoxia. The initial ER diagnosis was pneumonia, which was changed to respiratory distress, fluid overload, and pneumonitis. The discharge diagnosis included diastolic heart failure, with normal lab values in follow-up. The PCP documented a thorough hospital review in a form entitled "Post/ER Hospital Transfer Medical Chart Review Progress Record" of 4/24/13, with follow-up lab completed and reviewed. At the time of the Monitoring Team's review, there was no follow-up ISPA submitted to indicate awareness or discussion by the IDT. The PCP IPN reviewed the various labs of the recent hospitalization, but did not review the past history to determine the need for updating information. As an example, there was no information recorded whether the PCP or IDT reviewed the history of GERD that was last evaluated in 1995 (along with G-tube placement and Nissen fundoplication at that time), as a contributing cause for possible aspiration/pneumonitis. There was no information as to whether there was consideration of the need to verify that the Nissen fundoplication was intact. There was no information discussed about a review of residual gastric volume prior to enteral feeding and whether gastroparesis was a concern. *GERD* As part of the review of nine active medical records, GERD was reviewed. Of the nine, seven were diagnosed with GERD. For the following, not each case would have had the listed test or procedure, but provides evidence of the spectrum of treatment at the Facility. ▪ Of these seven, results of an EGD or upper gastrointestinal (UGI) report were available or discussed in the IPN/ISP for five of seven. ▪ Of these seven, four had a fundoplication. ▪ Of these seven, six had a feeding tube. ▪ Of these seven, seven had appropriate medication prescribed. ▪ Of these seven, one had a tracheostomy. ▪ Of these seven, one had periodic procedures and tests for monitoring potential	

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		worsening of GERD. ▪ Care was considered to follow clinical guidelines/national standards for evaluation and treatment of GERD in seven of seven (100%) reviews. *Tracheostomies* Eleven individuals currently had tracheostomies. *Newly diagnosed Chronic conditions* Information was submitted concerning new diagnoses of chronic conditions that occurred over the past year. Three individuals were newly diagnosed with diabetes mellitus type II. Seven individuals were newly diagnosed with cardiovascular disease. One case of a newly diagnosed cancer was reported in the past year. *Pica* An updated list of pica or ingestion of inedible objects was submitted for the time period of 180 days prior to the Monitoring Team's visit. This included 53 events involving 11 individuals. No pica incidents required an ER visit or hospitalization. An updated record was submitted entitled "Pica from March 2012 –April 2013." For the time period of 10/1/12 through 3/3/13, there were 46 pica events involving 11 individuals, none of which required an ER visit or hospitalization. *Acute Choking* There were two individuals that choked on food. Both required abdominal thrusts. One was observed overnight in the Infirmary. *Chronic constipation* A document was submitted entitled "Individuals with diagnosis of constipation" (undated). The document listed 299 individuals with a diagnosis of constipation. According to data submitted in a document entitled "Individuals' names, dates of diagnosis, specific diagnoses for past year for individuals who have been newly diagnosed with bowel obstruction or bowel perforation" (dated April 2013), three individuals developed bowel obstruction or bowel perforation/complication over the past year. Separately, a document entitled "Absolute numbers of new cases for the following (bowel obstruction)," listed five cases from April 2012 through March 2013. *Enteral feeding tubes* The Facility submitted information that five individuals were identified as having jejunostomy tubes or gastro-jejunostomy tubes as of 3/28/13. A review of the medication profiles was completed to determine whether medications not recommended for administration through these specific tubes were ordered through the tubes (e.g., Quinolones, Sucralfate, Anatacids, Bismuth, Beta blockers, Nitrates, Opioids, and Tricyclic	

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		anti-depressants). The review indicated that for five of five (100%) individuals with gastro-jejunostomy tubes or jejunostomy tubes, these medications were not prescribed. *Skin Integrity* A Skin Integrity Committee met monthly starting in 2013. Minutes were submitted for 1/31/13, 2/28/13, and 3/28/13. The 3/28/13 committee meeting provided graphs of the data from the 1st and 2nd quarters of fiscal year 2013 (September 2012 to February 2013). There was an improved downward trend of the number of individuals reported to have one pressure ulcer, with 17 recorded in September 2012 and 11 recorded in February 2013. Two individuals had more than one pressure ulcer. One individual had two pressure ulcers and one individual had five pressure ulcers. The number of individuals with new pressure ulcers varied from nine in September 2012 to a peak of 13 in November 2012, to four in February 2013. From September 2012 through March 2013, there appeared to be a plateau in the total number of ongoing and continuing cases of pressure ulcers. Per month this varied from 15 to 21, with the most recent February 2013 total as 18. A separate document entitled "Absolute numbers of new cases for the following: (decubitus)" dated April 2013, indicated that there were 60 new decubiti from April 2012 through March 2013. The month-to-month numbers did not appear to agree with the prior data. For instance, the number of new pressure ulcers in September 2012 in this second document was eight, the number in November 2012 was four, and the number in February 2013 was six. During the Monitoring Team's onsite review, on 5/6/13, at the QA/QI Leadership Council, an update was provided concerning the progress of this committee. Submitted records provided updated, but sometimes contradictory information. One record identified 17 pressure ulcers for the month of March 2013, and a separate table of data identified 20 pressure ulcers for March 2013. The reason for the discrepancy was not identified. From September 2012 through March 2013, the number of new cases varied from three to 13, with the same number of new pressure ulcers reported in September 2012 as March 2013. The number of individuals with decubiti appeared to have a downward trend from September 2012 through March 2013. A major challenge was the accuracy of the information reported at ABSSLC. Habilitation therapy provided an in-service to the PCPs focusing on date of initial diagnosis, date if stage worsens, date of resolution, accuracy of staging, and accurate anatomic location documentation for pressure ulcers. This in-service occurred on 2/15/13, and was entitled "Pressure Ulcer Staging." An in-service training to nurses concerning correct anatomic location and staging of the pressure ulcers occurred on 3/19/13 and 3/20/13. Twenty-two nurses attended the in-service training. This improved accuracy in documentation	

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		resulted in decreased total numbers of pressure ulcers (i.e., the downward trend was due to improved accuracy of the actual number of pressure ulcers that occurred). At the QA/QI Council meeting, there was little, if any, discussion about the quality of the plans designed to address the remaining pressure ulcers, or prevent new ones from occurring. There were a number of clinical indicators tracked monthly such as number of new decubiti per month, and the number of individuals with at least one decubitus each month. However, it was not clear what the rate of healing was. The number of healed decubiti per month would provide this information. Additionally, the number of ongoing Stage 3 and Stage 4 decubiti per month would be helpful. With a baseline of accurate data, the Facility should be able to focus on policy and procedure of the Skin Integrity Committee and review of care plans. It is recommended that the database include the geographic site of the initial report of the pressure ulcer (e.g., home, Infirmary, hospital, etc.). The committee should consider development of a clinical pathway/guideline for pressure ulcer prevention as well as pressure ulcer care. Another recommendation is monitoring of implementation of the care plan for the pressure ulcer (the positioning log matches the monitor's findings, for example). As an additional tracking step, the 3/28/13 minutes of the Skin Integrity Committee indicated that new pressure ulcers would be reported at the morning medical meeting. *Seizure management* The Facility submitted information concerning antiepileptic medication usage. As of 4/4/13, 201 individuals were prescribed antiepileptic medication. Of these, 100 (50%) were prescribed one antiepileptic medication, 67 (33%) were prescribed two antiepileptic medications, 30 (15%) were prescribed three antiepileptic medications, and four (2%) were prescribed four antiepileptic medications. Additionally, 14 individuals with a diagnosis of seizures were on no antiepileptic medications from a document (untitled), which provided a "list of all individuals being treated for seizure disorders, including medication regimen." From another document entitled "Newly diagnosed with malignancy, cardiovascular disease, diabetes mellitus, sepsis, bowel obstruction or perforation, and pneumonia," dated April 2013, the list included those with seizures on no medications, although the title did not indicate that data concerning seizures would be included. This document listed 30 individuals with seizures/seizure disorder with no medication. From a separate "Seizure List" (undated), which separated controlled from intractable seizures, the number of individuals with seizures was listed as 256. The reason for the difference in absolute numbers between the two documents was not clear. The Facility considered the definition of intractable seizure to be "difficult to manage or control." The seizure disorder was considered controlled when there was no recorded seizure in one year following the prior seizure. Using these definitions as guidance, the Facility provided	

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		a list of 127 individuals that were considered to have a refractory seizure disorder. Twenty-six of these individuals had a VNS implant. There were three individuals with a refractory seizure disorder who were currently being evaluated for a VNS. In the prior six months, four individuals were sent to the ER for an uncontrolled/ prolonged/new onset seizure. Four individuals were diagnosed with status epilepticus. The Facility definition did not reflect the State Office definition for intractable seizure. The State Office definition provided more detail and guidance. The Settlement Agreement Compliance Physician provided an in-service entitled "Seizure guidelines from State Office" on 3/26/13, which six PCPs attended. The Medical Records Department was informed of the change in definition to be used at ABSSLC, and a new diagnosis was added to the software program for retrieval as data began to be entered. Additionally, the "Annual Medical Summary" form was revised to include a specific section on seizure disorder with the State Office definition included as guidance to the PCPs. Additionally, this diagnosis was to be added to the Active Problem List, as appropriate. A list was submitted indicating the percentage of individuals prescribed older antiepileptic medications. Two hundred and one individuals were prescribed seizure medications. A total of 39 (19%) individuals were prescribed Dilantin, seven (3%) were prescribed Primidone, 66 (33%) were prescribed Phenobarbital, and 4 (2%) were prescribed Felbamate. Additionally, 26 individuals had a VNS implant. 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 five of the five (100%) individuals, the notes indicated a description of the seizures. ▪ For five of the five (100%) individuals, the notes documented frequency of seizures. ▪ For five of the five (100%) individuals, the notes included a review of current medications for seizures and dosages. ▪ For five of the five (100%) individuals, notes included the most recent blood levels of antiepileptic medications. ▪ For five of the five (100%) individuals, notes included recommendations. ▪ For five of the five (100%) individuals, reference was made to physical exam, and/or the Moses/Discus scores. ▪ For five of the five (100%) individuals, reference was made to wellness or level of control of seizures.	

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		Do Not Resuscitate Orders A total of 18 individuals at the Facility had DNR orders in place. The date of the DNR was submitted. DNR orders were initiated for one individual in 2013, one individual in 2012, for three individuals in 2011, for zero individuals in 2010, for two individuals in 2009, and for 11 individuals in years prior to 2009. For 14 of 18 (78%), adequate clinical justification was provided for the DNR. Clinical justification included the following: six individuals had severe osteoporosis, three had a cardiac diagnosis, one had cancer, one had a genetic disorder, one had a neurodegenerative disease, one had severe scoliosis, and one was failure to thrive. For four individuals, the reason for the DNR stated "no medical justification" followed by "qualified relative requests DNR remain." This was not an adequate clinical justification. For six of the 18, copies of an ethics committee meeting documentation were submitted. For 13 of the 18, there were IPN entries explaining the decision. For 15 of 18, copies of the original IPN documenting the decision for DNR was submitted. The Facility submitted a list of 33 individuals for whom a DNR order was rescinded. The Facility Ethics Committee met on the following dates to discuss specific individuals to review DNR status and/or admission to hospice care: 10/4/12 (two individuals discussed), 10/18/12 and 12/28/12 (two individuals discussed), and 3/11/13 (three individuals discussed). Minutes of the Facility Ethics Committee included the following components: ▪ Documentation indicated that a meeting was called for each individual separately. Although there were four meeting dates, there were eight sets of minutes. ▪ Eight of eight (100%) meeting minutes documented date and time. ▪ Eight of eight (100%) meeting minutes included the name of the individual for discussion of DNR or enrollment in hospice services. ▪ Eight of eight (100%) meeting minutes listed names of attendees. ▪ Zero of 8 (0%) meeting minutes included a signature sheet for attendees. ▪ Eight of eight (100%) meeting minutes included a synopsis of the proceedings and critical review of information. ▪ Eight of eight (100%) meeting minutes included a summary of critical discussion with family/guardian. ▪ Eight of eight (100%) meeting minutes included discussion by the PCP. ▪ Eight of eight (100%) meeting minutes included a recap with recommended action steps outlined. ▪ Zero of 1 (0%) meeting minutes for one meeting in which follow-up was assigned had subsequent documentation of closure of that assignment.	

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		The meeting minutes did not list specific documents that the committee might have reviewed, either clinical reports, hospital summaries, State Office policy, current regulations, etc. Overall, the committee needed to be specific in concluding whether the individual was had a terminal illness. In several cases, the individual was eligible for Hospice care or on Hospice care, suggesting that the individual was eligible (according to the State Office draft policy). However, in only one of six was the phrase "terminal illness" used in the minutes. The ethics committee should ensure the "qualifying condition" agrees with the wording/intent of the current State Office policy. Having a State Office representative familiar with this aspect of decision-making participate by conference call during the meeting would be an efficient approach to address this area of concern. The State Office draft policy also indicated hydration and nutrition was not optional, but there were discussions/decisions in which it was determined a feeding tube was inappropriate. Further guidance from the Ethics Committee referencing the State Office draft policy and providing rationale for how the decision in each case was consistent with the State Office draft policy would have provided needed clarity. <u>Mock Code Drills and Emergency Response Systems</u> Findings and recommendations related to mock code drills and emergency response systems are discussed with regard to Section M.1 of the Settlement Agreement.	
L2	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall establish and maintain a medical review system that consists of non-Facility physician case review and assistance to facilitate the quality of medical care and performance improvement.	<u>Non-facility Physician Case Reviews</u> During the prior six months, the Facility completed one non-facility physician audit review, Round #6. The following represents a synopsis of the information: ▪ For the one external peer review dated October 12 to 13, 2012, PCP compliance in essential areas ranged from 97 percent to 100 percent. For areas considered non-essential, compliance ranged from 89 percent to 100 percent. ▪ The external audit review process information indicated the number of records chosen for review of the general medical audit. Twenty-three records were chosen. ▪ The external audit review process information indicated how the sample was obtained. Selection was a five percent random sample of each provider's caseload. ▪ Areas that appeared to need improvement from the external peer review included answers to the following audit probe questions: One essential area needing improvement was (4) "Is the annual physical exam and summary current?" Other non-essential areas needing improvement were (9) "Have the appropriate immunizations been given?" (10) "Are the appropriate preventive screening services provided?" (11) "Is there documentation present for not providing preventive services?" (14) "Is there evidence that the provider responded to the pharmacist quarterly drug regimen review recommendations on the Quarterly Drug Regimen Review Form within 15 business days?" (15) "Did the provider document rationale for not following recommendations made by the pharmacist?"	Noncompliance

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		and (21) "Is each of this person's progress notes and orders signed, dated, and timed?" Two of the indicators (11) and (15) scored at or below 80 percent. Indicator (11) scored 72 percent and indicator (15) scored 34 percent. ▪ A total of seven of the 30 indicators fell at or below the compliance threshold of 80 percent. This indicated improvement as a total of 13 indicators fell at or below the compliance threshold of 80 percent during the prior external general medical audit. ▪ From the external general medical peer review audit of October 2012 Round #6, there were 19 corrective action plans generated (the table identifying action plans listed 21). ▪ An external medical management audit for Round #6 was also completed on October 12 to 13, 2012. ▪ A random sample of nine medical management audits was completed, with three records for each of three diagnoses: seizures, UTI within the prior six months, and constipation. The sample was derived from lists provided by the nursing/Medical Departments for each of these three diagnoses. ▪ Areas that appeared to need improvement from the external medical management peer review audit included answers to the following audit probe questions: Constipation (4) "Is there evidence that the PCP ordered non-pharmacological treatment?" with 33 percent compliance. Seizures (2) "Did the PCP complete appropriate labs at least every 6 months?" with 66 percent compliance, and (4) "Quarterly review of seizures documented by the PCP with recommendations?" with 33 percent compliance. UTI (1) "Is Urinary tract infection listed on the Active Problem List?" with 33 percent compliance, and (4) "Did the provider order a urology consult or other diagnostics if a male individual has had more than one UTI in a year or a female individual has had more than three UTIs in a year?" with 33 percent compliance. ▪ From the external medical management audit for October 2012 Round #6, there were nine corrective action plans generated. ▪ Compliance rates for the external medical management audit ranged from 70 percent to 100 percent for the PCPs. ▪ A Medical Provider Exit Interview was conducted on October 13, 2012. ▪ Compliance rates were calculated as an average of all PCP scores. ▪ The total sample size of records reviewed was 23+9 = 32/393 = 8 percent of the population. The goal is a 20 percent sample of the population at ABSSLC per year. ▪ A follow-up system was implemented to ensure compliance/completion of corrective action plans for each PCP's areas of noncompliance. ▪ The QA nurse/QI Department compiled compliance data with corrective action plans. ▪ The QA Department tracked corrective action plan resolution, but the interval of time was not included on the "Action Plan Follow-up by QA" records provided.	

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		Evaluation was expected to be every 30 days until resolution. ▪ The QA Department determined that for 21 of 21 issues identified (100%), providers corrected all deficiencies from the external general medical peer review audit. ▪ The QA Department determined that for nine of nine issues identified (100%), providers corrected all deficiencies from the external medical management peer review audit. ▪ Following an interview with the QA Department, a document entitled "External/Internal QA Medical Audit: Quarter 1 Fiscal Year 2013 conducted at ABSSLC October 12-13, 2012" dated 5/10/13, provided additional explanation. Twelve of 21 external general medical corrective action plans and nine external medical management corrective action plans were corrected within 30 days, and the remaining 18 corrective action plans were completed within 60 days. ▪ The QA Department provided a spreadsheet entitled "External Medical Audit QA Corrective Action Tracking," which included two pages of columns. The heading was not repeated on the second page, making interpretation difficult. It appeared to be a black and white copy of a color-coded spreadsheet, but there was no information provided as to what the various shades of gray meant. There were many columns with significant blank areas. A column indicating whether there was closure did not appear to be present. During the interview, the staff members were unable to provide an interpretation of this detailed document. As a result, this chart provided insufficient evidence to support that the corrective action plans had been implemented. Subsequently, information was provided in written narrative form. It appeared the QA Department had completed timely serial follow-up, but the submitted forms and database were difficult to interpret. Corrective action requires the QA Department to compile data (with dates) when the implementation of the corrective action occurred, and also determine the quality of the action taken (i.e., was the corrective action effective). The current template for the table listing corrective actions did not include 30-day intervals to track if the records were reviewed, and to identify the 30-day period in which the plan was completed. It is recommended that the QA Department create a user-friendly document to assist staff in tracking completion of needed actions. Such a document should be self-explanatory to ensure there is no misinterpretation of information, and to indicate results every 30 days (with dates of time period), and date of closure. ▪ There did not appear to be Medical Department staff meetings that were formalized with minutes. However, there were a series of in-service trainings for PCPs at which the peer review indicators were reviewed, demonstrating implementation of action plans to improve quality of care measured by these indicators.	

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		Mortality Reviews Since the start of the Monitoring Team's last visit, nine deaths had occurred from July 2012 through February 2013: ▪ The average age was 67 (varied from 28 to 91). ▪ Three died under the age of 65, and six died at age 65 or greater. ▪ Of the deaths, six were females, and three were males. ▪ The causes of death were: cardiovascular disease (1), end stage renal disease (1), sepsis (3), cancer (1), aspiration pneumonia (2), and cerebrovascular accident (1). ▪ An autopsy was performed in two of the nine. ▪ DNR status was ordered while residing at ABSSLC for six of the nine, and ordered for seven of nine while in the hospital. ▪ DNR status was in place prior to the final acute illness for four of nine individuals. DNR status occurred during the final acute illness for five of nine individuals. ▪ Four died in an acute care hospital setting. Four died at the Facility. One died at another site (inpatient Hospice). ▪ Five had multiple or prolonged hospitalizations within six months prior to death. Five had been hospitalized within four months of death. ▪ Eight of nine had a feeding tube. ▪ Seven of nine included documentation indicating they were aggressively managed or aggressively managed until a decision of DNR was made. ▪ Eight of nine were enrolled in hospice. ▪ Seven were considered ambulatory (either independently or with assistance). ▪ A copy of the death certificate had been received for nine of nine. Since the Monitoring Team's last visit, nine clinical death review investigations and nine administrative death reviews were completed. Clinical death review recommendations and nursing QI death review recommendations were discussed at the administrative death reviews. The administrative death reviews recorded the final list of recommendations for the death review process of the individual. ▪ From seven to 10 attendees were recorded at the clinical death reviews. ▪ From five to nine attendees were recorded at the administrative death reviews. ▪ Administrative death reviews included from zero to 12 recommendations per review, for a total of 20 recommendations. ▪ Systemic issues related to potential improvements in medical care were the topic of seven of the 20 recommendations from the administrative death reviews. ▪ Systemic issues related to potential improvements in nursing care were the topics of nine of the 20 recommendations from the administrative death reviews. ▪ Systemic issues related to potential improvements in transition of care to the ER, hospitalization, rehabilitation or nursing home, or hospice were the topic of one of the 20 recommendations from the administrative death reviews.	

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		▪ Systemic issues related to potential improvements in pharmacy services were the topic of zero of the 20 recommendations from the administrative death reviews. ▪ Systemic issued related to potential improvements in dental services were the topic of zero of the 20 recommendations from the administrative death reviews. ▪ Systemic issues related to potential improvements in habilitation therapies were the topic of two of the 20 recommendations from the administrative death reviews. ▪ Systemic issues related to potential improvements in residential care were the topic of one of the 20 recommendations. ▪ Systemic issues related to potential improvements in meaningful day activities (i.e., work, leisure programs, etc.) were the topic of zero of the 20 recommendations from the administrative death reviews. ▪ Systemic issues related to potential improvements in other departments (e.g., maintenance, housekeeping, furlough, etc.) were the topic of zero of the 20 recommendations from the administrative death reviews. The Facility submitted follow-up documentation for 10 of 20 recommendations (50%). The subject/material covered and training rosters were submitted for seven of the recommendations. Additional training occurred based on other clinical issues involving the individual. Training for the recommendations and additional training in-service included the following: ▪ On 3/18/13, training on the role of PCPs in verifying orders to transport an individual to the ER/hospital was attended by seven clinical staff, including six PCPs and the Settlement Agreement Compliance Physician. ▪ On 4/11/13, calcium supplementation and hyperparathyroidism training was attended by six PCPs. ▪ On 1/25/13, training on acute mental status changes was attended by six PCPs. ▪ On 4/11/13, training on antibiotic stewardship, chronic UTI medical management audit was attended by six PCPs. Additionally, the clinical death reviews identified four other recommendations for medical services, of which training occurred (if applicable) or other evidence of closure occurred for two of four (50%). Due to the type of recommendations, subject/material covered and training rosters were available for one of the two. Other confirmatory evidence was provided for closure of one recommendation. No evidence of closure was submitted for two recommendations. ABSSLC did not appear to conduct any rigorous tracking of the completion of recommendations. Only the department assigned the recommendations appeared to have tracked their completion. It is recommended that a system be created to ensure that recommendations from the various death reviews are followed to completion. As	

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		recommendations might apply to several departments, it would be appropriate for the QA Department to assume this monitoring role, with follow-up information and quarterly or monthly status reports provided to the QA/QI Council until closure occurs. Additionally, it was noted that although the PNMT is often involved with the critically ill individuals, a member of the PNMT was not represented on the Clinical Death Review Committee. It is recommended that a member of the PNMT attend this committee. As different PNMT members have various areas of expertise, it might be most valuable for the PNMT member that is most familiar with the individual or has needed expertise in an area contributing to decline and death to represent the PNMT for the case being reviewed.	
L3	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall maintain a medical quality improvement process that collects data relating to the quality of medical services; assesses these data for trends; initiates outcome-related inquiries; identifies and initiates corrective action; and monitors to ensure that remedies are achieved.	<u>Medical Department Internal QA System</u> *October 2012 Internal Review* The data from two internal medical peer reviews were provided. One internal general medical and medical management peer review occurred in October 2012, and was completed within one week of the external medical peer review audit. The audit questions were identical to those used in the external medical peer review audit. Compliance for PCPs in essential areas ranged from 75 percent to 100 percent. Compliance for PCPs in non-essential areas ranged from 75 percent to 99 percent. Essential areas that appeared to need improvement included responses to the following audit probe questions: (2) "Is the Active Problem List dated and signed when it was last reviewed?" (3) "Is there evidence that the Active Problem List was updated with each new problem or as problems were resolved?" (4) "Is the annual physical summary complete including PNH, family hx, and a plan of care?" (7) "Are drug and/or food allergies, intolerances or adverse drug reactions appropriately documented?" Non-essential areas that appeared to need improvement included responses to the following audit probe questions: (9) "Have the appropriate immunizations been given?" (10) "Are the appropriate preventive screening services provided?" (11) "Is there documentation present for not providing preventive services?" (12) "Does the 180 day Physician Orders document indication and duration for each medication?" (16) "Do the medication orders for acute conditions include indication and duration for all medications prescribed?" (18) "Are responses to lab values that needed interventions documented in the integrated progress note by the provider?" (19) "Are all diagnostic test results and consults initialed and dated?" (21) "Is each of this person's progress notes and orders signed, dated, and timed?" (22) "Is the provider's documentation legible?" (24) "Do individual progress notes regarding acute medical problems contain pertinent positive and negative findings?" (26) "When a referral for consultation is requested, is pertinent current and past medical history included in communication with the consultant?" and (27) "Are medical and/or surgical consultant recommendations addressed in the	Noncompliance

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		integrated progress notes within five business days after the consultation recommendations are received?" The indicators with the most deficiencies and lowest compliance scores included: (3), (7), (11), (18), and (19). Additionally, one indicator, (28) "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?" appeared to have a low compliance score not listed in the document "Questions with multiple no answers." For the internal medical peer review audit, there were 69 corrective action plans identified. An internal medical management audit was completed in October 2012, utilizing the same audit questions from the external medical management peer review for the following clinical concerns: Constipation, Seizures, and UTIs. Compliance among PCPs ranged from 14 percent to 100 percent. Areas that appeared to need improvement included answers to the following audit probe questions: Constipation: all indicators were scored at 100%. Seizures: (2) "Did the PCP complete appropriate labs at least every 6 months?" (4) "Quarterly Review of seizures documented by the PCP with recommendations?" UTI (1) "Is Urinary tract infection listed on the Active Problem List?" (2) "Did the provider prescribe the appropriate interventions and/or treatment?" (3) "Is there evidence that the PCP followed up the individual's response to treatment and is there documentation in the IPN of that individual's response?" and (4) "Did the provider order a urology consult or other diagnostics if a male individual has had more than one UTI in a year or a female has had more than three UTIs in a year?" For the internal medical management peer review audit, there were 10 corrective action plans identified. There were a total of 79 corrective action plans from the internal general medical and medical management audits. *Inter-rater reliability* The QA Department did not provide the inter-rater reliability for the past six months for the general medical audit. The reason for lack of inter-rater reliability information was a "glitch in the database." The QA Department did provide some comparison of scores for the medical management audit between the internal and external auditors. ▪ For the seizure indicators, there was agreement of five of the six indicators. Indicator (4) scores were 66 percent/33 percent, indicating need for review. ▪ For the constipation indicators, there was agreement on three of five indicators. Indicator (4) scores were 100 percent/33 percent, and indicator (5) scores were 0 percent and 100 percent, indicating need for review.	

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		▪ For the UTI indicators, there was agreement on one of the four indicators. Indicator (2) scores were 33 percent/100 percent. Indicator (3) scores were 0 percent/100 percent. Indicator (4) scores were 0 percent/33 percent. These indicated need for review. *Follow-up* From the charts "Action Plans Follow-up by QA," there were no dates included as to when the follow-up reviews occurred or when the action plans were completed. However the charts indicated the following: ▪ Sixty-nine of 69 (100%) of action plans for the internal general medical audit were completed. ▪ Ten of 10 (100%) of action plans for the internal medical management audit were completed. During discussion with the QA Department, a two-page spreadsheet entitled "Internal Medical Audit QA Corrective Action Tracking" was presented. As the headings were listed in a two-page document for the External Medical Review and not for the Internal Medical Review data, an interpretation of the data was difficult. Additionally, it appeared that the spreadsheet was color-coded on the computer screen, but it was black and white for the copy and added more questions than answers. Additionally, there were a considerable number of follow-up columns left blank or with "NO" recorded, indicating the need for further evaluation, but there was no further explanation or information. This did not provide the necessary evidence that the corrective action plans were completed, and completed in a timely manner. It appeared the staff interviewed were not readily familiar with the contents of the spreadsheet, nor what the entries, or color-coding might have represented. There was no column that was readily identified whether or not there was closure to the corrective action, although many dates were listed. A formal analysis report would have provided interpretation of the spreadsheet. For tracking of the results of the internal medical peer review audits, it is recommended that staff in the QA Department become familiar with the spreadsheet contents, and that a quarterly summary be completed that analyzes and interprets the results, with reference to specific columns, etc. It is also important that the dates of review of corrective action plans be captured in the tables provided, to determine how quickly the PCPs respond to implementing the corrective action plans. A copy of the quarterly summary/report should be provided to the Medical Department and Facility Administration. The QA Department subsequently submitted a document entitled "External/Internal QA Medical Audit: Quarter 1. Fiscal year 2013 conducted at ABSSLC October 12-13, 2012," dated 5/10/13. For the 79 corrective action plans generated by the internal medical and internal medical management audit, this document indicated that 23 of the action plans had been completed within the first 30 days, and 46 were completed within the next 30	

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		day follow-up time period. It was noted that 10 of the 79 records for which there were deficiencies no action plans were required, although the rationale for or examples of these 10 were not provided. *January 2013 Internal Review* A second internal general medical peer review and internal medical management peer review was completed January 29 to 30, 2013. A sample size of 24 records was generated, but one record was not available for audit during the window of time planned. There were three records each randomly sampled from diagnostic lists provided by the Nursing and Medical Departments. The diagnoses chosen were the same as in the prior internal medical management audit: constipation, seizures, and UTIs. For the internal general medical peer review audit, the following information was provided: PCP compliance in essential areas ranged from 88 percent to 100 percent. PCP compliance in non-essential areas ranged from 82 percent to 97 percent. The following indicators identified areas needing improvement: (3) "Is there evidence that the Active Problem List was updated with each new problem or as problems were resolved?" (5) "Is the annual physical summary complete including PMH, family hx and a plan of care?" (7) "Are drug and/or food allergies, intolerances, or adverse drug reactions appropriately documented?" (10) "Are the appropriate preventive screening services provided?" (11) "Is there documentation present for not providing preventive services?" (18) "Do the medication orders for acute conditions include indication and duration for all medications prescribed?" (17) "Are medically appropriate diagnostic tests and/or therapeutic procedures ordered?" (18) "Are all diagnostic test results and consults initialed and dated?" (26) "When a referral for consultation is requested, is pertinent current and past medical history included in communication with the consultant?" (27) "Are medical and/or surgical consultant recommendations addressed in the integrated progress notes within five business days after the consultation recommendations are received?" and (30) "If a medical treatment was ordered during an acute illness or injury was an assessment done within 24 hours and was it documented in the progress note?" Indicators (16), (26), and (27) had the most deficiencies. Indicators (3), (5), (7), and (17) were categorized as essential. From this internal general medical audit, 42 corrective action plans were generated. For the internal medical management peer review audit, PCP compliance was 87 percent for seizures, 91 percent for constipation, and 100 percent for UTI. Indicators identified the following areas as needing improvement: Constipation: (3) "There is evidence that the PCP documented follow-up effectiveness of treatment plan including side effects." Seizures (4) "Quarterly review of seizures are documented by PCP with recommendations." (6) "For	

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		individuals with stable seizures, the PCP considered and documented the need to continue the same seizure medications vs. a reduction in the medication." UTI: There were no indicators with deficiencies. For the constipation indicator, from the prior audit, the score dropped from 100 percent to 50 percent. For the seizure indicators the following scores represent prior and current scores: (4) 66 percent/66 percent, (6) 100 percent/66 percent (a worsening of the score). For the UTI indicators, improvement was noted in all scores. The indicators are followed by prior and current scores: (1) 33 percent/100 percent, (2) 33 percent/100 percent, (3) Zero percent/100 percent, (4) Zero percent/100 percent. The internal medical management audit for January 2013 generated three corrective action plans. *Follow-up* From a document entitled "Internal QA Medical Audit: Quarter 2, Fiscal Year 2013 conducted at ABSSLC January 28-30, 2013" dated May 10, 2013, follow-up information was provided on the corrective action plans. There were a total of 49 corrective action plans generated from the internal general medical peer review audit and three corrective action plans generated from the internal medical management peer review audit, for a total of 52 corrective action plans. In the first 30-day follow-up, nine action plans had been completed. At the 60-day review, an additional 36 corrective action plans had been completed. The remaining seven corrective action plans were completed within 65 days of the audit. <u>Medical Department Initiatives based on external and internal medical peer review findings</u> Based on the results of the external and internal medical peer review findings, a series of steps were taken to improve quality care as well as the medical audit process. For the six diagnoses that were the focus of the medical management audits, pocket size laminated cards with the specific indicators listed were distributed to the PCPs for review when they are treating one of those disorders. To improve the quality of the audit process and improve inter-rater reliability, there was an extra column added to the general medical audit set of 30 questions as well as the medical management audit set of indicators. This column was entitled "Auditor Guidance indicates Facility Specific Guidelines." For some indicators, this guided an auditor from another department, another facility, or outside the SSLC system, in clarifying locations of documents or defining terms in the indicator. Examples included finding the information in a specific section of the Active Record and stating which volume of the Active Record,	

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		and clarifying the definition of "current physical exam and summary." The Settlement Agreement Compliance Physician confirmed that the QA Department verified the list of diagnoses prior to providing a sample for medical management audits. As a collaborative effort, on 2/12/13, the Medical, Nursing, and Pharmacy Departments met to provide a system response to incomplete medication orders. A corrective plan was implemented. Incomplete verbal and written medication order tracking from February to March 2013 decreased, indicating the plan had a positive impact. As part of the implementation of this plan, on 4/9/13, an in-service training was completed on providing complete medication orders. Six PCPs attended. Nursing provided training to 91 nurses. Another system change was the revision of the consultation request form to allow more space for past and current medical history important to the clinical concern. A system was implemented in which the Settlement Agreement Compliance Physician reviewed all consultation requests for completeness, with guidance to the PCPs if indicated. On 2/20/13, training occurred, with six PCPs attending. Several indicators were reviewed as part of in-service training. Except as noted, the six PCPs attended the following: ▪ On 2/22/13, documentation when not providing preventive services; ▪ On 2/20/13, writing complete medication orders; ▪ On 2/26/13, follow-up of abnormal diagnostic test results; ▪ On 2/26/13, consultation recommendations addressed in progress notes; ▪ On 3/1/13, updating Active Problem List; ▪ On 2/22/13, component of the annual physical summary. Five PCPs attended ▪ On 3/1/13, documenting drug and/or food allergies; ▪ On 3/1/13, medically appropriate diagnostic tests; ▪ On 3/1/13, review of indicators for seizures; ▪ On 3/1/13, review of indicators for constipation; ▪ On 3/1/13, follow-up assessment of acute care treatment; ▪ On 3/8/13, legibility of documentation; ▪ On 3/8/13, IPN post-hospital documentation; ▪ On 3/19/13, aspiration; ▪ On 3/8/13, Diabetes mellitus; ▪ On 3/8/13, seizures; ▪ On 3/8/13, UTI; ▪ On 3/6/13, Osteoporosis; ▪ On 3/6/13, Constipation; ▪ On 3/9/13, aspiration guidelines, and constipation guidelines; ▪ On 3/26/13, seizure guidelines from state office; ▪ On 4/16/13, UTI, and osteoporosis guidelines from State Office; and	

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		▪ On 4/23/13, diabetes guidelines from State Office. The annual medical summary was revised to include additional components. The dosages and indications for medications were to be included. Under the preventive health section, the template also provided space for "preventive services planned for the next year." This prompted the PCP to complete this portion as required by the audit indicator. 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 Settlement Agreement Compliance Physician and 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, record reviews of selected conditions should 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 previous reports, 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 done so that the information and reports generate are useful to the department. The Medical Department should use information generated to determine strengths and weaknesses, and to act on areas of weakness. At the time of this most recent visit, some internal analysis of clinical information had begun to occur, but this was largely related to the internal and external audits, which were limited in scope. Additionally, as discussed with regard to Section H, the Facility had plans to use clinical indicators derived from the State Office clinical guidelines and external sources for data collection to determine quality of care for a number of clinical issues, but this process was in the initial stages of development.	

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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 approved and/or implemented: ▪ "Clinical Guidelines for Barrett Esophagus: Screening and Surveillance," approved and implemented 3/26/13; and ▪ "ABSSLC Participation in Morning Medical Meeting," approved 3/18/13, implemented 4/1/13. Since the Monitoring Team's last visit, the following policies/procedures/protocols were amended: ▪ "Medical Services," dated 9/11/12. It is recommended that the Medical Department create a policy and procedure manual that reflects all the aspects of medical services it provides. This would include such areas as: 1) Staffing and administration - caseloads, categories of topics for CME, CPR certification, etc.; 2) Organizational procedure and role of the morning medical meeting; 3) Routine care and documentation standards; 4) Updating diagnoses using ICD and DSM nomenclature; 5) Preventive care; 6) Acute care; 7) Utilization of clinical guidelines and national standards as part of practice pattern; 8) Tracking and addressing missed appointments; 9) External peer review; 10) Internal peer review and inter-rater reliability; 11) Role of QA/QI Department in monitoring/guiding the Medical Department; 12) Internal QI initiative; 12) Mortality reviews and recommendations; 13) Role of ethics committee; and 14) Others as indicated.	Noncompliance

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

1. Once the post-hospital review form is implemented, a monitoring tool should be created to track compliance with quality completion of the document and the improvement of care/treatment of the individuals. (Section L.1)
2. The morning medical meetings should be expanded to review recent consultations, determine assignment of tasks to specific IDT members or the IDT for ISPA development, and review completed ISPAs. These are critical areas that need further development, and would have ample time allowed if the teaching component was moved to the PCP only meetings. (Section L.1)
3. A tracking system should be created to provide an oversight mechanism for the activity of the morning medical meeting. This should include the number of concerns referred to IDTs per month, the number ISPAs reviewed at the morning medical meeting per month, the number of consult reports reviewed per month at the morning medical meeting, the number of assigned tasks per month, the number of assigned task with closure per month, the number of assigned tasks remaining open at the end of the month, the number of open record reviews by PCPs per month, and the number of open record reviews by nursing/residential staff, etc. (Section L.1)
4. Criteria should be developed to standardize documentation of/approaches to attempt to obtain family history, including the role of the QDDP or other departments in providing family contact information. (Section L.1)
5. The Infection Control Department should verify which individuals received the Tdap and ensure clear documentation of verification in the preventive care flow sheets. (Section L.1)
6. Information including test results and treatment of osteopenia/osteoporosis should be entered into a database and updated on an ongoing

basis, and the Medical Department's administration and PCPs should review the information quarterly. (Section L.1)

7. Individuals with a diagnosis of osteopenia and osteoporosis should be reviewed for optimal treatment (including a review of medications, as well as adequate Vitamin D supplementation) according to current guidelines. (Section L.1)
8. The nutrition assessment should be revised, with calculations of both daily calcium intake and daily Vitamin D intake (i.e., including food/formula, nutritional supplements, and total amount by daily medication), with a comparison to daily requirements, and formal recommendations to the PCP. (Section L.1)
9. The pressure ulcer database should include the geographic site of the initial report of the pressure ulcer (i.e., home, Infirmary, hospital, etc.). (Section L.1)
10. The committee should consider development of a clinical pathway/guideline for pressure ulcer prevention as well as pressure ulcer care. (Section L.1)
11. A process for monitoring the quality of care plans for the pressure ulcer and their implementation should be developed and implemented. (Section L.1)
12. To address the tracking of corrective actions for the external peer review audits, the QA Department should create a user-friendly document to assist staff in tracking completion of needed actions. Such a document should be self-explanatory to ensure there is no misinterpretation of information, and to indicate results every 30 days (with dates of time period), and date of closure. (Section L.2)
13. A system should be created to ensure that recommendations from the various death reviews are followed to completion. As recommendations might apply to several departments, it would be appropriate for the QA Department to assume this monitoring role, with follow-up information and quarterly or monthly status reports presented to the QA/QI Council until closure occurs. (Section L.2)
14. A member of the PNMT should attend the Clinical Death Review Committee meeting(s). As different PNMT members have various areas of expertise, it might be most valuable for the PNMT member that is most familiar with the individual or has needed expertise in an area contributing to decline and death to represent the PNMT for the case being reviewed. (Section L.2)
15. For tracking results of the internal medical peer review audits, staff in the QA Department should become familiar with the spreadsheet contents. A quarterly summary should be developed that would analyze and interpret the results. It is also important that the dates of review of corrective action plans be captured in the tables provided, to determine how quickly the PCPs respond to implementing the corrective action plans. A copy of the quarterly summary/report should be provided to the Medical Department and Facility Administration. (Section L.3)
16. The Medical Department should create a policy and procedure manual that reflects all the aspects of medical services it provides. (Section L.4)

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 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; o Infection Control Committee meeting minutes, dated 10/25/12, 2/14/13 (scan call), and 4/17/13; o Infection Control Rounds audit data; o Medication Variance Committee meetings minutes, dated 3/6/13, and 5/8/13; o ABSSLC Medication Variance Graphs; o ABSSLC's Infection Control overall summary report list; o ABSSLC's Immunization Database; o Drug Utilization Discrepancy Reports; o Medication Administration Observations data; o Program Compliance Nurse Medication Observation form for onsite medication observation; o Prescriber Medication Variances data; o Pharmacy Technician Medication Variances data; o Pharmacy and Therapeutics Committee meeting minutes, dated 11/14/12, and 2/3/13; o Medical records for the following individuals: Individual #418, Individual #199, Individual #545, Individual #383, Individual #463, Individual #55, Individual #217, Individual #315, Individual #127, Individual #226, Individual #535, Individual #37, Individual #165, Individual #138, Individual #138, Individual #26, Individual #76, Individual #27, Individual #146, Individual #297, Individual #447, Individual #493, Individual #152,

	Individual #200, Individual #495, Individual #194, Individual #34, Individual #179, Individual #163, Individual #48, Individual #253, Individual #287, Individual #407, Individual #443, Individual #181, Individual #165, Individual #275, Individual #530, Individual #382, Individual #7, and Individual #541; o Emergency Code Drill Trend Report for Quarter 1 2013; o Emergency Response Monitoring Data reports; o Emergency Drills Incident Management Review Team Meeting data for 2012 and 2013; o Mock Drill Scenarios; o ABSSLC 4444 and 911 log; o Emergency Response Committee meeting minutes dated 8/9/12; o Emergency Equipment Check Sheets; and o Recommendations from Mortality Reviews. ▪ **Interviews with**: o Cathy Northrup, RN, MSN, CPN, Chief Nurse Executive; o Amy Jo Bramlett, LVN, At-Risk Coordinator; o Mary White, RN, MSN, Nurse Operations Officer; o Jo Gloyd, RN, Quality Assurance; o Marjorie Hutchinson, BSN, RN, Case Manager Supervisor; o Krista Hamilton, RN, Infection Control Manager; o Mary Willingham, RN, Program Compliance Nurse; o Richard C. Martinez, Risk Manager; o Jeff Goza, Assistant Director of Administration; o Debbie Taylor, Assistant Director, Facility Competency Training/Development (CTD); and o Barbara J. Marrow, Director, Facility Competency Training/Development. ▪ **Observations of**: o Medication Administration in Building 6521; and o Use of emergency equipment in Building 6521.
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section M. 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. Since the last review, the Health Monitoring Tools for Nursing had been revised and consolidated into six tools. The Monitoring Team's review of the revised Monitoring Tools found problematic issues that could compromise the reliability of the data generated and result in insufficient measurement of the quality of the nursing services and documentation. (Specific details are provided with regard to Section M.1) At the time of the review, the Facility had only recently implemented the revised nursing monitoring tools and reported that there had not been enough data generated to conduct analyses. In addition, the Facility reported that due to significant staffing challenges in the Nursing Department, most of the previous monitoring activities since the last review had been suspended. Although very little data

	was included in the Self-Assessment for Section M, the data presented indicated that there continued to be significant problematic issues regarding the format, the organization, the presentation, the interpretation, and analysis of the Facility's data. o Although very limited, it was unclear why the specific data included in the Self-Assessment were presented since the Self-Assessment did not identify the specific criteria for compliance for the different areas audited or reflect the quality of the nursing services and documentation. In most cases, the data presented lacked significance in relation to the provision under which it was presented. o In most of the sub-sections for Section M, many of the items presented did not reflect review of the quality of the services provided and documentation for each area upon which the Monitoring Team's findings focused and the Settlement Agreement required. 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. o In addition, there was no inter-rater reliability reported for any of the monitoring tools. From the problematic issues the Monitoring Team found regarding the recently revised Health Monitoring Tools (discussed with regard to Section M.1) that could affect the consistency in monitoring and the validity of the results, it was likely that different auditors would score compliance differently. ▪ The Facility did not have a plan for consistently presenting the data in a meaningful/useful way. Specifically, the Facility's Self-Assessment: o Did not consistently present findings based on specific, measurable indicators, and in alignment with the specific provision. For example, as noted above, at times, it was unclear what criteria had been used to determine compliance without citing a standard, such as a nursing protocol. In addition, the lack of specific details explaining items in the Self-Assessment rendered much of the information meaningless and uninterpretable. In some cases, the information did not make any sense. o Did not address the quality as well as the completion of documentation. o Did not consistently identify the sample sizes used for some of the monitoring, including the description of the overall population from which the sample was selected (N) and a percent sample size. 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. o 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, most of issues noted in the Self-Rating sections indicating the rationale for the lack of compliance were not mentioned in the activities conducted to determine the Facility's compliance with the various provisions. The Facility's data identified some of the areas that were in need of improvement, but did not provide any information regarding initial attempts at analyzing the information, identifying some potential causes for

	the issues, and possible barriers to improvement. In addition, significant work was needed regarding the analysis of the data and connecting any monitoring 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, ABSSLC's Nursing Department experienced a significant increase in staff turnover as well as in some key leadership roles which included: ▪ In October 2012, the Nurse Operations Officer (NOO) position was filled; ▪ In January 2013, an additional full-time Registered Nurse Educator was hired; ▪ In February 2013, a full-time Quality Assurance Registered Nurse was hired; and ▪ One Case Manager position was vacant. The Nursing Department had a total of 175 allotted positions, including 80 for Registered Nurses (RNs) and 95 for Licensed Vocational Nurses (LVNs). The nursing vacancies at the time of the review included four RN positions and six LVN positions. From September 2012 through April 2013, the Nursing Department had experienced significant staffing challenges that warranted the use of Agency nurses. Although at the time of the review, the Facility had hired a number of LVNs, a majority of the new hires where recent nursing graduates with three months or less of nursing experience. Some of the Facility's positive steps forward included: ▪ The reliability of the Infection Control (IC) data continued to improve as reflected in data generated through comparisons of the Infection Control Reports and the Pharmacy reports for the utilization of antibiotics. ▪ Since the last review, the Facility had begun to aggregate and trend data generated from the Infection Control Real Time Audits. ▪ The outbreak timeline documentation the Facility provided indicated that since the last review, the IC Nurses provided a number of appropriate and timely in-service training sessions to staff in response to the outbreaks. In addition, the information was used to identify problematic issues that might have contributed to the spread to the infection resulting in some systematic changes in the Facility's procedures. ▪ The content of the minutes of the Infection Control Committee meetings continued to significantly improve regarding the information and issues discussed addressing the data generated from the IC Monitoring Tools, as well as including more detailed analyses of the acute infectious illnesses that had occurred and the development of corrective action plans. ▪ The Facility developed a new database to monitor the data regarding the Emergency Drills. The information could be aggregated by the items contained on the drill monitoring tool. ▪ The Facility had implemented procedures to track the excesses and shortages of medications being brought to the buildings in an attempt to reconcile these numbers and identify the issues related to medications that were being returned to the Pharmacy without explanation. Although the Facility had made some positive steps forward in the areas noted above, at this juncture in the review process, the overall lack of progress 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 actual implementation of nursing protocols, and the problematic issues regarding the under-reporting of medication variances and excessive unexplained medications being returned to the pharmacy were very concerning.

#	Provision	Assessment of Status	Compliance
M1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, nurses shall document nursing assessments, identify health care problems, notify physicians of health care problems, monitor, intervene, and keep appropriate records of the individuals' health care status sufficient to readily identify changes in status.	Given that this paragraph of the Settlement Agreement includes a number of requirements, this section of the report includes a number of different 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. 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: ▪ Since the last review, the State Office had modified the Nursing Health Monitoring Tools (HMTs). The Facility indicated that there was "insufficient data collected" to analyze at the time of the review using the new HMTs. The Monitoring Team's overall review of the new HMTs is discussed below. ▪ The Facility indicated that as of March 2013, 22 of 23 positions for Case Managers had been filled. Although the Self-Assessment noted that an analysis of the caseloads of the Case Managers was conducted in September 2012 in an attempt to decrease the caseload of each Case Manager, no specific information was provided regarding the results of this analysis or if a plan had been developed to actually decrease the current caseloads. ▪ The Facility's Self-Assessment indicated that: "0% of case manager reports for the past 6 months demonstrated consistency in reporting with regards to staging and anatomical location." However, there was no other information explaining what these data represented and meant. In addition, the Self-Assessment noted that pressure ulcers continued to be monitored. However, no specific information was provided addressing why the Facility indicated that no reliable data were available "because of the change in language used to describe." Consequently, due to the significant lack of information contained in the Facility's Self-Assessment for Section M.1, the Monitoring Team was not able to ascertain what specific activities the Facility was actually conducting to review its progress regarding this requirement of the Settlement Agreement.	Noncompliance

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		Self Rating The Facility's Self-Assessment indicated that: "Based on the findings from this self-assessment, this provision is not in substantial compliance. Staffing issues have been the largest factor is not gaining compliance. The involvement by educators, Nurse Managers, the NOO, and CNE is very high to make sure each nurse is properly oriented then trained on the home with the follow up needed. During monitoring of new nurses, care of the individuals must be the first concern. Working toward compliance in the risk assessment process as well as nurse assessments will improve as the new Case Managers become more knowledgeable and comfortable with the new procedures and they have less in each case load." Discussions with the CNE indicated that since the last review, the Facility had had major staffing challenges, and that efforts regarding recruitment and retention continued to present challenges. However, there was no indication from the Self-Assessment regarding how the staffing challenges were being addressed or how they had affected any care and services for the individuals. In addition, interviews with the NOO, QA Nurse, and the Program Compliance Nurse indicated that since the last review, very few monitoring activities had occurred resulting in little to no data generated to evaluate the Facility's compliance with the requirements of the Section M provisions. Although there was very little data contained in the Self-Assessment for Section M, it was evident that there continued to be significant problematic issues regarding the format, the organization, the presentation, and the interpretation and analysis of the Facility's data. As the Facility begins to generate more monitoring data, it is the Monitoring Team's hope that the ongoing analysis of data would then result in the development and implementation of plans of action addressing the areas that reflect problematic trends. It was clear to the Monitoring Team that the Facility continued to lack basic understanding regarding collecting monitoring data, organizing it in a meaningful way, and taking steps to interpret the findings. The Facility should consider adopting a standardized format for presenting data in a meaningful way that facilitates its interpretation and analysis, and then provide training to the disciplines regarding how to analyze their data to identify problematic trends. As noted above, since the last review, the State Office had modified the Nursing Health Monitoring Tools, including reducing the number of tools to six. These included: ▪ Annual Nursing Assessment Monitoring Tool; ▪ Care Plan Monitoring Tool; ▪ Nursing Infection Control Monitoring Tool; ▪ Nursing Pain Management Monitoring Tool;	

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		▪ Skin Integrity Monitoring Tool; and ▪ Urgent Care/ER/Hospitalizations Monitoring Tool. The Monitoring Team's review of these Monitoring Tools found some significant problematic issues that would affect the reliability of the data generated such as: ▪ The instructions contained on the tools addressing the nursing services and documentation did not indicate how the quality of the services and documentation was to be determined, such as using the nursing protocols as the standard for compliance rather than depending on auditor judgment; ▪ A number of items on the tools contained several elements within a given item making it difficult to identify which elements were in compliance and which were not. For example, one item contained on the Urgent Care/ER/ Hospitalizations Monitoring Tool included elements regarding a full set of vital signs, the chief complaint/presenting problem, a systems review including a skin assessment as appropriate, legibility, and accuracy. This one indicator was to be audited and scored either yes or no. However, in the event the item was found not to be in compliance, it would be difficult if not impossible to determine which of the above elements were found to be in or out of compliance, making it difficult to track trends and focus corrective actions plans on the problematic elements; and ▪ There was no mention in the items or the instructions on the Nursing Care Plan Monitoring Tool that the interventions found in the care plans should be in alignment with the assessments contained in the nursing protocols for specific health issues. Overall, the problematic issues found in relation to the current Health Monitoring Tools was troubling in that they did not lend to generating an adequate and accurate review of the quality of the clinical care and treatment an individual received. <u>Staffing</u> At the time of the review, ABSSLC had a census of 393 individuals. Since the last review, ABSSLC had some changes regarding the Nursing Department and nursing positions, which included: ▪ In October 2012, the Nurse Operations Officer position was filled; ▪ In January 2013, an additional full-time Registered Nurse Educator was hired; ▪ In February 2013, a full-time Quality Assurance Registered Nurse was hired; and ▪ One Case Manager position was vacant. 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. The current nursing vacancies included four RN positions and six LVN positions. From a review of	

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		the Facility's nursing staffing data and discussions with the CNE, since the last review, the Nursing Department had experienced significant staffing challenges from September 2012 through April 2013, which warranted the use of Agency nurses. Although at the time of the review, the Facility had hired a number of LVNs, a majority of the new hires where recent nursing graduates with three months or less of nursing experience. 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. <u>Quality Enhancement Efforts</u> In February 2013, the Facility had hired a full-time Quality Assurance Registered Nurse. At the time of the review, the Quality Assurance Nurse and the Program Compliance Nurse (PCN) only recently had implemented some of the newly revised HMTs and reported that only minimal data had been generated thus far and had not established inter-rater reliability for each tool. The QA Nurse and the PCN reported that they had begun using the Annual Nursing Assessment Monitoring Tool, the Care Plan Monitoring Tool, and the Nursing Protocol Tool. The Nurse Liaison and the QA Nurse were conducting audits using the Urgent Care/ER/Hospitalizations Monitoring Tool, and the QA Nurse had implemented the Infection Control Real Time audits. However, as noted above, the problematic issues found regarding the revised HMTs was of major concern in that the data generated might not accurately reflect the Facility's nursing practices. <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 CNE reported that five additional nursing protocols had been implemented, including those for: Emergency/Hospital Transfers, Fall or Suspected Fall, Pain, Hypoglycemia (low blood sugar), and Suspected Fracture/Dislocation. However, at the time of the review, little to no evidence was found in the care plans or in the nursing documentation reviewed that the nursing protocols were actually being used to drive the identification and implementation of the specific responsibilities of disciplines, provide clear and appropriate timeframes for initiating nursing assessments and the type of assessments that should be conducted, assist in determining the frequency of these assessments, and/or identify the parameters and time frames for reporting symptoms to the practitioner/physician and PNMT, if indicated. A review of 11 individuals' IPNs (i.e., Individual #253, Individual #287, Individual #407, Individual #443, Individual #181, Individual #165, Individual #275, Individual #530, Individual #382, Individual #7, and Individual #541) who had been transferred to a	

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		community hospital, emergency room, and the Infirmary found: ▪ Nurses promptly and consistently performed a physical assessment on any individual displaying signs/symptoms of potential or actual acute illness in none (0%) of the cases in alignment with the nursing protocols. ▪ The documentation indicted that the licensed nursing staff timely and consistently informed the PCP of symptoms that required medical evaluation or intervention in none (0%) of the cases. Due to the lack of ongoing clinically appropriate nursing assessments, changes in status were only identified when the individual was already acutely ill. ▪ The documentation indicated that appropriate information was communicated to the PCP in none (0%) of the cases. ▪ The nurse consistently performed appropriate ongoing assessments as dictated by the symptoms in none (0%) of the cases in alignment with nursing protocols. ▪ The nurse conducted assessments at the appropriate frequency for the individual's clinical condition in none (0%) of the cases in alignment with the individuals' overall medical status. ▪ An adequate plan of care was developed including instructions for implementation and follow-up assessments in none (0%) of the cases in alignment with the nursing protocols addressing the specific health issue. ▪ The documentation indicated that all acute illness/injuries were followed through to resolution in none (0%) of the cases. A review of these 11 individuals found essentially the same significant problematic clinical issues regarding nursing assessments and documentation that the Monitoring Team identified during the past six reviews. The overall problematic issues that were found in all 11 records included: ▪ Although since the last review, an increase in nursing documentation was found in the IPNs, the documentation did not address the emerging clinical issues. This was due to the lack of use of a structured system driving the type of nursing assessments that should have been conducted for the health issues and the associated documentation of those assessments. This structure was available through the nursing protocols, but nurses were not using the protocols to drive their assessments and/or documentation; ▪ There was a consistent lack of recognition that the symptoms the individuals experienced were signs of changes in status, and warranted nursing assessments; ▪ Due to the lack of consistent nursing assessments found in the documentation, it was largely impossible to accurately determine when changes in status were initially occurring; ▪ There continued to be a lack of follow-up for health issues noted in previous nurses' progress notes;	

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		▪ There continued to be inadequate documentation and nursing assessments addressing the administration and follow-up of the effectiveness of pro re nata (PRN, or as needed medications) medications; ▪ There continued to be a lack of assessment and/or inadequate assessments and follow-up addressing indications and/or complaints of pain; ▪ The IPNs continued to lack specific description, size, and location of skin issues, such as reddened area, injuries, or bruises; ▪ There continued to be 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 continued to be a 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 issues or receiving PRN laxatives; ▪ Physicians/Practitioners were not timely notified of changes in status, due to nurses' inadequate follow-up; ▪ There was little documentation that nursing communicated with the PNMT regarding changes in status for individuals at risk of aspiration/choking; ▪ There was a lack of specific descriptions of the individuals' behaviors, assuming that all staff reading the progress notes were familiar with the individuals; ▪ There were missing weights, and intake and output values for individuals with significant fluid and weight issues; ▪ There was a lack of communication noted between shifts regarding status changes, and the need for regular nursing 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 IPNs, there was a consistent lack of documented analysis of contributing problematic issues affecting changes in status; ▪ There was a lack of regular follow-up days after the transfer occurred for symptoms related to the initial reason for the hospitalization; ▪ When nursing protocols were used to guide nursing assessments, they were found to be initiated only after the individual was ill and not as proactive measures to prevent the occurrence of acute health issues; ▪ Care Plans addressing health issues were consistently inadequate with regard to individualized goals and nursing interventions, and were not effectively modified after hospitalizations or in alignment with nursing protocols; ▪ Dates and times were not consistently documented for progress notes; ▪ Late entries were not appropriately documented according to nursing standards of practice;	

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		▪ A significant number of nursing progress notes and signatures were illegible; and ▪ There was inconsistent documentation addressing the care of healthcare equipment individuals required, such as catheters, tracheotomies, and G-tubes. Although some IPNs were found that contained an adequate nursing assessment, the lack of consistency of the nursing assessments rendered the overall care of the individuals insufficient to address their specific needs. Although the Facility reported that the nursing protocols had been implemented, there was no indication they were being used consistently to guide nursing assessments and documentation. The Facility should continue to implement and expand the use of nursing protocols (as is discussed in further detail with regard to Section M.4) to guide nursing practices. In addition, mentoring and supervision of nurses should focus on the consistent use of the nursing protocols. As noted in previous 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 specific action plans addressing the continuing problematic issues 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 review of records while on site, it was noted that a number of documents were missing from the active records. For example, a number of the most current Integrated Risk Rating Forms were not found in the Active Records. In addition, several Integrated Health Care Plans and Comprehensive Nursing Assessments were also missing from the records. However, it was unclear if these documents were missing or if the documents had not been completed. 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> From the Facility's Self-Assessment, a review of 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, the Infection Control Nurses continued to move forward in the process of building an infrastructure to meet the requirements of the Settlement Agreement. Some of the progress noted included: ▪ Consistent with past reviews, the Facility again created an exceptional separate	

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		Presentation Book addressing Infection Control. It clearly presented a significant amount of organized and detailed information regarding the activities of the IC Nurses since the last review. ▪ The Facility continued to address data reliability, to ensure the accurate identification of the Facility's trends related to infectious and communicable issues. From data generated by comparing the Infection Control Reports, Infection Control Logs from the residences, and the Pharmacy reports for the utilization of antibiotics, the following represents the number of discrepancies identified and corrected regarding infections each month: eight, 10, 29, 10, 17, 11, 15, and 13 from August 2012 through March 2013, respectively. The IC Nurse reported that these variations in the discrepancy data reflected the nursing staffing challenges the Facility had experienced since the last review. ▪ Since the last review, the Facility had begun to aggregate and trend data generated from the Infection Control Real Time Audits. Although these data were included in the Infection Control Committee meeting minutes, which was a positive step forward, the presentation of the data included just one overall compliance score for each month rendering it uninterpretable. However, some data was provided for the specific items in the auditing tool, and this provided some valuable findings regarding the strengths and weaknesses of the Facility's practices related to acute infectious illnesses. As mentioned previously, a standardized format for data presentation should be considered in order to facilitate the interpretation and analysis of the data generated. ▪ At the time of the review, 88% of the individuals' immunization data had been entered into the AVATAR database and the documentation placed in the Active Records. ▪ The outbreak timeline documentation the Facility provided indicated that the IC Nurses provided a number of appropriate and timely in-service training sessions to staff in response to the outbreaks that occurred since the last review. In addition, the information was used to identify problematic issues that might have contributed to the spread to the infection resulting in some systematic changes in the Facility's procedures. ▪ The content of the minutes of the Infection Control Committee meetings continued to significantly improve in terms of the information and issues discussed, including the data generated from the IC Monitoring Tools as well as more detailed analyses of the acute infectious illnesses that had occurred and the development of corrective action plans. Although the IC Nurses had made some significant positive steps forward, there continued to be some problematic areas regarding infection control that were in need of further attention, including; ▪ Although the Facility had transferred 88% of the immunization data into the	

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		AVATAR system at the time of the review, the Facility needed to confirm the immunization status and immunizations for all the individuals to ensure individuals received all the required immunizations as outlined in the Health Care Guidelines. ▪ Since the last review, the following episodes of contagious infectious illnesses had occurred: eight episodes of MRSA, four episodes of C-diff, 54 episodes of conjunctivitis, and 28 cases of Gastroenteritis. In response to the document request for "The Health Management Plans (HMPs) for all individuals who had MRSA, C-Diff, Positive PPDs, Hepatitis A, B, C, and conjunctivitis. Also the HMPs for individuals who were affected by any outbreaks for the last six months," the Facility only provided the Monitoring Team with a small sample of the requested HMPs. Consequently, due to an insufficient sample size, the Monitoring Team was not able to accurately score the following metrics: Of the 94 episodes, ____ (___ %) were found to have had an acute care plan addressing the infectious issue; and of the ___ Nursing Care Plan reviewed, ___ were found to be clinically adequate (___ %). ▪ A review of the Real Time IC raw data indicated that significant problematic issues continued regarding the development, implementation, and individualization of care plans addressing acute infectious illnesses. Discussions with the Infection Control Nurse also indicated that there continued to be significant problematic issues with the initiation and quality of the care plans addressing infectious illnesses. At the time of the review, although ABSSLC's Infection Control Nurse was identifying some of the same problems the Monitoring Team was finding, this system was still developing. In addition, even when problems were identified, the Facility did not have a system in place to follow-up to ensure that individuals with infectious diseases were being provided care plans that included the appropriate infection control measures, or clinically appropriate interventions to prevent the spread of infections. The Facility should develop and implement a system to ensure the care plans for individuals with infectious/communicable disease are clinically appropriate and consistently implemented. The Facility continued to make a number of positive steps forward in the area of Infection Control. However, there continued to be a significant amount of work yet to be done, especially regarding the care plans addressing Infection Control issues. As noted in previous reports, consideration should be given to providing additional expertise in Infection Control 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.	

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		Mock Code Drills and Emergency Response Systems No information regarding this area was provided in the Facility's Self-Assessment. However, from interviews conducted on site with CTD staff the following steps were initiated since the last review regarding this area: ▪ Emergency drills continued to be conducted routinely with no advanced warning. If prompting was needed, the drill was failed, retraining was conducted, and the drill was repeated. ▪ The Facility continued to use a variety of eight different scenarios when conducting the monthly drills. ▪ In January 2013, the Facility developed a new database for the Emergency Drills. As a result, the Facility could aggregate the data for items contained on the drill monitoring tool. ▪ A review of the daily Emergency Equipment Checklists from each building indicated there was an increase in compliance regarding the daily Emergency Equipment checks ensuring that the equipment was available and operational for emergency situations. ▪ In addition, since the last review, the Facility had initiated conducting Emergency Mock Drills at the Laundry. Although the Facility had implemented some positive steps addressing the Emergency Response System, problematic issues were found that should be addressed in order for additional progress to be made: ▪ As noted from past reviews, no clinical review was conducted of the Mock Code Drills and the actual medical emergencies (4444 and 911 calls) that occurred at the Facility. Consequently, no clinical staff were reviewing, discussing, or tracking the status of the Facility's emergency systems. Clinical staff, including nursing staff, should be involved in the review and analysis of Emergency Mock Code Drill data and data addressing the actual medical emergencies, and should participate, as appropriate, in the development and implementation of action plans to address any problematic trends identified. ▪ Although the Facility had a system in place to track failed drills and the reasons for the failed status, there was no analysis of trends or associated plans of correction found regarding the data addressing the failed Emergency Mock Drills. ▪ No information was provided in the Facility's Self-Assessment indicating if the Emergency Competency Checklist that should be conducted at least every quarter for each nurse had been conducted. The Monitoring Team's observations of nurses demonstrating the emergency equipment at building 6521found that one of the two nurses that were observed was somewhat unfamiliar with the emergency equipment and needed several prompts to complete the demonstration. In light of the fact that the Facility had recently	

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		hired a number of LVNs with little to no previous nursing experience, conducting the Emergency Competency Checklists as required would be crucial. The data from the Emergency Mock Drills conducted since the last review were as follows: ▪ 72 drills conducted in January 2013 – 71 passed (99%); ▪ 73 drills conducted in February 2013 –73 passed (100%); ▪ 97 drills conducted in March 2013 – 80 passed (82%); and ▪ 79 drills conducted in April 2013 – 73 passed (92%). The Facility had made some positive steps forward regarding ABSSLC's Emergency Response System. However, there continued to be some problematic issues as noted above. As noted above, in the Facility Self-Assessment, ABSSLC indicated it was not in compliance with this provision. Based on the Monitoring Team's findings, the Facility remained out of compliance with this provision.	
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.	As detailed below, the Monitoring Team conducted its own review of the requirements of this section. However, it also reviewed the Facility's Self-Assessment. ABSSLC indicated its Self-Assessment that since the last review, the following steps had been taken regarding this requirement of the Settlement Agreement: ▪ The Facility indicated that a review of their nursing training records in February 2012, found that of 65 RNs, all but two had successfully completed the state-supported Physical Assessment training. The Facility's Self-Assessment indicated that additional classes would be scheduled as new RNs were hired. ▪ In addition, the Facility indicated that in January 2012, 100% of the Case Managers received training regarding the timeliness of nursing assessments. However, there was no indication that any training was conducted regarding the quality of the nursing assessments and no data was included in the Self-Assessment addressing this requirement of the Settlement Agreement. <u>Self-rating</u>: The Facility's Self-Assessment indicated that: "Based on the findings of the self-assessment, this provision is not in substantial compliance." 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 based on specific findings related to the significant problems with the quality of the content of the Comprehensive Nursing Assessments. This issue was not included in the Facility's Self-Assessment.	Noncompliance

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		During the Monitoring Team's onsite review, the CNE reported that since the last review, a number of challenging staffing issues had contributed to the lack of overall progress for the Nursing Department. However, of major concern for the Monitoring Team was that thus far in the review process, ABSSLC had not yet developed a clinically appropriate curriculum and/or mentoring program to address the quality of the Comprehensive Nursing Assessments. In addition, an example of a Comprehensive Nursing Assessment was provided to the Monitoring Team on site that the Facility indicated contained an adequate clinical analysis of the individual's progress. However, due to the lack of the Facility's use of the nursing protocols, relevant ongoing nursing assessments had not been conducted on the individual, and, as a result, there was a significant lack of clinical data generated during the past several quarters to even analyze. Consequently, the Monitoring Team found the sample Comprehensive Nursing Assessment to be clinically inadequate. Unfortunately, this reflected that nursing staff lacked competency with this requirement of the Settlement Agreement as was also noted from the Monitoring Team's findings below. The Quarterly/Annual Nursing Assessments for 21 individuals who the Facility identified as being at risk for specific health indicators were reviewed, including those for: Individual #418, Individual #199, and Individual #545 for weight issues; Individual #383, Individual #463, and Individual #55 for seizures; Individual #217, Individual #315, and Individual #127 for dental issues; Individual #226, Individual #535, and Individual #37 for fluid imbalance; Individual #165 for choking; Individual #138, and Individual #26 for urinary tract infections; Individual #76, Individual #27, and Individual #146 for skin issues; Individual #297, Individual #447, and Individual #493 for infections. ▪ Of the 21 individuals' nursing quarterly assessments reviewed, 18 (86%) were timely completed. Assessments not timely completed included those for: Individual #463, Individual #37, and Individual #76. ▪ There was an adequate analysis of the health/mental health data between the previous and current quarters in none (0%) of the Nursing Summaries contained in the Comprehensive Nursing Assessments to indicate if the individual was making progress related to their health/behavior issues. ▪ There was an adequate assessment of the high and medium risk health indicators included in none (0%) of the Comprehensive Nursing Assessments. ▪ Nursing assessments were updated as indicated by the individual's health status in none (0%) of the Comprehensive Nursing Assessments reviewed. The Monitoring Team found that there had been no progress made regarding the quality	

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		of the quarterly/annual Comprehensive Nursing Assessments since the last review. Consistent with the findings from the previous six reviews, none of the Comprehensive Nursing Assessment summaries reviewed included an adequate analysis of the individuals' health/mental health issues between quarters indicating if the health issues were improving, maintaining, or getting worse. In addition, ABSSLC's action plan addressing this requirement did not include any specific action steps regarding improving the quality of the nursing assessments. This was very troubling to the Monitoring Team since during the review, members of Nursing Department articulated that they recognized there were significant problematic issues regarding the quality of the Comprehensive Nursing Assessments. The consistent lack of progress found regarding the quality of the Comprehensive Nursing Assessments continued to be very concerning to the Monitoring Team due to the potential impact it had on the health and wellbeing of individuals residing at the Facility. As noted in previously, this area should be considered a priority. It is essential that nurses responsible for completing the quarterly/annual Comprehensive Nursing Assessments have the ability and understanding to analyze, summarize, and document health/mental health issues to determine whether the individuals under their care are actually making progress regarding their health status. The Facility should provide appropriate competency-based training and mentoring 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. Regarding the nursing documentation for discharges/individuals transitioning to the community, a review of the nursing notes and Nursing Discharge Assessment Summaries for eight individuals including: Individual #152, Individual #200, Individual #495, Individual #194, Individual #34, Individual #179, Individual #163, and Individual #48 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 specifically guide the community staff in providing the needed nursing care to the individual. ▪ A current nursing assessment was conducted at the time of the discharge from the Facility and documented in the IPNs for none (0%) of the individuals. ▪ There was adequate documentation identifying specific nursing interventions needed for all health/mental health issues in none (0%) of the cases reviewed. Consistent with the findings from the previous reviews, a number of problematic issues were found in the nursing documentation reviewed for all eight individuals, including:	

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		▪ 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; and ▪ A lack of clear information addressing the nursing interventions that were needed to care for individuals. Again, as noted in previous reports, 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. A review of the Facility's Self-Assessment for Section M found that there was no indication that the Facility was reviewing this area. In addition, it was troubling to the Monitoring Team that the Action Plan for this provision included no action step addressing this consistent problematic area. Based on the Monitoring Team's findings, the Facility remained in noncompliance with this provision.	
M3	Commencing within six months of the Effective Date hereof and with full implementation in two years, the Facility shall develop nursing interventions annually to address each individual's health care needs, including needs associated with high-risk or at-risk health conditions to which the individual is subject, with review and necessary revision on a quarterly basis, and more often as indicated by the individual's health status. Nursing interventions shall be implemented promptly after they are developed or revised.	As detailed below, the Monitoring Team conducted its own review of the requirements of this section. However, it also reviewed the Facility's Self-Assessment. ABSSLC indicated that since the last review, the following steps were taken regarding this requirement of the Settlement Agreement: ▪ The Facility indicated that 100% of current RN Case Managers received training regarding the Integrated Health Care Plans (IHCPs) and the Integrated Risk Rating Forms (IRRFs), which will be conducted on a quarterly basis. ▪ In addition, the Facility's Self-Assessment indicated that of 36 IHCPs that were reviewed, 28 (78%) were implemented within 14 business days of the ISP and eight (22%) had a person-centered measurable nursing goal. However, it was unclear what criteria were used to determine compliance with these particular indicators, and no information was provided regarding what efforts were being implemented in response to the Facility's findings. In addition, no data were provided to assess whether care plans were in alignment with the nursing protocols for the specific health issues, which is crucial to the quality of care provided to the individuals, especially during an acute illness. <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. The process of getting new Case Managers hired and trained, then adding the new ISP process has taken time. As the	Noncompliance

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		integration of health information and risks improve, the monitoring tools will pick up higher percentage of compliance and better identification of individuals' needs." The records of 21 individuals who the Facility identified as being at high risk for specific health indicators were reviewed, including: Individual #418, Individual #199, and Individual #545 for weight issues; Individual #383, Individual #463, and Individual #55 for seizures; Individual #217, Individual #315, and Individual #127 for dental issues; Individual #226, Individual #535, and Individual #37 for fluid imbalance; Individual #165 for choking; Individual #138, and Individual #26 for urinary tract infections; Individual #76, Individual #27, and Individual #146 for skin issues; Individual #297, Individual #447, and Individual #493 for infections. Of the 21 individuals' Nursing Care Plans/Health Management Plans/Integrated Health Care Plans reviewed: ▪ Twelve (57%) were found to have a care plan addressing their high or medium risk health/mental indicator. Individuals who did not have a related care plan included Individual #418, Individual #199, Individual #463, Individual #226, Individual #37, Individual #165, Individual #76, Individual #447, and Individual #27. ▪ None (0%) of the nursing interventions contained in the 12 care plans 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. The nursing interventions listed in the care plans reviewed were not in alignment with the nursing protocols addressing the specific health issues. ▪ None (0%) of the 12 care plans were found to be clinically adequate. There was no indication that any type of nursing assessments were to be conducted addressing the specific health issue in alignment with the nursing protocols. The overall quality of the nursing interventions was poor in that they were generic, and non-specific to the individual's health care needs. ▪ None (0%) of the 12 care plans contained adequate proactive interventions addressing the health indicator. ▪ None (0%) of the 12 care plans were adequately individualized. ▪ Due to the nonspecific interventions contained in all of the 12 care plans, validating the implementation of the interventions was not possible, rendering them inadequate guides for the provision of care. For example, generic interventions such as "encourage fluids" could not be substantiated as being implemented. The Facility had a variety of formats of care plans that included Risk Action Plans, Acute Care Plans, and Integrated Health Care Plans due to the number of changes that had been	

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		made in the At-Risk system. It was very concerning to the Monitoring Team to note the lack of progress since the last review in the content of the care plans regardless of the format used. The Monitoring Team had noted previously that the transition to the use of an integrated care plan was a promising step forward. However, the current findings of the Monitoring Team regarding this provision indicated that thus far, the implementation of this promising process had resulted in the previous problematic issues that existed regarding care plans being repeated in the current system. Specifically, some of the problematic issues identified in the previous Health Management Plans that were found in the current IHCPs included: ▪ The rationale for several risk levels did not include the needed clinical justification to support the designated level. In addition, the most current IRRFs were not consistently found in the Active Record. 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 risks. ▪ IHCPs/Risk Action Plans/Care Plans were not consistently found in the Active Records. ▪ The goals listed in the care plans did not address the etiology of the health problem as an objective clinical indicator on which to focus. Consequently, most action steps found in the care plans did not address the underlying cause of the health issue and had no association with the goals listed. ▪ None of the nursing action steps found in the care plans were in alignment with the clinical assessments required by the nursing protocols for the specific health issues. ▪ The action steps contained in the care plans frequently did not include 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; noting consistently 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 generic, and non-specific to the individual's health care needs. ▪ At the time of the review, the care plans reviewed were found to be clinically inadequate, lacked appropriate proactive action steps addressing the health indicator, and were not adequately individualized. ▪ The generic nature of the action steps prohibited validation that the step was actually being implemented. 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 its care. The Facility should develop and implement appropriate care plans based on priority and risk for all the individuals at ABSSLC	

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		Since the last review, the following contagious infectious illnesses had reportedly occurred: eight episodes of MRSA, four episodes of C-diff, 54 episodes of conjunctivitis, and 28 cases of Gastroenteritis. In response to the document request for: "The Health Management Plans (HMPs) for all individuals who had MRSA, C-Diff, Positive PPDs, Hepatitis A, B, C, and conjunctivitis. Also the HMPs for individuals who were affected by any outbreaks for the last six months," the Facility indicated that it had only provided a sample of HMPs. Consequently, due to an insufficient sample size, the Monitoring Team was not able to accurately score the following metrics: ▪ Of the episodes, ____ (___ %) were found to have had an acute care plan addressing the infectious issue. ▪ Of the ___ Nursing Care Plan reviewed, ___ were found to be clinically adequate (___ %). However, discussions with the Infection Control Nurse indicated that there were continuing significant issues with the initiation and quality of the care plans addressing infectious illnesses as found from the data generated through the Facility's Real Time Infection Control audits. At the time of this review, although the Infection Control Nurse was identifying problems, ABSSLC had no system in place to follow-up to ensure that individuals with infectious diseases were being provided care plans that included the appropriate infection control measures, or clinically appropriate interventions to prevent the spread of infections. Consistent with findings from previous reviews, Nursing Administration, in conjunction with the Infection Control Nurses 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. For progress to be made regarding this provision of the Settlement Agreement, the Integrated Health Care Plans should: ▪ Be in alignment with interventions and assessments 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 for plans of care. Overall, there had been essentially 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	

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		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.	As detailed below, the Monitoring Team conducted its own review of the requirements of this section. However, it also reviewed the Facility's Self-Assessment. With regard to this provision, ABSSLC's Self-Assessment indicated the following: ▪ According to the Facility's Self-Assessment, since the last review, the education and training database had not yet been completed. Thus, there were no data to analyze at the time of the review. ▪ The additional information contained in the Facility's Self-Assessment regarding Medication Administration training did not address this specific provision. Although this training was a positive step, it was unclear to the Monitoring Team how these training classes related to this particular provision. In addition, although the Facility's Action Plan addressing this area indicated that training regarding the use of Nursing Protocols to define nursing practice was "in process," there was no information found in the Facility's Self-Assessment addressing this issue for Section M.4. <u>Self-rating</u>: 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. This provision is not in compliance because of multiple factors. One is the staffing, or lack of staffing with the subsequent hiring and training and monitoring needed to replenish over 25% of the FTEs [full time equivalents] allotted to this facility during a 7-month time frame. The educator has been orienting four weeks out of each month during this time. A new assistant Educator has been hired but not been able to leave her position as a Case Manager to assume duties in Education department. There has been no time to establish a database. The new Nurse Medication Administration class with integration of Habilitation therapy has been instituted which will provide a much needed component to provide continuity of care for the individual." Although the Facility had experienced challenging staffing issues since the last review as noted above, there was no information provided that specifically addressed how the Facility planned to address the barriers to compliance that were listed in their self-rating regarding this area. In addition, the CNE indicated that since the last review, additional nursing protocols had been developed by the State Office and had been implemented at the Facility. However, the Monitoring Team found little to no evidence that they were actually being used. Essentially, the same significant problematic issues were found for the current review regarding nursing assessments, care plans, and the overall nursing care, as well as the associated documentation as was found during the previous reviews. Specifically, the problematic findings found in the nursing documentation reviewed for Sections M.1 regarding nursing care for individuals admitted to a community hospital,	Noncompliance

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		Section M.2 regarding nursing assessments, Section M.3 regarding nursing care plans, and Section M.5 related to individuals with high-risk health indicators demonstrated that the Facility was not implementing nursing protocols sufficient to address the health status of the individuals served. In addition, the major concerns the Monitoring Team had regarding these consistent problematic issues, especially related to individuals with high/medium risk health indicators and their changes in status warranting hospital admissions were exemplified in a review of Individual #454's health care prior to his death in May 2013. Based on the documentation the Facility provided identifying risk ratings, Individual #454 was noted to be at high risk for weight due to being 21% above his recommended weight range and having a Body Mass Index (BMI) of 30.2 indicating obesity. His medium risk indicators included seizures, skin integrity, falls, fractures, choking, gastrointestinal issues related to diagnosis of Gastroesophageal Reflux Disease, constipation, and cardiac disease due to Hyperlipidemia. He was admitted to the Infirmary in May 2012 for significant weight loss, dehydration, anorexia, and agitation, and continued to have issues, particularly with weight loss, throughout the months until he died. In reviewing the documentation for Individual #454, a number of significant problematic issues were found regarding the care of this individual. Some of these problems included: ▪ The summary section of the Comprehensive Nursing Assessment dated 3/6/13 did not include any information or analysis regarding the individual's high-risk weight issues. ▪ Although the Nutrition and Weight Management section on the Comprehensive Nursing Assessment, dated 3/6/13, addressing weight indicated that he was admitted to the Infirmary in May 2012 for weight loss, dehydration, anorexia, and agitation and was restarted on Zyprexa, and his Desired Weight Range was 95 to 115 with his current weight being 138.1, the documentation found in the Summary Section of the assessment stated "His appetite is good, no problem noted at this time." ▪ The summary section of the Comprehensive Nursing Assessment, dated 3/6/13, did not adequately address any of the high or medium health risks or changes in status that this individual had experienced during the year. ▪ The Annual Integrated Risk Rating Form dated 3/26/13 from the Active Record was missing a number of pages addressing some of the risk categories. ▪ The Integrated Health Care Plan dated 3/26/13 from the Active Record contained little to no individualization for an individual with a number of health risks. ▪ The nursing interventions contained in the Integrated Health Care Plan were not	

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		in alignment with nursing protocols in that no interventions addressing nursing assessments for any of the individual's health risks were included. ▪ 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, skin assessments, treatments provided, pain assessments, vital signs, lung sounds, oxygen saturations, bowel and urinary output, daily food and fluid input, assessments for hydration, bowel sounds and abdominal palpation. ▪ There were no regular nursing assessments found documented in the IPNs in response to vomiting episodes that the individual experienced days prior to his death. ▪ There were no specific descriptions included in the IPNs of what behaviors constituted Individual's #454 "agitation and anxiety." ▪ There were no nursing assessments found regarding Individual's #454 "agitation and anxiety," or interventions implemented to alleviate these symptoms that indicated a change in status. ▪ There were no IPNs found from the PNMT a month prior to Individual's #454 death indicating that they were involved in his care related to his weight issues. ▪ There were no Dietician IPNs found a month prior to Individual's #454 death. ▪ There was no indication that either the PNMT or Dietician was notified of the vomiting episodes that had occurred in May 2013. ▪ There were no regular nursing assessments addressing the individual's health issues in alignment with the assessments required by nursing protocols for an individual with health risks and demonstrating a change in status. ▪ There was no description documented of the Individual's status at the time he was transported to the hospital via Emergency Medical Services (EMS). ▪ Late Entries from nursing found in IPNs were not appropriately designated as such. ▪ The ISP signature sheet dated 3/26/13 indicated that the Dietician was not present for ISP meeting for an individual with significant weight issues. Also, a review of an additional 11 individuals that were admitted to the hospital since the last review (i.e., Individual #253, Individual #287, Individual #407, Individual #443, Individual #181, Individual #165, Individual #275, Individual #530, Individual #382, Individual #7, and Individual #541) found similar problematic issues throughout the nursing documentation as those found in Individual #454's record (more detailed findings are provided with regard to Section M.1). These consistent problematic findings clearly showed that the Facility had not actually implemented the use of nursing protocols as required by the Settlement Agreement. From the Monitoring Team's review, there was no indication that nursing was actually	

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		using nursing protocols as part of a structured system to guide nursing practice and the associated 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; and ▪ Appropriate and clinically adequate care plans were developed that outlined specific nursing interventions for specific health issues. Consistent with past reviews, the problematic findings from this review indicated that ABSSLC continued to fail to adequately and timely implement nursing assessment and reporting protocols sufficient to address the health care needs of the individuals residing at the Facility. The Facility indicated that it was not in substantial compliance with this requirement, which was consistent with the findings of the Monitoring Team.	
M5	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall develop and implement a system of assessing and documenting clinical indicators of risk for each individual. The IDT shall discuss plans and progress at integrated reviews as indicated by the health status of the individual.	As detailed below, the Monitoring Team conducted its own review of the requirements of this section. However, it also reviewed the Facility's Self-Assessment. 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, statewide revisions had been made to the At-Risk Individuals system since the last review. The Facility reported that facility-wide training had been conducted in October 2012 regarding the Integrated Risk Rating Form and the Integrated Health Care Plan. The Facility reported that monitoring had been initiated. However, due to the updates to the new process, the Facility indicated that the data generated were unreliable. Thus, it was unclear to the Monitoring Team why monitoring data was included in the Facility's Self-Assessment without explanation regarding its meaning related to this provision. ▪ The Facility's Self-Assessment also indicated that mentoring for the Case Managers was conducted in January and April 2013. However, no specific information was included describing the mentoring process, if it was to be continued, and what outcomes were expected and achieved. Additional training was provided to the Case Managers in March 2013 regarding the IHCP with emphasis on preventive interventions and clinical indicators. However, the Monitoring Team's findings noted below indicated that essentially no progress had been made addressing this requirement of the Settlement Agreement. ▪ Additional information was included in the Facility's Self-Assessment. However, it did not address the requirements of this provision. Also, there was no information included addressing the problematic issues that had been found	Noncompliance

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		during the previous reviews with regard to the specific area of nursing related to this provision of the Settlement Agreement. Self-rating The Facility's Self-Assessment indicated that: "Based on the findings from this self-assessment, this provision is not in substantial compliance. The renovated ISP process is just being understood and applied across campus. The current process, as it gets put in place and learned promises to be an excellent vehicle for the assessing and documenting an integrated approach to clinical indicators of risk. This can also be an effective integrative tool to address and supplement all departments. The provision discusses 'develop and implement a system of assessing and documenting clinical indicators of risk for each individual'. This is in place; there is no data yet to prove." Consistent with past reviews, the findings from the Monitoring Team detailed below indicated the documentation reviewed did not adequately address individuals' health/mental clinical health risks in alignment with the requirements of this provision. A review of records for 21 individuals determined to be at risk (i.e., Individual #418, Individual #199, and Individual #545 for weight issues; Individual #383, Individual #463, and Individual #55 for seizures; Individual #217, Individual #315, and Individual #127 for dental issues; Individual #226, Individual #535, and Individual #37 for fluid imbalance; Individual #165 for choking; Individual #138, and Individual #26 for urinary tract infections; Individual #76, Individual #27, and Individual #146 for skin issues; Individual #297, Individual #447, and Individual #493 for infections) found that none (0%) included adequate nursing risk assessments including individual-specific information to clearly justify the risk ratings assigned. A review of the most current quarterly or annual Comprehensive Nursing Assessments for the 21 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. A review of these 21 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. As noted with regard to Section I, the Monitoring Team found that there was an overall increase in some of the specific clinical information contained on the IRRF forms. However, for some of the areas that nursing was responsible for assessing and/or providing information, such as constipation, weight issues, cardiac, and falls, injuries and/or fractures, there was a lack of individual-specific information noted that made it difficult to determine the accuracy of the risk rating that	

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		was assigned. Consistent with the findings from previous reviews, the CNE reported that since the previous review, there had been no modifications or specific procedure implemented to address the nursing assessment process and the analysis of the identified risk indicators. Consistent with the findings from past reviews, the nursing assessments reviewed for the At-Risk individuals identified above did not adequately address their health risks, and in some cases, did not even include all the high/medium health risks in the Summary Section of the Comprehensive Nursing Assessments. In addition, a review of the 21 records for these individuals determined to be at risk found 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%). In addition, only 12 individuals (57%) were found to have a care plan addressing their high or medium health/mental risk indicator in the Active Record. Individuals who did not have a related care plan included Individual #418, Individual #199, Individual #463, Individual #226, Individual #37, Individual #165, Individual #76, Individual #447, and Individual #27. ▪ Implemented a plan within fourteen days for each individual, as appropriate in none (0%) of the cases reviewed. The 12 Integrated Health Care Plans that were actually found in the Active Records included a date of implementation. However, there was no supporting documentation verifying that the action steps contained in the plans 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 to encourage adequate fluids, 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%). ▪ Integrated the plans into the ISPs in 12 of the 21 cases (57%). Individuals who did not have their IHCPs/Risk Action Plans included as part of the ISP in the Active Record included: Individual #418, Individual #199, Individual #463, Individual #226, Individual #37, Individual #165, Individual #76, Individual #447, and Individual #27. ▪ None (0%) of the plans reviewed showed adequate integration between all of	

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		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 Plans contained a heading addressing "Monitoring Frequency," the frequency was either noted generally as daily or weekly without the specific shift or day included to ensure accountability or it was not addressed. At the time of the review, the Facility had begun to implement the additional changes that had been made to the ISP and At-Risk process. 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 interventions contained in the Risk Action Plans, HMPs, and IHCPs still needed to be addressed. 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, the Facility 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 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	As detailed below, the Monitoring Team conducted its own review of the requirements of this section. However, it also reviewed the Facility's Self-Assessment. In response to this requirement, ABSSLC's Self-Assessment indicated that since the last review, activities addressing this provision included the following: ▪ The Facility's Self-Assessment indicated that their numbers of medication variances increased after an analysis demonstrated that the Facility was under-reporting, and in January 2013, began reporting medication variances in alignment with the Medication Variance policy. The Self-Assessment noted that the number of variances reported for November 2012 was 189 while the number of variances for January 2013 rose to 867, when shortages and excesses of medications that were returned to the pharmacy were included in the medication variance data. However, no additional information was provided in the Facility's Self-Assessment addressing what steps the Facility was taking regarding this significant problematic issue, or pointing the reader to other documents that would illustrate actions planned or taken. ▪ In addition, the Facility indicated that since 9/1/12, 417 of 1862 medication variances were dispensing medication variances. However, no additional	Noncompliance

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	a separate monitoring plan.	information was provided regarding these data addressing if any specific trends were identified and associated corrective actions implemented. ▪ The Facility's Self-Assessment indicated that from 100% (24 homes) of the Medication Station Surveys conducted since September 2012, 87% of the medication carts were attended when unlocked and 64% of the refrigerator temperatures were documented. However, it was unclear to the Monitoring Team why only these particular data were included in the Self-Assessment as well as their overall significance regarding this provision. Self-rating: Regarding the Facility's compliance rating, the Self-Assessment stated: "Based on the findings from this self-assessment, this provision is not in substantial compliance. There is a good process, which is being perfected, in place at this time to allow prompt discussion of medication variances from provider, Pharmacy techs, Pharmacists, and nursing to ensure delivery of pharmacological interventions that meet best practice as well as evidence-based practice. The facility is attempting to utilize (sic) to continually improve delivery of care." Although the Monitoring Team's findings were consistent with the Facility's self-rating of noncompliance regarding this provision, it was unclear to the Monitoring Team what "good process" the Facility was referring to in the Self-rating section since no information was provided in the Self-Assessment addressing this. Additional information should have been provided in order for the Monitoring Team to fully understand what actions had been implemented, the resulting outcomes, and the plan for future actions addressing this crucial requirement of the Settlement Agreement. In addition, there were a number of documents contained in the Presentation Book for Section M.6 that were uninterpretable due to the poor quality of the copies provided. While essentially no information was provided in the Facility's Self-Assessment or Presentation Book regarding progress made since the last review addressing this provision, interviews with the Nursing and Pharmacy Departments, and review of the Medication Variance Committee meeting minutes indicated that the following steps regarding the Facility's overall medication administration system had been initiated: ▪ In January 2013, the Facility began including excesses and shortages of medications in the medication variance data. ▪ In February 2013, the statewide Medication Administration Competency class was implemented at ABSSLC. At the time of the review, 20 nurses had attended and passed the class. The Monitoring Team's previous review of the curriculum found it to be exceptionally comprehensive. ▪ At the time of the review, the Facility had ordered two medication carts to	

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		replace ones that were unable to be locked as required. ▪ The Pharmacy and Nursing Departments had implemented new processes regarding the auto-fill procedure for medications in order to begin to identify and reconcile excess and shortages of medications. Although the steps discussed above had resulted in some forward movement, at the time of the review, the Monitoring Team found that ABSSLC continued to have significant problems regarding its overall medication administration system as noted below: ▪ In January 2013, the Facility, implemented a system to address medication reconciliation that included medication counts between shifts and separating the medications for each medication pass to timely identify excess or shortages of medications. Although the CNE indicated at the time of the review that this process had not been implemented facility-wide, it was unclear to the Monitoring Team which specific units had actually implemented this new process. However, the minutes of the Medication Variance Committee meeting dated 5/8/13 indicated that although the medication variances had "decreased significantly" for Unit IV where the new process was being conducted, concerns related to time factors and manpower precluded the process from being implemented facility-wide. The Facility reported that since the new procedure was initially implemented, the number of total medication variances including the unknown excess medications had increased from 189 to 867 in November 2012 and January 2013, respectively. Although the Facility's data for February and March 2013 indicated an overall decrease in the number of unexplained excess medications, it was alarming to the Monitoring Team that in the absence of a facility-wide procedure (i.e., as opposed to a the current procedure that was limited to just one unit) to accurately identify excesses and shortages regarding medications, the Facility's current medication variance data was unreliable. A significant number of the excess medications that were identified and not reconciled were quite probably medications that had not been administered as ordered for the individuals at ABSSLC. The clinical ramifications of this issue could be dire in that medications prescribed for medical issues such as seizures and constipation were noted to be among the many medications that were found to be in excess without explanation. ▪ Although at the time of the review the Pharmacy and Nursing Departments had been focusing significant energy on systems related to the number of unexplained excess/shortage of medications, there was no indication that the Facility had focused any efforts on determining if this had any clinical impact resulting in changes in status for the individuals. For example, if seizure medications were being returned in large numbers, the Facility should have determined if an associated trend was occurring with increases in seizure	

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		activity. ▪ Although the Facility was spending much time reconciling excesses and shortages of medications, the number of medication variances addressing the wrong patient, the wrong time, the wrong dose, and the wrong route suggested that ABSSLC continued to have a significant problem regarding the under-reporting of medication variances. ▪ The Facility's Medication Administration Data from October 2012 through May 2013 indicated that medication administration observations had not been conducted as required. This was very concerning since the majority of newly hired nurses were recent nursing graduates with little to no previous experience. ▪ The auditing data from the Medication Administration Observations could not be accurately interpreted since only the number of passed and failed observations was reported for each month. Thus, the information did not indicate the specific problematic areas regarding the medication observations. ▪ The Facility's data indicated that from the 80 Medication Administration Observations conducted from October 2012 through May 2013, 76 (95%) were deemed as passing. However given that the Facility's data showed that 1,474 unreconciled medications were identified from October 2012 through March 2013, the high passing rate regarding the Medication Administration Observations was highly suspect. There was no indication at the time of the review that nursing was analyzing these obvious discrepancies between data and practice. A review of the medication variances (Category A-E) reported by the Facility indicated the following: ▪ October 2012 – 191 variances, (including 83 excess); ▪ November 2012 – 189 variances, (including 72 excess); ▪ December 2012 – 393 variances, (including 280 excess); ▪ January 2013 – 867 variances, (including 533 excess); ▪ February 2013 – 501 variances, (including 248 excess); and ▪ March 2013 – 428 variances, (including 252 excess). Based on observations of medication administration at Building 6521, the following problematic issues were found. Specifically, the nurse did not: ▪ Check the correct positions for the individuals during medication administration. Although the nurses looked at the PNMPs before administering the medications, they did not physically check the individuals' wheelchairs to ensure they were in the correct position in alignment with the PNMP. When prompted to do so, none of the individuals' observed were in the correct	

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		position; ▪ Assess lung sounds when an individual demonstrated significant congestion and began to cough during administration of medications; ▪ Tell the individuals what medication they were receiving; ▪ Provide instructions for positioning after medication administration to the direct support professionals; ▪ Flush the G-Tube before or after administering medications; or ▪ Consistently check for tube placement prior to medication administration. In addition, the Facility Nurse conducting the medication administration observations: ▪ Did not review the PNMPs to recognize that the individuals' were not in the appropriate positions; and ▪ Indicated that the nurses were not required to assess lung sounds prior to administering medications since the Facility policy did not require it. This was very concerning, because the need for such assessment should have been based on an assessment on the clinical needs of individuals at high risk for aspiration. A number of problematic issues continued to be noted regarding the medication administration systems at ABSSLC. At the time of the review, the Facility was beginning to take steps to review and implement strategies addressing some of the problematic elements of the medication administration system noted above. The Facility should continue its efforts to critically review all aspects of the medication administration system in order to accurately identify problematic areas, and implement actions aimed at long-term resolutions. The Facility also should continue to develop and implement strategies to increase the reliability of the medication variance data, such as continuing to conduct regular reviews of the Medication Administration Records, and review the discrepancies between data sets including the Medication Administration Observations. In addition, further collaboration should occur between the Pharmacy, Nursing, and the Medical Departments in constructing a format and structure to critically review the overall medication system. The Monitoring Team found the Facility was not in compliance with this provision. The Facility's finding in its Self-Assessment was consistent with the Monitoring Team's finding.	

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. As ABSSLC policies are reviewed and/or revised, the Facility should ensure that policies, procedures, or protocols address the integration of any new positions, such as the Nurse Case Manager Supervisor position. (Section M.1)
3. As previously recommended, the Facility should continue to implement and expand the use of nursing protocols to guide nursing practices. In

order to ensure this occurs, mentoring of nurses should be offered in conjunction with the adequate competency-based nursing skills training that was previously provided by the State Office Nurse Practitioner Group. Due to the number of individuals with complex medical needs at ABSSLC, this area should be considered a priority for Facility review, including the development and implementation of action plans addressing the significant deficits that exist in nursing care. (Section M.1)

4. The Facility should continue to confirm the immunization status and immunizations for all the individuals to ensure individuals receive all the required immunizations as outlined in the Health Care Guidelines. (Section M.1)
5. As recommended in past reports, additional expertise in Infection Control is needed to assist in implementing systems to effectively operationalize the Infection Control program in alignment with IC standards of practice, as defined in the Health Care Guidelines and the Settlement Agreement. Such expertise also should be used to obtain professional feedback regarding the quality and completeness of the Infection Control Program. (Section M.1)
6. Clinical staff, including nursing staff, should be involved in the review and analysis of Emergency Mock Code Drill data and data addressing the actual medical emergencies, and should participate, as appropriate, in the development and implementation of action plans to address any problematic trends identified. (Section M.1)
7. The Facility should provide appropriate competency-based training and/or mentoring 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)
8. The Facility should review and revise its current nursing discharge/transition procedures and documentation requirements to ensure that upon an individual's transition from the Facility to the community, the nursing documentation is specific and detailed enough to maintain continuity of care. (Section M.2)
9. The Facility should develop and implement appropriate care plans based on priority, and risk for all individuals at ABSSLC. (Section M.3)
10. Nursing, 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)
11. 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)
12. The Facility should continue its efforts to critically review all aspects of the medication administration system in order to accurately identify problematic areas, and implement plans of action aimed at long-term resolutions. (Section M.6)
13. The Facility also should continue to develop and implement strategies to increase the reliability of the medication variance data, such as continuing to conduct regular reviews of the Medication Administration Records, and review the discrepancies between data sets including the Medication Administration Observations. (Section M.6)
14. Further collaboration should occur between the Pharmacy, Nursing, and the Medical Departments in constructing a solid process that results in a critical review of the overall medication system. (Section M.6)
15. 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)

SECTION N: Pharmacy Services and Safe Medication Practices	
Each Facility shall develop and implement policies and procedures providing for adequate and appropriate pharmacy services, consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o Any policies, procedures and/or other documents addressing the provision of pharmacy services, including for updated policies, highlights of the approved changes; o List of staff who work in the Pharmacy Department, including names, titles, and degrees; o Any pharmacy surveys completed within the last year, plans of correction and/or internal auditing procedures and reports related to pharmacy services; o All Drug Utilization Evaluation (DUE) reports completed over the last six months, 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 for the past six months; o Minutes of any committee addressing polypharmacy for non-psychotropic medications; o Minutes of any committee addressing medication error/variance for the past six months; o Minutes of the committee addressing seizures, with any attachments, for the past six months; o DUE calendar for next 12 months, including specifications whether fiscal year or calendar year; o For Quarterly Drug Regimen Reviews, 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 are actually completed for the last one year period (beginning 1/1/12); o For Quarterly Drug Regimen Reviews, two most recent per residential home that have been completed with physician signatures and dates, including for anticholinergic justification, documentation or document (with date) of risk/benefit analysis completed in relation to side effects; and for polypharmacy justification, documentation or document (with date) in which rationale was discussed for polypharmacy for psychotropic and non-psychotropic polypharmacy including those for: Individual #138 10/16/12, 1/7/13; Individual #126 10/18/12, 1/10/13; Individual #95 12/12/12, 3/22/13; Individual #295 10/12/12, 1/7/13; Individual #220 12/12/12, 3/22/13; Individual #4 12/12/12, 3/22/13; Individual #373 10/25/12, 1/18/13; Individual #417 11/14/12, 2/18/13; Individual #437 11/7/12, 2/6/13; Individual #32 11/19/12, 2/18/13; Individual #478 11/26/12, 2/24/13; Individual #422 12/6/12, 3/12/13; Individual #228 11/14/12, 2/18/13; Individual #289 11/19/12, 2/18/13; Individual #485 10/23/12, 1/15/13; Individual #515 11/19/12, 2/18/13; Individual #237 10/4/12, 1/4/13; Individual #224 10/4/12, 1/4/13; Individual #470 11/27/12, 2/24/13; Individual #441 10/12/12, 1/7/13; Individual #104 12/10/12, 3/16/13; Individual #434 11/7/12, 2/6/13; Individual #187 10/18/12, 1/10/13; Individual #523 10/4/12, 1/4/13; Individual #166

	11/12/12, 2/14/13; Individual #157 11/19/12, 2/18/13; Individual #191 12/12/12, 3/20/13; Individual #349 11/12/12, 2/14/13; Individual #57 11/27/12, 2/24/13; Individual #353 12/4/12, 3/11/13; Individual #98 11/7/12, 2/6/13; Individual #383 11/26/12, 2/24/13; Individual #513 10/16/12, 1/7/13; Individual #408 11/7/12, 2/6/13; Individual #172 10/4/12, 1/4/13; Individual #165 12/10/12, 3/16/13; Individual #409 12/4/12, 3/11/13; Individual #69 12/6/12, 3/12/13; Individual #182 12/12/12, 3/22/13; Individual #284 12/12/12, 3/20/12; Individual #70 10/25/12, 1/18/13; and Individual #100 10/23/12, 1/15/13; o For 10 most recent QDRRs in which recommendations were made and accepted, copies of physician orders; for 10 most recent QDRRs in which recommendations were made and not accepted, copy of IPN or other entry indicating reason for non-agreement, including those for: Individual #540 9/21/12; Individual #281 2/18/13; Individual #479 11/12/12; Individual #147 2/18/13; Individual #229 12/12/12; Individual #441 10/12/12; Individual #538 2/18/13; Individual #24 11/7/12; Individual #210 9/7/12; Individual #456 10/18/12; Individual #439 10/23/12; and Individual #513 10/16/12; o All "single patient intervention reports" in WORx system for the last six months; o For the past six months, copy of any internal Pharmacy Department audits/monitoring data to review Section N of the Settlement Agreement (i.e., pharmacist review and placement of new orders in WORx system); o Copy of all "notes extracts" associated with "single patient intervention reports;" o For the past six months, any Adverse Drug Reaction (ADR) reports completed; o Any 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, as well as corrective action plans, root cause analysis summaries, etc.; o Copies of the last 10 medication error forms completed and any plans of correction arising from review of the medication errors; o Copy of any communication between pharmacy and Nursing Department concerning medication errors/variance (e.g., emails, memos, etc.) for the past six months; o For the past two months, reports and/or summaries of any medication administration observations conducted; o Any policies, procedures and/or other documents addressing medication administration; o List of antibiograms per month for last six months by building; o Medication history for individuals with J or G/J tubes (not G tubes); o A schedule of when Quarterly Drug Regimen Reviews are conducted by residence/unit; o All documentation for each emergency chemical restraint, including restraint checklist. Information for the following individuals was submitted: Individual #87 1/31/13; Individual #120 11/13/12, 12/31/12, and 1/13/13; Individual #318 1/3/13, 1/14/13, 2/18/13, and 2/20/13; Individual #99 10/31/12, 11/7/12, and 11/12/12, Individual #430 8/27/12 and 11/21/12; and Individual #525 10/4/12 and 12/20/12;

	o Any trend analysis of chemical restraint use (e.g., 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, with the name/source of the database clearly identified; o For 10 new orders involving drug-drug interactions, copy of original new order, computer screen shots for each step, copy of change in new order by PCP, and snapshot verifying change in order received by pharmacy. Submitted documents were for the following 10 individuals: Individual #440, Individual #540, Individual #464, Individual #185, Individual #27, Individual #196, Individual #470, Individual #407, Individual #522, and Individual #9; o For five new orders involving potential allergic reactions, copy of original new order, copies of serial computer screen shots for each step, copy of change in new order by PCP, and snapshot verifying change in order received by pharmacy. Submitted documents were for the following individuals: Individual #30, Individual #538, Individual #37, Individual #181, and Individual #117; o For five new orders involving drug dosages below or exceeding normally prescribed dosage regimens, copy of original new order, copies of computer screen shots for each step, copy of change in new order by PCP, and copy of snapshot verifying change in order received by the pharmacy. Submitted documents were for the following individuals: Individual #19, Individual #476, Individual #92, Individual #82, and Individual #386; o For five new orders in which labs are reviewed/monitored, copy of original new order, copies of serial computer screen shots for each step, copy of change in order by PCP, and copy of snapshot verifying change in order received by the pharmacy. Submitted documents were for the following individuals: Individual #38, Individual #533, Individual #407, Individual #252, and Individual #386; o For five new orders for which there was potential for significant side effects, copy of original new order, copies of serial computer screen shots for each step, including any written documentation/ information provided to the PCP and response of the PCP, copy of change in new order by PCP, and copy of snapshot verifying change in order received by the pharmacy. Submitted documents were for the following individuals: Individual #250, Individual #7, Individual #476, Individual #464, and Individual #275; and o Presentation Book for Section N. ▪ **Interviews with**: o Marla Knight, Pharm.D. ▪ **Observations of**: o Medication Variance Committee, on 5/8/13; and o Pharmacy and Therapeutics Committee, on 5/8/13.
	Facility Self-Assessment: For Section N, 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: New Order Audit, and QDRR Audit. ▪ The Pharmacy Department had created an internal quality improvement process to review new order processing. The tool audited each of the components of new order processing: correct patient, correct drug, correct signature, correct start date, correct stop date, indication, correct prescriber, and correct route. The new tools were implemented as of 2/1/13. For February 2013, 28 new orders were audited for quality. For March 2013, 30 new orders were audited for quality. In both months, compliance for each indicator of the process was 100%. The submitted information indicated that two pharmacists each randomly selected 10 new orders from the prior month. A third pharmacist pulled five orders from each of the two samples of 10. This was for inter-rater reliability. From this information, 20 new orders were reviewed monthly, but the data results indicated more than 20 orders were reviewed for each of February and March. The reason for the discrepancy was not determined. If this was not already in a written procedure, completion of a protocol would allow standardization and guidance for future auditors. ▪ The Pharmacy Department had an internal quality audit monitoring tool for QDRRs. Each month 15 QDRRs were reviewed for completion of the contents in the areas of metabolic risk, benzodiazepine use, anticholinergic use, polypharmacy, lab values, and MOSES/DISCUS. Scores indicated 100% compliance in all areas. Data was submitted for February 2013 and March 2013. The submitted information indicated that 10 QDRRs randomly selected were reviewed each month (two QDRRs from each of five residences). A third staff pharmacist randomly chose five of these 10 for inter-rater reliability. However, the numbers provided indicated more than 10 records were reviewed each month. The auditors were identified as a staff pharmacist, and the other was the clinical pharmacist who completed all QDRRs. In the future, as staffing allows, it is recommended that both auditors be pharmacy staff not completing the QDRRs. If there was not a written protocol, it would be important to create one to ensure future auditors completed the monitoring tool in a standardized approach. o These monitoring/audit tools included indicators to allow the Facility to determine compliance with some aspects of 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, such as documenting communication with the PCP, as well as ensuring review of lab information, drug-drug interactions, etc. In addition: o The Facility Self-Assessment for Section N.6 indicated that adverse drug reaction reporting from 10/11/12 through 3/21/13 was tracked for timeliness of identification of a potential ADR, reporting of the ADR, and follow-up and closure of all significant or unexpected ADRs. The review indicated that seven of nine (78%) of the ADRs met compliance with timely identification and reporting, as well as closure. There was no further information submitted providing further

	details of the review. There was no monitoring tool submitted for Section N.6 to determine the indicators and the threshold values for meeting compliance. It is recommended that a formal monitoring tool be developed for timely identification, reporting, and closure of ADRs. o The monitoring tools included adequate methodologies, such as record reviews. o The Self-Assessment identified the sample(s) sizes, including the number of individuals/records reviewed per month, in comparison with the number of individuals/records in the overall population (i.e., n/N for percent sample size). These sample sizes were adequate to consider them representative samples. o The submitted information did not include 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: ABSSLC pharmacists, and ABSSLC clinical pharmacist. o The staff responsible for conducting the audits/monitoring had clinical/programmatic experience in the relevant area(s). o Adequate inter-rater reliability had not been established between the various Facility staff responsible for the completion of the tools. There was a methodology to establish inter-rater reliability for the new order audit and QDRR audit, but no data was submitted to indicate this aspect had been analyzed. ▪ The Facility used other relevant data sources to show whether or not the intended outcomes of the Settlement Agreement were being reached. The quality of the data maintained in some of the databases was noted to be complete and accurate, such as the patient intervention log, QDRR spreadsheet, and the emergency chemical restraint spreadsheet. There was no information concerning the emergency chemical restraint spreadsheet to determine whether it was complete and accurate, and consistent with data from the Psychology Department. ▪ The Facility consistently presented data in a meaningful/useful way. Specifically, the Facility's Self-Assessment was clear and concise. Terminology did not need re-interpretation, but was generally self-explanatory. Areas needing additional information included the QDRR 13-day due date past the three-month due date. Due to the large amount of information in that table of dates of completed QDRRs, it was difficult to read and interpret. The Facility: o Generally presented findings consistently based on specific, measurable indicators. One area needing attention was the review of the ADR identification, reporting, and follow-through. There did not appear to be a monitoring tool in place, and no supporting documentation was provided. o Consistently measured the quality as well as presence of items. o Distinguished data collected by the QA Department versus the program/discipline. ▪ The Facility rated itself as being in compliance with the following sub-sections of Section N.1, N.2, N.3, N.4, N.5, and N.7. This was consistent with the Monitoring Team's findings, except that the Monitoring Team did not find the Facility in compliance with Section N.3 due to issues with Psychiatry's review of the use of chemical restraints. ▪ The Facility data identified areas in need of improvement. For those areas of need, the Facility Self-Assessment provided an analysis of the information, identifying for example the lack of

	reporting, timeliness and closure to ADRs. The Facility identified a number of deficiencies for Section N.8.
	Summary of Monitor's Assessment: Many aspects of pharmacy services at ABSSLC represented a mature process. The new order system appeared to work well, and the internal audit process appeared to verify this. The QDRRs were done in a timely manner, were thorough, and offered practical recommendations, which were implemented in most cases. The drug utilization evaluations were timely, and follow-ups were numerous. The Pharmacy Department provided valuable information on the chemical restraint form in a consistent manner. Challenges included the consideration of refresher courses for adverse drug reaction identification. Although nursing staff appeared to be trained, it was less clear if that has occurred with other departments on campus. The Psychiatry Department needed to thoroughly conduct reviews of chemical restraints. The medication variances internal to Pharmacy Department remained problematic, and the new Pharmacy Director will be challenged to resolve this quickly. There was a need for expanded collaboration with the Nursing Department in resolving the unexplained overages that were returned to the Pharmacy Department. The Pharmacy Department had made considerable, consistent progress. The Facility was found to be in substantial compliance with Sections N.1, N.2, N.4, N.5, and N.7. For Sections N.6 and N.8, considerable challenges remained.

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N1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, upon the prescription of a new medication, a pharmacist shall conduct reviews of each individual's medication regimen and, as clinically indicated, make recommendations to the prescribing health care provider about significant interactions with the individual's current medication regimen; side effects; allergies; and the need for laboratory results, additional laboratory testing regarding risks associated with the use of the medication, and dose	The Pharmacy Department staffing included two clinical pharmacists (Pharm.D.), one of whom recently filled the position of Pharmacy Director; three pharmacists (R.Ph.); and four pharmacy technicians (C.Ph.T.) "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: ▪ August 2012 – nine; ▪ September 2012 – 43; ▪ October 2012 – 98; ▪ November 2012 – 87; ▪ December 2012 – 75; ▪ January 2013 – 114; ▪ February 2013 – 54; ▪ March 2013 – 49; and ▪ April 2013 – 23. The total number of patient interventions completed was 552. Each included the	Substantial Compliance

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	adjustments if the prescribed dosage is not consistent with Facility policy or current drug literature.	medication, dosage, and route, along with the concern. When a PCP or nurse was contacted, this was recorded. Interventions were not further broken down into different categories. Only four of the 552 orders were classified. If used accurately and consistently, this aspect of the software program might provide additional information concerning the type of interventions provided. However, it is not a requirement of the Settlement Agreement. The new Pharmacy Director was expecting to review the program to determine practical applications of its components. A sample of 10 new prescriptions was reviewed. The following summarizes the results: ▪ Ten new orders were submitted in which the Pharmacy Department found concerns with **drug-drug interactions** with the current drug regimen. A copy of the new order was submitted in 10 of 10 (100%). A computer screen shot of the order was submitted for 10 of 10 (100%). For 10 of 10 (100%), a copy of the patient intervention form was submitted. A handout was provided to the PCP in 10 of 10 (100%). A change in the order occurred for the new medication for six orders, a change occurred for orders of the other medication with potential drug-drug interaction in two cases, and additional testing was ordered for three orders. For one order, a change of order occurred, but a copy of the change in order was not submitted. More than one action step occurred in one case. No change occurred in zero orders. For each new order, four pharmacy process steps were required as evidence. For 10 new orders, nine (90%) showed evidence of appropriate processing. For a total of 40 steps, 39 (98%) were submitted. ▪ Five new orders were submitted in which **allergies** were reviewed and determined by the Pharmacy Department as a concern. A copy of the new order was submitted in five of five (100%). 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 Department review, there was a documented change in order for five of five orders. A copy of the change in order was submitted for five of five (100%). For each new order, four pharmacy process steps were required as evidence. Five of five new orders (100%) showed evidence of appropriate processing. For a total of 20 steps, 20 (100%) were submitted. ▪ Five new orders were submitted in which **significant side effects** were reviewed by the Pharmacy Department and determined to be a concern. A copy of the new order was submitted in five of five (100%). A screen shot was submitted in five of five (100%). A patient intervention note was submitted for five of five (100%). Verification of follow-up was provided in five of five (100%), an order change had occurred in four of four and an order change did	

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		not occur in one of five, but an explanation was provided in the patient intervention report. Evidence of an order change was submitted in four of four (100%) new orders. Five of five (100%) new orders had supportive evidence of appropriate processing. Four pharmacy process steps were required as evidence. For a total of 20 such steps, 20 (100%) were submitted. ▪ Five new orders were submitted in which **current laboratory results and potential need for further testing** were identified by Pharmacy Department during initial review. A copy of the new order was submitted in five of five (100%). A copy of the screen shot was submitted in five of five (100%). A copy of the patient intervention or justification/explanation not requiring patient intervention form (labs had already been ordered by the PCP) was submitted in five of five (100%). New orders were written for one of the medications based on communication with the PCP, and four orders had not changed. Lab monitoring was in place for five of five (100%), either prior to administration of medication for renal function calculation, or ordered for future monitoring. For each new order, four pharmacy process steps were required as evidence. Five of five new orders (100%) had supportive evidence of appropriate processing. For a total of 20 such process steps, 20 (100%) were submitted. ▪ Five new/renewed orders were submitted in which the Pharmacy Department had concerns about the potential need for **dosage adjustments**. For five of the five (100%) orders, a copy of the order was submitted. For five of five (100%) orders, there was a copy of the screen shot order submitted. A copy of the patient intervention was submitted for this in five of five (100%) orders. A change of order based on pharmacy review and PCP contact occurred in one of five. A copy of the change in order was submitted for one of one (100%). Documentation of rationale for no change in dosage was submitted in four of four (100%). For each new/renewed order, four pharmacy steps were required as evidence. Five of five (100%) new orders had supportive evidence of appropriate processing. For a total of 20 such steps, 20 (100%) were submitted. Based on this review, the Facility was in substantial compliance with this provision.	
N2	Within six months of the Effective Date hereof, in Quarterly Drug Regimen Reviews, a pharmacist shall consider, note and address, as appropriate, laboratory results, and identify abnormal or sub-therapeutic medication values.	A schedule of completed QDRRs was submitted for 2012 and 2013. For each month, three to four residences were assigned for review. This cycle was repeated every three months. The schedule included all residences at ABSSLC. For purposes of this review, focus was on the time period from September 2012 through April 2013. In April 2012, the parties and the Monitors agreed on a methodology for calculating timeliness of QDRR completion. Two timelines were addressed in the guidelines. The quarterly due date was every three months, the same calendar day of the month (e.g., 3/1, 6/1, 9/1, and 12/1) every three months of the year. The Facility was to	Substantial Compliance

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		establish this for each individual. The other parameter was the window of time allowed for completion of the QDRR. This was agreed upon as seven days prior to the due date through 13 days after the due date. In table format, for each individual, ABSSLC had provided the due date and actual date for serial quarters of the year. For those QDRRs due from September 2012 through April 10, 2013, 100 percent of QDRRs were completed in the accepted time period of three months after the due date of the prior QDRR (from seven days prior to 13 days after the agreed upon due date). A sample of 42 QDRRs was reviewed. These are listed above in the documents reviewed section. The following summarizes the results of this review: ▪ Laboratory information was submitted as part of 42 of 42 (100%) QDRRs. ▪ The lab results included exact values or indication of normal range for indicated lab tests 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). ▪ 42 of 42 (100%) QDRRs had the date the lab was drawn. ▪ Abnormal values were listed under the notes/comments section line for that particular lab. Twenty-two of 42 QDRRs indicated abnormalities of lab necessitating comments. Of these 21 out of 22 (95%) QDRRs provided comments with lab values. ▪ The lab testing completed, and the frequency with which laboratory testing was completed indicated that the PCPs generally were providing appropriate lab monitoring of medication side effects, adverse effects, and therapeutic drug levels. Based on this review, ABSSLC was in substantial compliance with this provision.	
N3	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, prescribing medical practitioners and the pharmacist shall collaborate: in monitoring the use of "Stat" (i.e., emergency) medications and chemical restraints to ensure that medications are used in a clinically justifiable manner, and not as a substitute for long-term treatment; in monitoring the use of benzodiazepines, anticholinergics,	This provision of the Settlement Agreement encompasses a number of requirements. Each of them is discussed below, including the Pharmacy and Medical Departments' roles in addressing the use of "Stat" medications and chemical restraints, as well as benzodiazepines, anticholinergics, polypharmacy, and monitoring the metabolic and endocrine risks associated with second generation antipsychotics. <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 15 chemical restraints used from August 2012 through February 2013. These are listed above in the documents reviewed section. For the 15 chemical restraints, the pharmacy sections were reviewed for adequacy of	Noncompliance

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	and polypharmacy, to ensure clinical justifications and attention to associated risks; and in monitoring metabolic and endocrine risks associated with the use of new generation antipsychotic medications.	completion and compliance. The following summarizes the review of these documents: ▪ Of the 15 chemical restraint forms, 15 (100%) forms included information concerning the justification of use due to the behavior. ▪ Effectiveness of the chemical restraint was reviewed in 15 of 15 (100%) chemical restraint forms completed. ▪ Side effects/adverse effects/drug-drug interactions were noted in 15 of the 15 (100%) completed chemical restraint forms. ▪ There were seven statements that were considered recommendations. ▪ The range of time for completion of the forms from the date of the chemical restraint was from one to 14 days. The pharmacy completed the chemical restraint form in one to five days for eight chemical restraints, in six to 10 days for six chemical restraints, and in 11 to 14 days for one chemical restraint. Separate from the pharmacy section, the psychiatrist also had a designated space for completion on the Face-to-Face Assessment, Debriefing, and Reviews for Crisis Intervention Restraint. It is essential that the Psychiatry Department complete this component of the review form consistently and thoroughly. The Settlement Agreement clearly requires: "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." Review of these documents showed: ▪ Of the 15 completed, there were 15 (100%) forms on which the psychiatry comment section was completed. ▪ For zero (0%) of the chemical restraints used, was there a description of the behaviors and prior steps taken by the IDT/psychologist. ▪ For 15 of 15 (100%), clinical justification was documented. ▪ Whether side effects/drug-drug interactions/other risks were a significant concern were mentioned in 15 of the 15 (100%) reviews. For seven of the 15 (47%), the psychiatrist indicated side effect concerns and/or drug-drug interactions were present. As noted below, at times entries were inconsistent with information the Pharmacy Department provided. ▪ Effectiveness was documented in zero (0%) of the cases. ▪ There were four recommendations made by the psychiatrist. There was considerable variability in completing the psychiatry section of the chemical restraint form. In some instances, there was conflicting information. For example, the pharmacist indicated potential significant side effects, and the psychiatrist indicated no potential medication related risks. The psychiatry entries included few recommendations. Additionally, there was no follow-up noting agreement or disagreement with pharmacy recommendations on some chemical restraint forms.	

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		Polypharmacy Of the 42 QDRRs reviewed, polypharmacy was noted in 10 reviews. There was one QDRR in which three hypertensive medications were prescribed, but the QDRR documented that there was no polypharmacy. ▪ Justification by diagnosis of each of the medications listed in the polypharmacy regimen was documented in nine of 10 (90%). ▪ Clinical justification for the use of polypharmacy was addressed in nine of 10 (90%). ▪ Potential interactions with other drugs or food/side effect risks were reviewed with reference to other active record documents in nine of 10 (90%). Although not essential to compliance, it is suggested that as an additional enhancement this area be further expanded for the non-psychotropic medications in addition to the current referencing of documents, to ensure the PCPs review the drug and side effect profiles of antihypertensives, etc. ▪ For nine of 10 (90%), the QDRRs reviewed whether there was documentation for effectiveness and appropriateness of the drug regimen. It was documented in the minutes of the 11/14/12 P&T Committee meeting that total psychotropic drug use had been reduced by 51% over the prior 11 quarters. It was documented in the minutes of the 2/13/13 P&T Committee meeting that the total decrease in antipsychotic use was 52%, indicating a sustained reduction in prescribing this class of medication. Benzodiazepine Use Benzodiazepine use was noted in three of the three QDRRs. ▪ Of these, three of three (100%) documented justification with appropriate diagnoses; and ▪ Three of three QDRRs (100%) indicated whether side effects or other adverse risks were present. Anticholinergic Monitoring Of the 42 QDRRs, 42 (100%) were screened for medications associated with potential significant anticholinergic side effects. Nineteen QDRRs identified anticholinergic medications. The results of the review of the QDRRs are as follows: ▪ The anticholinergic section of the QDRR was completed in 19 of 19 (100%) of cases with this medication prescribed; ▪ Nineteen of 19 (100%) documented clinical justification of the use of each of the medications contributing to anticholinergic load/effect, indicating the clinical burden of the side effects was less than the benefit (18 of 19), or requesting further documentation from the PCP in the recommendation section (one of 19). ▪ Nineteen of 19 (100%) QDRRs listed/addressed side effects/significant risks.	

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		It was documented in the minutes of the 11/14/12 P&T Committee meeting that high anticholinergic drug use had been reduced by 55% over the prior 11 quarters. It was documented in the minutes of the 2/13/13 P&T Committee meeting that high anticholinergic drug use had sustained this reduction of 55%. <u>New Generation Antipsychotic Endocrine and Metabolic Side Effects</u> Out of the 42 QDRRs reviewed, two listed atypical antipsychotic medication. Of these, two (100%) included lab values that reviewed endocrine and metabolic risks (i.e., BMP, glucose level, Hgb A1C, and/or lipid panel as appropriate). The Facility remained out of compliance with this provision. Although many of the requirements of this provision had been met, the content and quality of the Psychiatry Department's reviews of chemical restraints required improvement and standardization of content.	
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 42 QDRRs showed the following: ▪ Of the 42, 42 QDRRs (100%) included the PCP signature. ▪ Of the 42, 42 (100%) had the date the PCP reviewed the document. ▪ There were 12 recommendations from the 42 QDRRs. ▪ Evidence of PCP review of recommendations and agreement or disagreement with justification and plan was documented in 12 out of 12 (100%). o Agreement was documented in 12 out of 12 (100%). There was disagreement by the PCP for none of 12 QDRR recommendations. o For 11 of 12, (92%) a note of justification and plan was recorded on the QDRR. o For 30 of the QDRRs, there were no specific recommendations. Based on review of the content of the QDRR for these 30, the PCP agreed that there were no recommendations/actions needed in 30 of 30 (100%) QDRRs. o The PCP responded within 14 days of the QDRR being completed by pharmacy in 40 of 42 (95%) QDRRs. ▪ Psychotropic polypharmacy was documented in none of the 42 QDRRs. ▪ The QDRRs were reviewed for psychiatry documentation/evaluation when there was polypharmacy due to psychotropic medication. Because none of the 42 met the criteria, psychiatry review was not indicated for any of the QDRRs submitted. There was a Facility change in psychiatry signatures required on the QDRR beginning March 2013, as the phrase "The Psychiatrist's signature is required only if the client has polypharmacy for psychoactive medications" was removed from QDRRs. The rationale for this change was not provided nor the date of change, and the prior system format was utilized for this review period.	Substantial Compliance

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		To determine if the recommendations that were agreed upon were actually acted upon, the Facility submitted 10 active records in which recommendations were made on the QDRR. These are listed above in the documents reviewed section. In the sample of 10, 10 (100%) demonstrated that the PCP/psychiatrist acted upon the recommendation. The Facility submitted two active records in which recommendations from the QDRR were not followed, which are listed in the documents reviewed section. In two of two cases (100%), the response, rationale, and plan were written on the QDRR. The Facility had noted that only two recommendations from the Pharmacy Department could be found during the review period for which there was disagreement. Based on this review, the Facility was found to be in substantial compliance with this provision.	
N5	Within six months of the Effective Date hereof, the Facility shall ensure quarterly monitoring, and more often as clinically indicated using a validated rating instrument (such as MOSES or DISCUS), of tardive dyskinesia.	As discussed with regard to Section J.12, This provision of the Settlement Agreement requires systemic, quarterly monitoring for the emergence of motor side effects related to the utilization of antipsychotic medication with the Dyskinesia Identification System: Condensed User Scale, and the monitoring of more general systemic side effects related to psychotropic medication with the Monitoring of Side Effects Scale every six months per the Health Care Guidelines. 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 the nurse completed the exam, and the documentation was reviewed and signed by the prescribing physician. The review of the sample of records for 27 individuals prescribed psychotropic medication showed that the MOSES evaluation was current (completed within the last six months) and had been performed at least every six months for the prior year, was present for all of the 27 (100%) individuals. The records of 26 of the 27 (96%) individuals contained documentation that the prescribing physician had reviewed the MOSES evaluation in a timely manner, which had been defined as 14 calendar days. The individual whose MOSES documentation was not reviewed in a timely manner (latency between dates) was that of Individual #460 (10/31/12 to 11/27/12). 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 27 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	Substantial Compliance

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		these medications was an antipsychotic agent. This was similar to the findings of the Monitoring Team's prior 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 Facility's rationale is 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 who require 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 of the individuals in the sample. Thus, the DISCUS had been performed as specified for all of the 27 (100%) individuals 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 three individuals whose records indicated 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 #460 (12/11/12 to 12/31/12); Individual #534 (10/31/12 to 11/27/12); and Individual #168, for whom the 12/17/12 evaluation did not contain the signature of the prescriber who reviewed the document. Thus, the prescribing physician reviewed the DISCUS in a timely manner for 24 of the 27 (89%) individuals. 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 18 individuals receiving Reglan who were not also prescribed a psychotropic medication. The following sample of six individuals (33 percent of the 18 individuals who fit the above criteria) was selected, including: Individual #296, Individual #162, Individual #265, Individual #117, Individual #333, and Individual #385. Review of the records of these individuals related to the MOSES indicated that the	

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		examination had been performed at least every six months for all six (100%) individuals. 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 six (100%) individuals. With regard to the completion of the DISCUS for the individuals in the sample, these evaluations were completed as specified for all of the six (100%). Once completed, the prescribing physician had reviewed the DISCUS evaluations in a timely manner for all six (100%) individuals in the sample. During the Monitoring Team's initial 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 had 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 Monitoring Team's previous review and the 5/7/13 Psychiatry Clinic, a member of the Monitoring Team discussed the process with a nurse who had completed the MOSES and DISCUS evaluations. She indicated that linking the evaluations to the Quarterly Psychiatry Reviews had been helpful, because she had to prepare other documentation for these reviews, and that 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 the Monitoring Team's previous review, a 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. During the Monitoring Team's current onsite review, a request was made for this documentation, and the Facility provided a detailed three-page spreadsheet, which described the training materials, and the scoring methods for assessing competence. 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 included the review of every MOSES and DISCUS evaluation performed at ABSSLC from 3/12 to 2/13. The spreadsheet that reported this data provided monthly results and quarterly summaries. The results of the quarterly summaries from 3/12 to 2/13 were as follows: ▪ 3/12 to 5/12 = 74 percent; ▪ 6/12 to 8/12 = 91 percent;	

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		▪ 9/12 to 11/12 = 88 percent; and ▪ 12/12 to 2/13 = 90 percent. This data was consistent with the results of the Monitoring Team's current review in terms of both the significant improvement and the current status. 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 was found to be in substantial compliance with this provision. The methods that the Facility implemented to improve both the timely administration of the MOSES/DISCUS, as well as the review of these documents had been successful. Specifically, the results from the Monitoring Team's current review of the 27 records of the 182 individuals who were prescribed psychotropic medication indicated that the MOSES was completed as specified for 100 percent of the individuals and had been reviewed in a timely manner for 96 percent. The corresponding review for the DISCUS indicated that it had been performed as specified for 100 percent of individuals and reviewed in a timely manner for 89 percent. The MOSES and DISCUS monitoring for the individuals receiving Reglan was 100 percent complete for both the timely administration and the prescribing physician's review of these evaluations.	
N6	Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall ensure the timely identification, reporting, and follow-up remedial action regarding all significant or unexpected adverse drug reactions.	<u>ADR Training</u> It was documented in the minutes of the 11/14/12 P&T Committee meeting that 100% of nursing staff had been trained on Adverse Drug Reaction recognition and reporting. It was documented in the minutes of the 2/13/13 P&T Committee that 100% of nursing staff had been trained on "Recognizing and Reporting of Adverse Drug Reactions." This appeared to indicate that all current and newly employed nursing staff had completed training in this area. As evidence of in-service training in Adverse Drug Reactions, 10 training rosters were provided totaling 165 nursing signatures from June through August 2012. It was noted that as of September 2012, the Nursing Orientation class included training in ADRs. All new nurses would be required to complete this training prior to clinical work. DSPs were trained using a presentation "Observing and Reporting Clinical Indicators of Health Status Change." The submitted document stated that all staff were trained with this presentation. It was not clear if this was a campus-wide program for all employees, or whether it was focused on residential staff. It was not clear if this was training for new employees only or included training of all current employees. From a document entitled "Course Participation Report" from 8/25/12 to 4/16/13, for the course entitled "Observing and Reporting Clinical Indicators of Health Status," 264 employees were documented as having completed the training. The total number of DSPs on campus was	Noncompliance

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		not provided, and no information was provided on percentage of DSPs that had completed the training. It is recommended that DSP completion of ADR training/Clinical Indicators of Health Status Change be tracked quarterly with absolute numbers and percentage of all DSPs who were employees as of the last day of each quarter. The information provided was helpful, but did not provide a denominator to determine if adequate numbers of DSPs had been trained. There did not appear to be formal training of PCPs. It is recommended that formal training be provided focused on the PCP role in the ADR process. It is recommended that a refresher course be held annually for DSPs in the ADR training as part of the review of clinical indicators of change in health status. <u>ADR reports</u> There were two Adverse Drug Reaction Investigations presented to the 11/14/12 P&T Committee. It was determined, during the investigation, that neither situation was an adverse drug reaction. However, one involved Metformin and IV contrast for radiologic studies, and a new procedure was created and approved by the committee based on this investigation. The "Medication Adverse Reaction Report" forms were completed with final investigation determinations documented on the forms. There were three Adverse Drug Reaction Investigations presented at the 2/13/13 P&T Committee meeting. One was considered an adverse reaction to a vaccine and reported to the "Vaccine Adverse Event Reporting System." The other two were considered known drug side effects. According to the minutes of the 5/8/13 P&T Committee, there were five Adverse Drug Reaction Investigations presented, one of which was subsequently reported to the FDA Medwatch and the "Prolia Hotline." The others were considered known potential side effects. There was also follow-up of two prior ADR reports from the previous P&T Committee meeting. Due to issues related to training, 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	A list of DUE study topics was provided for the calendar year 2013, and included in the minutes of the 11/14/13 P&T Committee meeting. Topics which were approved included: Chlorpromazine monitoring (including tachycardia) for February 2013, enteral feedings and multivitamin use for May 2013, antipsychotics and annual EKG monitoring for August 2013, and Quetiapine monitoring for November 2013. Two follow-up studies were also scheduled for February 2013. One was a follow-up study on Zostavax, and the	Substantial Compliance

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	accordance with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	other a follow-up study on weight gain in those prescribed Risperdal. During the prior nine months, several DUE studies and follow-up studies were completed: ▪ A follow-up of the DUE on "Monitoring of Zyprexa" (completed June to August 2012) was presented at the 11/14/12 P&T Committee meeting. The follow-up indicated compliance of at least 90 percent in areas monitored (i.e., DISCUS performed quarterly and DISCUS reviewed timely). ▪ The results of a DUE for monitoring Risperdal were presented at the 11/14/12 P&T Committee meeting. For the sample of 20 individuals, there were two areas below a compliance score of 90 percent. Concerns included timely serial glucose monitoring, as well as excessive weight gain. Minutes of the 2/13/13 P&T Committee indicated that a follow-up of the serial glucose monitoring was to be completed, and data collection sheets were distributed at this meeting. The PCPs of those individuals identified as exceeding a threshold weight gain on Risperdal provided background information at the 2/13/13 P&T Committee meeting for three of four identified individuals. One individual had been transitioned to the community. ▪ It was announced at the 11/14/12 P&T Committee meeting that a follow-up study would be completed on timely Zostavax administration. The data collection form for the upcoming DUE for Hepatitis A vaccine was presented for PCP review. ▪ The 2/13/13 P&T Committee minutes indicated the follow-up study for Zostavax was completed. Compliance was 100 percent over the prior year. The DUE Hepatitis A vaccine results also were presented at the 2/13/13 P&T Committee, and compliance of 90 percent was exceeded. Additionally, based on an FDA warning, an additional DUE was completed on Ambien in women. The review focused on dosage range, and the one individual identified eligible for review was in the new recommended dosage range. No further action was necessary. ▪ The 2/13/13 P&T Committee also discussed the data collection sheet for the next DUE, Chlorpromazine monitoring. ▪ The 5/8/13 P&T Committee reviewed the results of the follow-up of blood glucose "Monitoring of Risperdal Use." An additional follow-up of the DUE for Hepatitis A was provided. During the DUE, one individual had been identified as meeting criteria for vaccine administration, but had not received the full series. This was resolved. ▪ Also discussed at the 5/8/13 P&T Committee meeting, an "impromptu" DUE was completed 3/8/13, based on new information from the Drug Safety and Risk Management Advisor Committee concerning Miacalcin. On 3/7/13, PCPs were given a list of individuals on their caseloads currently receiving this medication.	

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		They were given the literature reviewing the new warnings, and if applicable, information to change to alternative options. A follow-up 4/23/13 list of individuals on Miacalcin indicated that all individuals had been changed to alternative medication and no one remained on Miacalcin. ▪ Also discussed at the 5/8/13 P&T Committee meeting were the results of an impromptu DUE for Metoclopramide. The PCPs received training on 4/11/13 concerning use of this medication. On 4/23/13 a list of current orders was obtained, which included 21 individuals on the medication. The PCPs were requested to review the active record and justify long-term use of the medication or begin to taper and discontinue the medication. A copy of the PCP IPN and physician order provided documentation of the PCPs actions. On 5/2/13, a rerun of those on this medication indicated the medication was discontinued in four individuals, continued with justification in two individuals, was tapered in 14 individuals, and generated a referral to a GI consultant for one individual. ▪ The minutes of the 5/8/13 P&T Committee also documented that the next DUE was Vitamin D with enterally fed individuals, and would be a collaborative effort between the Pharmacy Department and the Dietary Department. Based on this review, the Facility maintained substantial 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 indicated there were no new policies, procedures, or other documents addressing medication administration/variances. Submitted was a draft policy "ABSSLC: Medication Variances," dated 1/14/13, which was submitted 2/26/13 for review by the ABSSLC Policy and Procedure Committee. A new or updated subsection of the policy was entitled; "ABSSLC Process: Discovering medication variance." This policy was the State Office medication variance policy adapted for implementation at ABSSLC. <u>Committee Monitoring of Medication Errors/Variances</u> The development, progress, and tracking of a medication error process and trend analysis were reflected in the minutes of the Medication Variance Committee meetings. Minutes of the Medication Variance Committee were submitted for 9/26/12, 11/8/12, 12/19/12, 1/23/13, 3/6/13, 3/28/13, and 5/8/13. The following describes some of the findings of this committee: ▪ The minutes showed the committee had begun to build a system, which identified medication variances, and had begun to determine the definitions of the various components of the medication variance monitoring system. The	Noncompliance

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		minutes of the 9/26/12 committee indicated the Hospital Liaison Nurse and Program Compliance Monitor Nurse were to complete competency-based training on medication administration observations. This would increase the number of observations per month and quarter. Pharmacy would review a random sample of the forms submitted by nursing which included the categorization of medication variance, to determine agreement or not. ▪ The 1/23/13 committee meeting minutes indicated that the revised reporting system for medication variances had been implemented. Data collection resulted in an increase in medication variances based on the revised reporting system. Unexplained excesses returned to the pharmacy and unexplained shortages of medication began to be included in the data tracked. For December, it was determined there were 273 excess medications returned. There were 13 true omissions (reconciled variances) of medication identified. The data also tracked pharmacy, medical, and nursing variances. There were 74 pharmacy variances for December, two medical staff variances, and 307 nursing variances. This was a total of 383 medication variances identified for December 2012. Although this was the first month of a more rigorous reporting process and trends could not be identified until several months of data were accumulated, the preliminary information revealed five medications (i.e., Docusate, Doxycycline/Periostat, Keppra, Miralax, and Vitamin D) had "high" numbers of variance and the Facility began to analyze these to try to determine the cause. A number of follow-up reports that were due remained outstanding. This appeared to be a challenge to the committee, and it is recommended that assigned tasks be tracked for timely completion, given that progress toward reducing medication variances was being hindered by lack of timely follow-up. ▪ The 3/6/13 committee minutes reflected the continued increase in medication variances identified by the new process (i.e., medication variance reports, auto fill verification, excess/shortages returned to the pharmacy). For January 2013, there were a total of 867 medication variances. Data could be further analyzed per residence, by type of error, per individual, per nursing staff, and per pharmacy technician. It was noted that the medications with "high" variance numbers had a worsening trend according to the January 2013 data, which might have reflected a more thorough reporting system. One outcome of the process was the identification and creation of a more formal process for follow-through of orders written in the residences by the Psychiatric Nurse Practitioner. The Medication Variance Committee also was tracking the indicators on the monitoring tool for medication room inspections. A number of identified deficiencies were assigned to members for follow-up. This remained an ongoing challenge.	

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		During the Monitoring Team's visit, on 5/8/13, a Medication Variance Committee meeting was held. The observations and review of the minutes follow: The total number of medication variances peaked in January 2013, and decreased in February 2013, with a further reduction in March 2013. The minutes indicated this improvement might have been due to stabilization of the nursing staff, and some residences bagging medication per shift. For the residence that utilized this approach, there was a reduction in medication variances. The process was summarized as follows: At the time of the auto-fill, the medications were separated by shift and by day. When the nurse assigned that shift passed medication, the bag would be empty by the end of the shift. If the passing of medications resulted in an error of omission, then medication would remain. This was considered a short-term solution. March 2013 data indicated that the Pharmacy Department had 98 variances, the Medical Department had one variance, and the Nursing Department had 326 variances. There was one Severity Level D medication variance in March 2013 (individual required monitoring), and one Severity level E medication variance (individual required intervention and treatment due to medication variance). There was discussion of errors due to a single dosage, which required multiple tablets or measuring specific milliliters for suspensions. The Pharmacy and Therapeutics Committee additionally, routinely received a report on medication variances. However, from the 11/14/12 P&T Committee minutes, a report was not received on medication variances. The minutes of the 2/13/13 P&T Committee indicated a report on medication variances was reviewed. <u>Medication Error Reports</u> Copies of the last 10 medication error forms were submitted for review. There were zero Class A medication errors, zero Class B medication errors, 10 Class C medication errors, and zero Class D medication errors. Two errors were misclassified. The nurse completing the form indicated the omission of medication was Class B when by definition, these were Class C. For three of the forms, no classification was indicated, but they were also Class C. For one form, the name of the individual was not included. For six of 10, additional information included a comment of "heavy med pass." It is recommended that this comment be reviewed and processes created and implemented to reduce circumstances in which a nurse may be "rushed" in completing a medication pass in the assigned window of time. It would appear there is need for further training on correct categorization of medication variances. That these ten errors occurred over three days in March 2013 suggested there was a spike in the true omission error rate, or that the summary reported omission error rates reflected under-reporting. Of concern, one individual missed 2.5 doses of Keppra, totaling 18 liquid "formats" being returned as excess to the pharmacy. The form was difficult to interpret as it listed	

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		"tablet" as the form but subsequently discussed 500mg/5ml solution. It is recommended, when individuals miss doses of seizure medications, a system be created to review these individuals for an increase in seizure activity that might have occurred prior to discovery of the medication variance and immediately following the time period in which the error was to have occurred. A corrective action plan was initiated to resolve this issue with this individual. There was no information whether this would also be implemented for other individuals taking multiple tablets or liquid amounts in order to complete a single dose. <u>Medication Observation Monitoring</u> The Facility submitted copies of 14 Medication Administration Observation forms completed between 2/13/13 and 3/27/13. Thirteen of 14 were scored, and scores ranged from 91 percent to 100 percent. Several comments were made by the observer, which reflected discussion with the nurse administering the medication. The Facility did not submit data summary reports for medication administration observations prior to the Monitoring Team's visit. The notation submitted was "No data summary reports available for the past two months." This indicated that this key area for improvement in medication variances had not been analyzed further. Raw data had been collected but not reviewed for trends and areas of strengths, and areas of weaknesses that needed focused attention. It is recommended that quarterly reviews of medication administration observations be completed, and analysis, findings, and corrective action plans for medication administration be included in these quarterly reviews. The Facility Self-Assessment for Section N.8 identified areas of need for Pharmacy Services based on a review of the minutes of the Medication Variance Committee. This review recognized the lack of monthly pharmacy reports/reviews focusing on concerns/challenges, action steps completed, timeframes, and any on-going monitoring. The Monitoring Team agreed that these were areas requiring attention. In addition, documentation of the Pharmacy Department's role/activity in reducing medication variances in collaboration with Nursing Services was lacking. As noted above, even when corrective actions had been identified as requiring follow-up, actions were not taken and reported back to the Medication Variance Committee in a timely manner. The Facility remained out of compliance with this provision.	

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

1. The non-psychotropic medication polypharmacy comments should include drug and side effect profiles for PCP review. (Section N.3)
2. DSP completion of ADR training/Clinical Indicators of Health Status Change should be tracked quarterly with absolute numbers and percentage of all DSPs who were employees as of the last day of each quarter. (Section N.6)
3. Formal ADR training of PCPs should be documented. (Section N.6)

4. A refresher course should be held annually for DSPs in ADR training as part of the review of clinical indicators of change in health status. (Section N.6)
5. A formal monitoring tool should be developed for timely identification, reporting, and closure of ADR events. (Section N.6)
6. For the Medication Variance Committee, assigned tasks should be tracked for timely completion. (Section N.8)
7. Processes should be created and implemented to reduce circumstances in which a nurse might be "rushed" in completing a medication pass in the assigned window of time. (Section N.8)
8. There should be further training of nurses in correct categorization of medication variances. (Section N.8)
9. When individuals miss doses of seizure medications, a system should be created to review these individuals for an increase in seizure activity that might have occurred prior to discovery of the medication variance and immediately following the time period in which the error was to have occurred. (Section N.8)
10. Quarterly reviews of medication administration observations should be completed, and analysis, findings, and action plans for medication administration should be included in the quarterly reviews. (Section N.8)
11. If it has not been already, the new order audits should be formalized in a written format. Such a protocol would allow standardization and guidance for future auditors should be completed. (Facility Self-Assessment)
12. When staffing allows, both auditors for the QDRR monitoring tool should be staff pharmacists not completing the QDRRs. (Facility Self-Assessment)
13. The QDRR monitoring tool and process should be memorialized in written format and should include instructions. In addition, a written protocol or format that would allow standardization and guidance for future auditors should be completed. (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 15 individuals in Sample O.1 (i.e., Individual #418, Individual #378, Individual #26, Individual #55, Individual #411, Individual #443, Individual #86, Individual #253, Individual #33, Individual #344, Individual #525, Individual #353, Individual #142, Individual #452, and Individual #392), including: Preferences and Strengths Inventory, list of assessments/reports needed for the annual ISP meeting, list of Interdisciplinary Team members to attend the annual Individual Support Plan meeting, ISP Preparation Meeting documentation, Occupational Therapy/Physical Therapy (OT/PT) comprehensive assessment, OT/PT assessment of status, OT/PT update, Nutrition assessments, Aspiration Pneumonia/Enteral Nutrition (APEN) assessment/tool, Speech Language Pathology (SLP) comprehensive assessment, SLP assessment of status, SLP update, 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 Health Care Plan, Integrated Progress Notes (IPNs) 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, 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 (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 nine individuals in Sample O.2 (i.e., Individual #7, Individual #255, Individual #385, Individual #226, Individual #3, Individual #297, Individual #493, Individual #524, and Individual #17) on the Physical and Nutritional Management Team (PNMT) caseload who were assessed or reviewed in the last six months; as well as for a sample of five individuals who had been discharged by the PNMT: Individual #27, Individual #409, Individual #80, Individual #70, and Individual #498, including: Preferences and Strengths Inventory, list of assessments/reports needed for the annual ISP meeting, list of IDT members to attend the annual ISP meeting, ISP Preparation Meeting documentation, PNMT assessment, PNMT action plan and supporting

	documentation, HOBE assessment, APEN assessment/tool, 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 The following documents for nine individuals in Sample O.3 (i.e., Individual #378, Individual #55, Individual #443, Individual #253, Individual #33, Individual #184, Individual #454, Individual #262, and Individual #467) including: OT/PT comprehensive assessment, OT/PT assessment of status, OT/PT update, Nutrition assessments, APEN assessment/tool, SLP comprehensive assessment, SLP assessment of status, SLP update, HOBE assessment, annual ISP and ISAs for past year, Integrated Risk Action form, IDT 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, 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, documentation of staff successfully completing 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 List of Physical and Nutritional Management Team members and curriculum vita; o List of all individuals seen by the PNMT; o List of all individuals the PNMT assessed and the date of assessment; o List of all individuals the PNMT discharged; 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 needs; 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 competency 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 percent or greater over a six-month 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 the 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 residence; o Schedule of all PNM-related meetings occurring during the week of the Monitoring Team's 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 List of completed PNMT Nursing Post Hospitalization Assessments/Evaluations; o The following documents for Individual #250 and Individual #2 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, PNMPs, PNMT Nursing Post-hospitalization Assessments, and ISPA meeting documentation related to integration of

	PNMT assessments and Action Plans; o Quality Assurance/Quality Improvement 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 the Monitoring Team's last review; o Changes to PNMP templates since the Monitoring Team's last review; o QA/QI Quarterly Section Review for Section O for last two quarters; o From November 2012 to April 2013, number of new staff who successfully completed New Employee Orientation (NEO) PNM foundational performance check-offs (n), over number of staff in NEO over last six months (N); o From November 2012 to April 2013, number of current staff who have successfully completed PNM performance check-offs (n), over number of current staff (N); o From November 2012 to April 2013, number of current staff who have completed annual refresher training (n), over number of staff required to complete annual refresher training (N); o At Risk Rating List; o Curriculum vitas for PNMT core members; o License numbers of PNMT core members; o Copy of PNMT referral form; o Copies of Facility's PNMT policies; o List of approved trainers for NEO and annual refresher PNM foundational training; o List of approved trainers for PNM individual-specific training (i.e., non-foundational); o PNMPs for 32 individuals; o PNMT reports to Medical Morning meeting for the past three months; o List of PNM monitors, and for each monitor listed, include date of NEO training competencies completed, check-offs completed for validation and inter-rater agreement; o PNMT meeting minutes and attendance sheets complete after submission of pre-document request; o NEO training curriculum for PNM foundational training; o New dental policy; o Completed PNMP audit for Individual #399; o Vacuum tooth brushing instructions; and o Competency check-off for vacuum tooth brushing. ▪ **Interviews with:** o Bobbie Holden, OTR, Director of Habilitation Therapies; o Amy Gleaton, PNMT Coordinator and PNMT OT; o Tammy Bayer, RN, PNMT RN; o Luke Palmer, Doctor of Physical Therapy (DPT), PNMT PT; o Donna Boulette, MS, CC/SLP/A, PNMT SLP; o Tricia Reyes, MS, RD, LD, PNMT RD; o Nicole Spalding, RD, LD, PNMT RD; and o Leslie Riggins, SLP Assistant.

	▪ **Observations of:** o Individuals in the Infirmary; residences and dining rooms, including; and o PNMT meeting on 5/6/13.
	Facility Self-Assessment: Facility Self-Assessment: The Facility submitted a Self-Assessment for Section O, dated 4/13/13. In its Self-Assessment, for each subsection, 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: ▪ Based on a review of the Facility Self-Assessment, as well as interviews with the Director of HT the following was found: o The monitoring/audit tool the Facility used to conduct its self-assessment included: the Compliance Monitoring tool. This monitoring/audit tool's primary purpose was to monitor staff implementation of prescribed strategies in individuals' PNMPs. The Facility was not using the Settlement Agreement Monitoring Tool for Section O. o The Compliance Monitoring tool did not include adequate indicators to allow the Facility to determine compliance with the Settlement Agreement. However, the data presented in the self-assessment reflected the completion of additional activities and audits, such as results from a PNMP audit tool. These audits represented a positive move forward in monitoring compliance with Section O. The Facility is encouraged to review the Monitoring Team's report to identify additional indicators/metrics that are relevant to making compliance determinations. o The monitoring tool included adequate methodologies, such as observations, record review, and staff interview. o The Self-Assessment identified the sample(s) sizes. However, the Self-Assessment did not identify how the sample was chosen. The Facility Self-Assessment should identify how sample sizes were chosen for each of the subsections, including sample sizes adequate to consider them representative. o The monitoring/audit tool 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 tool: The Director of HT, therapists, PNMP Coordinators, Habilitation Therapy Technicians and a PCM. o Adequate inter-rater reliability had not been established between these monitors. ▪ The Facility used some other relevant data sources, including, for example, PNMT meeting sign-in rosters, continuing education database, PNMP database/spreadsheet, etc. ▪ The Facility presented some of the data in a meaningful/useful way, but in other instances work was needed. 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 subsections of Section O. This was consistent with the Monitoring Team's findings.

	▪ The Facility data identified areas in need of 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 referencing 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 Facility's PNMT had the required core members as outlined in the Settlement Agreement, and was meeting regularly. However, PNMT members were responsible for large individual caseloads beyond their PNMT caseload and responsibilities. These caseloads likely will present challenges as the PNMT members work to complete their respective roles and responsibilities. The Facility PNMT had a medical liaison. However, a review of PNMT documentation did not support routine participation by medical consultants. Based on interview, the Facility PNMT policy had been revised. The Monitoring Team requested copies of the Facility's PNM policies, but the only policy submitted was the State PNM policy. Consequently, the Facility PNM policies could not be reviewed to ascertain if necessary components were present. Some individuals who met the State Office policy's PNMT referral criteria had not been referred to the PNMT. A review of individuals' PNMT assessments, Integrated Health Care Plans, and PNMT individual discharge summaries identified multiple missing components. Progress had been made since the last review with individuals' PNMPs having more of the necessary components. The Facility had developed and implemented a PNMP audit tool, which included the necessary components. The Monitoring Team, members of the PNMT, and Facility therapists completed multiple direct observations of staff's implementation of individuals' PNMPs and dining plan strategies. These observations revealed that staff often did not follow prescribed PNMP strategies, which had the potential to place individuals at risk. The Facility had provided PNM foundational training to some new employees and veteran staff. However, additional work needed to be done to ensure all new employees and veteran staff successfully completed PNM foundational training. The Facility also needed to develop and implement training on PNMPs that included non-foundational components. The Facility had not yet developed or implemented a PNM monitoring policy that included the necessary components. Based on interviews with the HT Director and therapists, there was no confidence in the accuracy of the monitoring data and the Monitoring Team agreed with this assessment. The Facility had made revisions to the monitoring indicators on the forms for meals/snacks and positioning, which were positive additions. The HT Department planned to expand indicators for all the PNM monitoring areas. The Facility had not implemented an effectiveness monitoring system to assess individuals' progress in

	relation to their physical and nutritional management needs, or provide evidence that interventions were modified if an individual was not making progress. More specifically, the implementation of individuals' IHCPs did not generate individual-specific clinical data to substantiate individuals' progress or to assess if the individual was better or worse. Monthly progress notes were not completed to report on the effectiveness of individuals' 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. The Facility maintained an updated list of individuals who received enteral nutrition. Individuals in the sample, who received enteral nutrition, were reviewed by their IDTs. However, the annual assessment did not include necessary components. Individuals who were transitioning to oral eating did not have formal plans.

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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	As noted above with regard to the documents reviewed section, four samples were selected for the review of Section O. These included: ▪ **Sample O.1** consisted of a non-random sample of 15 individuals chosen from a list the Facility provided of individuals identified as being at a medium or high risk of PNM related issues [i.e., aspiration, choking, falls, fractures, respiratory compromise, weight (over 30 or under 20 BMI), enteral nutrition, GI, osteoporosis], require mealtime assistance and/or are prescribed in a dining plan, were at risk of receiving a feeding tube, and/or who have experienced a change of status in relation to PNM concerns (i.e., admitted to the Facility Infirmary, if applicable, emergency room and/or hospital). Individuals within this sample could meet one or more of the preceding criteria. These 15 individuals were: Individual #418, Individual #378, Individual #26, Individual #55, Individual #411, Individual #443, Individual #86, Individual #253, Individual #33, Individual #344, Individual #525, Individual #353, Individual #142, Individual #454, and Individual #392. ▪ **Sample O.2** consisted of 100 percent of the individuals who were assessed, reviewed, and/or tracked by the PNMT over the last six months. This sample included nine individuals: Individual #7, Individual #255, Individual #385, Individual #226, Individual #3, Individual #297, Individual #493, Individual #524, and Individual #17. In addition, a sample of five individuals who had been discharged by the PNMT was selected, including: Individual #27, Individual #409, Individual #80, Individual #70, and Individual #498. This did not include any duplication from Sample O.1. ▪ **Sample O.3** consisted of nine individuals who received enteral nutrition. These nine individuals were: Individual #378, Individual #55, Individual #443, Individual #253, Individual #33, Individual #184, Individual #454, Individual	Noncompliance

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	physical and nutritional management team. The Facility shall maintain a physical and nutritional management team to address individuals' physical and nutritional management needs. The physical and nutritional management team shall consist of a registered nurse, physical therapist, occupational therapist, dietician, and a speech pathologist with demonstrated competence in swallowing disorders. As needed, the team shall consult with a medical doctor, nurse practitioner, or physician's assistant. All members of the team should have specialized training or experience demonstrating competence in working with individuals with complex physical and nutritional management needs.	#262, and Individual #467. Some of these individuals were included in one of the other samples. ▪ **Sample O.4** consisted of 37 individuals (i.e., Individual #253, Individual #359, Individual #347, Individual #370, Individual #472, Individual #543, Individual #203, Individual #238, Individual #497, Individual #162, Individual #233, Individual #270, Individual #429, Individual #492, Individual #353, Individual #264, Individual #54, Individual #470, Individual #236, Individual #265, Individual #297, Individual #335, Individual #515, Individual #250, Individual #464, Individual #429, Individual #7, Individual #353, Individual #255, Individual #524, Individual #27, Individual #3, Individual #53, Individual #91, Individual #452, Individual #385, and Individual #236) observed in the Infirmary, residences, and day programs. This included random individual-specific observations as well as observations of individuals in Sample O.1 and O.2. 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, Section O.1 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. **<u>PNM Policy and Role of the PNMT</u>** The Facility submitted the following policy: ▪ State Policy 012.3: Physical Nutritional Management. The Monitoring Team requested copies of the Facility's PNMT policy. However, no Facility PNMT policy was submitted. Although the Facility did not submit anything beyond the State policy, the State policy only addressed some, but not all of the components necessary for a comprehensive PNM policy. (Note: This addresses the presence of a State/Facility PNM policy. The implementation of these elements is addressed in Section O.2 through O.8). The elements that are underlined below were	

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		covered in the State PNM policy. In addition to adopting the State Policy, the Facility PNM policy should address the remaining components that are listed, but not underlined below: ▪ Definition of the criteria for individuals who require a Physical and Nutritional Management Plan ("PNMP"); ▪ The annual review process of an individual's PNMP as part of the individual's ISP; ▪ The development and implementation of an individual's PNMP shall be based on input from the IDT, home staff, medical and nursing staff, and, as necessary and appropriate, the physical and nutritional management team; ▪ The roles and responsibilities of the PNMT; ▪ The composition of the Facility Physical and Nutritional Management Team (i.e., registered nurse, physical therapist, occupational therapist, dietician, and a speech pathologist with demonstrated competence in swallowing disorders) to address individuals' physical and nutritional management needs; ▪ Description of the role and responsibilities of PNMT consultant members (e.g., medical doctor, nurse practitioner, or physician assistant); ▪ The requirement of PNMT members to have specialized training or experience demonstrating competence in working with individuals with complex physical and nutritional management needs; ▪ Requirements for continuing education for PNMT members; ▪ Referral process and entrance criteria for the PNMT; ▪ Discharge criteria from the PNMT; ▪ Assessment process; ▪ Process for developing and implementing PNMT recommendations with IHCPs; ▪ The PNMT consultation process with the IDT; ▪ Method for establishing triggers/thresholds; ▪ Evaluation process for individuals who are enterally fed; ▪ PNMT follow-up; ▪ Collaboration with the Dental Department to address the risk of aspiration during and after dental appointments, including after the use of general anesthesia; ▪ A comprehensive PNM monitoring process designed to addresses all areas of the PNMP, including: o Definition of monitoring process to cover staff providing care in all aspects in which the person is determined to be at risk; o Definition of staff compliance monitoring process, including training and validation of monitors, schedule, instructions and forms, tracking and trending of data, actions required based on findings of monitoring (for individual staff or system-wide); o Identification of monitors and their roles and responsibilities;	

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		o Revalidation of monitors on an annual basis by therapists and/or assistants to ensure format remains appropriate and completion of the forms is correct and consistent among various individuals conducting the monitoring; o Evidence that results of monitoring activities in which deficiencies are noted are formally shared for appropriate follow-up by the relevant supervisor or clinician; and o Frequency of monitoring to be provided to all levels of risk. ▪ A system of effectiveness monitoring; and ▪ Description of a sustainable system for resolution of systemic concerns negatively impacting outcomes for individuals with PNM concerns. The system should include: o Requirements that the QA matrix include key indicators related to PNM outcomes and related processes; o Monitoring data from the QA Department as well as Habilitation Therapies and the PNMT is collected, trended, and analyzed; o Process for the HT and the PNMT to present the identified systemic issue requiring resolution to entities with responsibilities for the resolution of such issues (e.g., Medical Morning meeting, QA/QI meeting): o A process for identifying who will be responsible for resolution of the systemic concern with a projected completion date (e.g., action plan); o Process to determine effectiveness of actions taken, and revision of corrective plans, as necessary; and o If requested by the QA Department or QA/QI Council, development and implementation of additional monitoring, as appropriate to measure the resolution of systemic issues. **<u>Core PNMT Membership</u>** Based on interview with the Director of HT and review of PNMT minutes, the Facility PNMT had the appropriate disciplines as defined in the Settlement Agreement. PNMT members included a Registered Nurse, Physical Therapist, Occupational Therapist, two Registered Dieticians, and a Speech Language Pathologist. Of note, some of the PNMT members were responsible for individual caseloads beyond their PNMT responsibilities. The PNMT PT had a caseload of 85 individuals, the PNMT OT had a caseload of 106, the PNMT SLP had a caseload of 96, and the two PNMT RDs had caseloads of 234 and 161. These caseloads likely will present challenges as the PNMT members work to complete their respective roles and responsibilities. Although this was not related to compliance with the requirements related to the composition of the PNMT, the Facility is encouraged to review the impact that the size of the caseloads had on its	

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		ability to substantially comply with the remaining requirements of Section O, as well as with Sections P and R. **Consultation with Medical Providers and IDT Members** The Settlement Agreement Compliance Physician was identified as the physician liaison to the PNMT. The first PNMT meeting he attended was on 3/25/13. The addition of a physician liaison to the PNMT should assist in addressing some of the issues noted below. For none of the nine (0%) individuals in Sample O.2, evidence was provided of routine participation of medical providers in meetings, review of assessments, and other needed activities. The PNMT should always consult with the individual's medical provider during the completion of the PNMT assessment and ongoing follow-up, because they provide supports to high-risk individuals with significant health, physical, and nutritional concerns. Medical providers were present in six of 69 (9%) PNMT meetings. The physician liaison was present for two of these six meetings. For none of the nine (0%) individuals in Sample O.2, evidence was provided of routine participation of other IDT members in meetings, review of assessments, and other needed activities. According to the minutes, for some PNMT meetings, IDT members were present (i.e., QDDP, RN). However, for multiple meetings, IDT members were not present. The Facility PNMT policy should define which team members should be present during PNMT meetings. **Qualifications of PNMT Members** Six of six (100%) PNMT members were licensed to practice in the state of Texas. Six of six (100%) PNMT core members had specialized training in working with individuals with complex physical and nutritional management needs in their relevant disciplines. Specialized training is defined as graduate education or continuing education content that is relevant to enhancing the provision of supports to individuals with identified PNM concerns. **Continuing Education** Six of six (100%) PNMT staff had completed at least 12 hours of continuing education directly related to physical and nutritional supports and transferrable to the population served within the past 12 months. Attendance rosters, course certificates of completion, and agendas were submitted and reviewed. ▪ PT attended: Annual Habilitation Therapies Conference (9/20/12 to 9/21/12), Functional Core Movement Exercise Program (10/9/12), Equipment and Positioning DADS Webinar (2/7/13), Contoured Seating Using Foam in Place	

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		Technology DADS Webinar (2/27/13), and Equipment Webinar (3/14/13) for a total of 15 hours; ▪ SLP attended: Practically Speaking: AAC Strategies for Beginning Communicators (7/4/12), Evidence-Based Practice for AAC Evaluations (8/1/12 to 8/2/12), Annual Habilitation Therapies Conference (9/20/12 to 9/21/12), Autism Part 2: Communication Apps and Devices (9/27/12), Comprehensive Dysphagia Interventions: The Esophagus, Acid Reflux Disease, Oral Hygiene and Free Water (9/29/12 to 9/30/12), Normal Aging and Hearing: An Update for SLPs (1/6/13), Video Technology: Reinventing Pragmatic Therapy (2/2/13), Designing Optimal Learning Environments for Children with Developmental Disabilities, Autism or other Behavior Challenges (2/2/13), Equipment and Positioning DADS Webinar (2/7/13), Swallowing Screening: How and Why (3/9/13), Performing a Clinical Swallow Evaluation (3/9/13), AAC: Demystifying the "Assessment Process" (3/9/13), Hearing Aids 2010: A Review of Our Favorite Publications (3/10/13), Ethics in Audiology (3/10/13), Ethics in Hearing Healthcare – The Basics (3/10/13), and Equipment Webinar (3/14/13) for a total of 52 hours; ▪ OT attended: Medication Administration for Nurses (9/19/12) and Annual Habilitation Therapies Conference (9/20/12 to 9/21/12) for a total of 18 hours; ▪ RD attended: Dysphagia: A Growing Concern in Healthcare (7/25/12), Annual Habilitation Therapies Conference (9/20/12 to 9/21/12), Enteral Nutrition: Role in Maintaining Gut Structure and Function (1/24/13), Recognizing and Defining Adult Malnutrition: An Etiology Based Approach (1/24/13), and Equipment and Positioning – DADS Webinar (2/7/13) for a total of 15 hours; ▪ RD attended: The Elderly: Nutritional Needs, Challenges, Screening, and Solutions (5/24/12), From Metabolism to Epidemiology: Understanding Dietary Sugars and Health (6/4/12), Attacking Urinary Tract Infections with Cranberry and Prebiotic Therapy (6/7/12), Annual Habilitation Therapies Conference (9/20/12 to 9/21/12), and Equipment and Positioning – DADS Webinar (2/7/13) for a total of 15 hours; ▪ RN attended: From Metabolism to Epidemiology: Understanding Dietary Sugars and Health (6/4/12), Attacking Urinary Tract Infections with Cranberry and Prebiotic Therapy (6/7/12), Dysphagia: A Growing Concern in Healthcare (7/25/12), Medication Administration for Nurses (9/19/12), Annual Habilitation Therapies Conference (9/20/12 to 9/21/12), Equipment and Positioning DADS Webinar (2/27/13), Type 2 Diabetes Management (2/7/13), and Equipment Webinar (3/14/13) for a total of 25 hours. **<u>PNMT Meetings</u>** From October 1, 2012 to May 6, 2013, the PNMT met 69 times. The team met 31 of the 31 (100%) weeks, and often met more than once a week.	

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		There were four back-up members (i.e., OT, PT, RN, and SLP). Attendance by core PNMT and back-up members for 69 meetings conducted during the time frame from October 1, 2012 to May 6, 2013 was: ▪ RN: 91 percent attendance by core member, one percent for back-up member, and 92 percent overall; ▪ RD: 100 percent attendance between two RDs; ▪ PT: 87 percent attendance by core member, four percent for back-up member, and 91 percent overall; ▪ OT: 74 percent attendance by core member, 13 percent for back-up member, and 87 percent overall; and ▪ SLP: 83 percent attendance by core member, seven percent for back-up member, and 90 percent overall. None of the 69 (0%) PNMT meeting minutes (October 2012 to May 2013) included documentation of appropriate topics, including at a minimum: a) referrals; b) review of individual health status; c) PNMT actions; d) follow-up; and e) outcomes/progress toward established goals and exit criteria for individuals in the sample. For example: ▪ The PNMT minutes did discuss individual referrals; ▪ PNMT meeting minutes did not consistently report on the status of individuals' clinical health indicators to assess whether individuals were better or worse, and to analyze the efficacy of their interventions; ▪ PNMT actions to implement previous recommendations were not consistently discussed; ▪ Follow-up on individuals was not consistently documented; and ▪ The status of an individual's outcomes and/or progress toward established goals was difficult to track and/or was not present in meeting minutes. The Facility PNMT did not have a sustainable system fully implemented for resolution of systemic issues/concerns. A review of PNMT meeting minutes and PNMT Report on Rounds found the following: ▪ PNMT ISPA meetings were held with Individual #297's IDT to discuss resolution of environmental concerns. Action steps were developed, however, subsequent minutes did not address the completion of all action steps. ▪ The PNMT Nurse submitted nine individual-specific updates that were presented at the Medical Morning meeting for the past three months. However, none of these updates provided a discussion of strategies to address systemic issues that the PNMT had identified. For example, the systemic issues raised in the IDT meeting with Individual #297 (i.e., environmental concerns) should have been discussed in medical morning meetings as well as QA/QI meetings. In addition, these updates did not support an established schedule for presentation	

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		during the Medical Morning meetings. In summary, at the time of the Monitoring Team's review, the Facility's PNMT had the required qualified core members as outlined in the Settlement Agreement, and was meeting regularly. A medical liaison recently had been appointed to the PNMT, but medical consultation with the PNMT on a consistent basis was not evident. The Facility did not submit their PNM policy. The Facility's PNM policy should address the necessary components presented within this section that were not addressed in the State PNM policy. The Facility remained out of compliance with this provision.	
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.	**Identification of PNM Risk** Based on interview with the HT Director, the Facility did not have policies and/or procedures to define their process for implementing a sustainable system to maintain and update lists of individuals who required positioning assistance associated with swallowing activities, who have difficulty swallowing and individuals who required assistance to eat. A sustainable system is needed 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. The State Physical Nutritional Management policy stated: "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." During the Monitoring Team's last review, 94 individuals had been identified as not having a PNMP. At the time of the review, this number had decreased to 60 individuals. However, a review of these individuals found the following concerns: ▪ Ten individuals at medium risk for aspiration did not have a PNMP (i.e., Individual #412, Individual #169, Individual #209, Individual #231, Individual #151, Individual #191, Individual #95, Individual #481, Individual #323, and Individual #397; ▪ Individual #169 was at high risk for choking and did not have a PNMP and/or dining plan; and ▪ Thirty-five individuals at medium risk for choking did not have a PNMP and/or dining plan (i.e., Individual #412, Individual #305, Individual #105, Individual #209, Individual #502, Individual #246, Individual #440, Individual #248, Individual #50, Individual #144, Individual #84, Individual #371, Individual #427, Individual #151, Individual #509, Individual #191, Individual #141, Individual #30, Individual #4, Individual #99, Individual #56, Individual #363, Individual #324, Individual #95, Individual #207, Individual #481, Individual	Noncompliance

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		#323, Individual #405, Individual #444, Individual #273, Individual #365, Individual #159, Individual #522, Individual #87, and Individual #224. Based on the examples presented above, some individuals who had been identified as not having a PNMP did, in fact, have PNM needs and might require a PNMP. **Physical and Nutritional Management Team Referral Process** Individuals in Sample O.1 were reviewed to determine if they met the State PNM policy criteria for referral to the PNMT. The review found that three of nine individuals (i.e., Individual #33, Individual #353, and Individual #344) (33%), who should have been referred, were appropriately referred to the PNMT based on the criteria included in the Facility policy. More specifically: ▪ Five individuals (i.e., Individual #418, Individual #378, Individual #55, Individual #443, and Individual #452) did not meet the referral criteria. ▪ Three individuals (i.e., Individual #33, Individual #353, and Individual #344) were referred and/or reviewed by the PNMT based on the referral criteria. ▪ Six of the individuals met the referral criteria and should have been referred to the PNMT, but were not (i.e., Individual #26, Individual #411, Individual #86, Individual #253, Individual #525, and Individual #142). ▪ The Monitoring Team could not determine if Individual #392 met the referral criteria, as her pressure ulcer did not have a stage classification. None of the nine (0%) individual records reviewed indicated that when an individual experienced a change in status that would initiate a referral to the PNMT, there was evidence of an IDT referral to the PNMT within five working days of the ISPA meeting. For the three individuals referred to the PNMT as noted above, documentation did not reveal that a referral had been made within five working days of an ISP and/or ISPA meeting. As stated above, six of these nine individuals had not been referred to the PNMT although they met PNMT referral criteria. These timeframes should be followed, but actions that are identified earlier or require more expedient implementation should be implemented as they are identified. Three of three (100%) individuals (i.e., Individual #27, Individual #226, and Individual #386) who received a feeding tube (not on an emergency basis), since the last Monitoring Team review had been referred to the PNMT prior to the placement of the tube. Based on interview, no individual had received an emergency feeding tube placement since the last review. However, if any had, then the Monitoring Team would have assessed whether they had been referred to the PNMT after the emergency feeding tube placement.	

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		PNMT Assessment For the individuals in Sample #P.2, two of nine (22%) PNMT assessments (i.e., Individual #3 and Individual #17) were initiated at a minimum within five working days of the referral (or sooner as specified in the PNMT policy). Three of nine (33%) PNMT assessments (i.e., Individual #297, Individual #3, and Individual #17) were completed in no less than 30 days of the date initiated, or no more than 45 days in extenuating circumstances (i.e., critical diagnostics requiring outside appointments, hospitalization, etc. with clearly stated rationale). These timeframes should be followed, but actions that are identified earlier or require more expedient implementation should be implemented as they are identified. Based on review of individuals' records, the comprehensiveness of the PNMT assessment components were as follows: ▪ Three of nine (33%) (i.e., Individual #297, Individual #3, and Individual #17) contained date of referral by the IDT. The remaining assessments did not include the date of referral by the IDT and/or PNMT; ▪ Eight of nine (89%) (i.e., Individual #524, Individual #255, Individual #226, Individual #385, Individual #297, Individual #493, Individual #3, and Individual #17) contained the date the assessment was initiated; ▪ Nine of nine (100%) contained evidence of review and analysis of the individual's medical history; ▪ None of nine (0%) identified the individuals' current risk rating(s), including the current rationale. The PNMT assessments identified the individuals' risk ratings, but did not include the rationales; ▪ None of nine (0%) included updated risk ratings based on the PNMT's assessment and analysis of relevant data. The assessments identified an individual's risk ratings, but did not include a discussion of the PNMT's rationale; ▪ None of nine (0%) contained evidence of discussion of the individual's behaviors on the provision of PNM supports and services, including problem behaviors and skill acquisition; ▪ None of nine (0%) contained assessment of current physical status. The assessments did not include a section and/or discussion of an individual's physical status; ▪ None of nine (0%) contained assessment of musculoskeletal status. The assessments did not include a section and/or discussion of the assessment results of an individual's musculoskeletal status; ▪ None of nine (0%) contained evaluation of motor skills. The assessments did not include a section and/or discussion of the assessment results of an individual's motor skills;	

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		▪ None of nine (0%) contained evaluation of skin integrity. The assessments did not include a section and/or discussion of the assessment results of an individual's skin integrity; ▪ None of nine (0%) contained evaluation of posture and alignment in bed, wheelchair, or alternate positioning, including during bathing and oral hygiene; ▪ None of nine (0%) contained evaluation of current adaptive equipment. The assessments did not include a section and/or discussion of the assessment results on the effectiveness of an individual's current adaptive equipment; ▪ None of nine (0%) contained nutritional assessment, including, but not limited to, history of weight and height, intake, nutritional needs, and mealtime/feeding schedule. The assessments did not include the individual's history of height; ▪ None of nine (0%) contained evaluation of potential or actual drug/drug and drug nutrient interactions; ▪ None of four (0%) identified residual thresholds, if enterally nourished. PNMT assessments indicated that five individuals within the sample ate orally (i.e., Individual #524, Individual #226, Individual #493, Individual #3, and Individual #17); ▪ Two of nine (22%) (i.e., Individual #524 and Individual #3) contained a tableside oral motor/swallowing assessment, including but not limited to mealtime observation; ▪ One of nine (11%) (i.e., Individual #7) contained respiratory status. The remaining assessments did not include a section and/or discussion of the assessment results of respiratory status; ▪ None of nine (0%) contained evidence of review/analysis of lab work. The assessments listed lab results, but did not include a review and/or analysis of the lab work; ▪ None of nine (0%) contained evidence of review/analysis of medication history over the last year and current medications, such as changes, dosages, administration times, and side effects; ▪ None of nine (0%) contained discussion as to whether existing supports were effective or appropriate; ▪ One of nine (11%) (i.e., Individual #226) contained oral hygiene status; ▪ Three of nine (33%) (i.e., Individual #7, Individual #524, and Individual #255) contained evidence of observation of the individual's supports at their residence and day/work programs; ▪ Eight of nine (89%) (i.e., Individual #7, Individual #524, Individual #255, Individual #226, Individual #297, Individual #493, Individual #3, and Individual #17) contained evidence that the PNMT conducted hands-on assessment; ▪ Seven of nine (78%) (i.e., Individual #7, Individual #226, Individual #385, Individual #297, Individual #493, Individual #3, and Individual #17) identified the potential causes of the individual's physical and nutritional management	

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		problems; ▪ None of nine (0%) identified the physical and nutritional interventions and supports that were clearly linked to the individual's identified problems, including an analysis and rational for the recommendations; ▪ None of nine (0%) contained recommendations for measurable skill acquisition programs, as appropriate; ▪ None of nine (0%) contained the establishment and/or review of individual-specific clinical baseline data to assist teams in recognizing changes in health status; ▪ None of nine (0%) contained measurable outcomes related to baseline clinical indicators, including but not limited to when nursing staff should contact the PNMT; ▪ None of nine (0%) contained evidence of revised and/or new interventions initiated during the 30-day assessment process (i.e., revision of the individual's PNMP); and ▪ Four of nine (44%) (i.e., Individual #7, Individual #524, Individual #226, and Individual #3) contained recommendations for monitoring, tracking or follow-up by the PNMT; and ▪ Two of the nine (22%) (i.e., Individual #3 and Individual #17) contained signatures with dates. Individuals should, at a minimum, be provided with a comprehensive PNMT initial assessment upon referral that covers all the components listed below. **<u>Integration of PNMT Recommendations into IHCPs and/or ISPs</u>** For none of the nine (0%) individuals, all recommendations by the PNMT were addressed and/or integrated in the ISPA, Action Plans, IRRFs and IHCPs. Plans resulting from PNMT recommendations included the following components: ▪ In none of the nine (0%) individuals' plans reviewed, the plans addressed the individual's identified PNM needs as presented in the PNMT assessment. The individuals' plans were not integrated into IHCPs. The IHCPs should have included specific and measurable steps that incorporated relevant clinical interventions and addressed recommendations discussed in the individual's PNMT assessment to minimize the individual's identified PNM problems. The PNMT action plan (i.e., integrated into the IHCP) should have included interventions across the 24-hour day, seven days a week to be implemented by PNMT members, nursing staff, direct support professionals and other staff as identified. There should be interventions developed and implemented within relevant risk areas to minimize these risk conditions. Preventative interventions should address the etiology of the problem, and be written in measurable terms.	

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		▪ For none of the nine (0%) individuals for whom HOBE assessments were conducted, the HOBE recommendations were integrated into individuals' plans. Individuals had HOBE assessments; however, the recommendations from these plans were not consistently integrated into IHCPs. ▪ In none of the nine (0%) individuals' plans reviewed, there were appropriate, functional, and measurable objectives to allow the PNMT to measure the individual's progress and efficacy of the plan. The IHCPs did not include appropriate, functional and measurable objectives. "Appropriate" is defined as objectives that are relevant to the PNM problem, and "functional" means, when appropriate, objectives that increase an individual's independence. ▪ In none of the nine (0%) individuals' plans reviewed, there were established timeframes for the completion of action steps that adequately reflected the clinical urgency. A review of PNMT action plans indicated that some of the recommendations were assigned timeframes, but other action steps did not have established timeframes. ▪ In none of the nine (0%) individuals' plans reviewed, the plans included the specific clinical indicators of health status to be monitored. ▪ In none of the nine (0%) individuals' plans reviewed, the plans defined triggers. Some plans identified triggers, however, there were risk areas where triggers were not identified. ▪ In none of the nine (0%) individuals' plans reviewed, the frequency of monitoring was included in the plans. **PNMT Follow-up and Problem Resolution** With regard to plan implementation: ▪ In none of nine (0%) individuals' documentation reviewed, supporting documentation was present to confirm implementation of individuals' action plans within 14 days, or sooner as needed, of the plan's finalization. A review of PNMT action plans indicated that some of the recommendations were addressed in a timely manner. However, there were recommendations that were not addressed with the necessary sense of urgency. ▪ In none of the nine (0%) individuals' plans reviewed, documentation was provided to show action plan steps had been completed within established timeframes, nor were IPNs/monthly reports provided with an explanation for any delays, including a plan for completing the action steps. **Individuals Discharged by the PNMT** Review of five individuals' discharge summaries (i.e., Individual #27, Individual #80, Individual #70, Individual #409, and Individual #498) developed by the PNMT and ISPAs found: ▪ Five of the five (100%) individuals had a meeting with the PNMT and IDT to	

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		discuss the discharge of the individual from the PNMT to the IDT. There was documentation of a joint meeting between the PNMT and IDT, but the meeting was not documented as an ISPA. As a result, it was not clear that the meeting had resulted in changes to the individuals' ISP, as appropriate. ▪ Three of the five (60%) (i.e., Individual #409, Individual #498, and Individual #70) individuals' discharge summary/action plans provided objective clinical data to justify the discharge. ▪ None of the five (0%) individuals' ISPA meeting documentation provided evidence that any new recommendations, as appropriate, were integrated into the IHCP. As noted above, it was unclear whether or not individuals' ISPs were appropriately modified through an ISPA. ▪ Two of the five (40%) (i.e., Individual #498 and Individual #70) individuals' action plans included criteria for referral back to the PNMT if they differed from the criteria included in the PNMT policy. In summary, the PNMT should ensure assessments, IHCPs, and discharge summaries include the necessary components discussed within this section. The Facility's PNMT audit tools should assess the quality of PNMT work products and incorporate the necessary components of assessments and plans. The Facility remained out of compliance with this provision.	
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** None of the 15 (0%) individuals' annual ISPs in Sample O.1 noted that the appropriate disciplines were present to approve and integrate the PNMP in the ISP. Individuals' annual ISP meetings lacked attendance by appropriate disciplines and/or there was not adequate justification in the ISP Preparation meeting documentation to support non-attendance of therapists and/or dieticians. 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. Per current State Office policy, each individual's team should decide which team members should attend the annual meeting. For individuals with therapeutic needs, teams will need to provide clear justification if they decide that therapists involved in the individuals' care and treatment do not need to attend. In assessing this requirement, the Monitoring Team reviewed the ISP Preparation Meeting documentation that should have included such documentation, as well as the ISP sign-in sheets. None of 15 (0%) individual's PNMPs in Sample O.1 were reviewed by the individual's IDT in the annual ISP meeting. Individuals' ISPs would state the PNMP was reviewed, but there was no evidence that the teams addressed the effectiveness of the PNMP and/or discussed any updates and/or revisions to an individual's PNMP. This needed to include evidence of review, update/revision, effectiveness, and specified changes required with	Noncompliance

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		rationale. **PNMP Format and Content** A review of 24 individuals' PNMPs in Sample O.1 (15 individuals) and O.2 (nine) individuals) found the following: ▪ PNMPs for 24 of 24 (100%) individuals were current within the last 12 months. ▪ PNMPs for three of 24 (13%) (i.e., Individual #83, Individual #142, and Individual #452) individuals included a list of all high-risk levels, individual triggers, and outcomes. The primary missing component from the PNMPs reviewed was outcomes. ▪ In two of 24 most current PNMPs (8%) (i.e., Individual #3 and Individual #17) there were large and clear photographs with instructions. ▪ Fourteen of 24 (58%) PNMPs (i.e., Individual #418, Individual #378, Individual #26, Individual #55, Individual #411, Individual #443, Individual #86, Individual #33, Individual #344, Individual #353, Individual #142, Individual #452, Individual #3, and Individual #17) listed the adaptive equipment required by the individual with rationale. ▪ In none of 19 (0%) PNMPs for individuals who used a wheelchair as their primary mobility, positioning instructions for the wheelchair, including written and pictorial instructions were provided. The PNMPs reviewed for individuals who used wheelchairs as their primary mobility did not include written and/or pictorial instructions for staff to achieve safe elevation ranges, and/or the frequency of re-positioning. Five individuals in the samples (i.e., Individual #418, Individual #411, Individual #142, Individual #3, and Individual #17) did not use wheelchairs as their primary mobility. ▪ In none of 19 (0%) PNMPs, positioning was adequately described per the individuals' assessments. A review of individual's OT/PT assessments showed they did not provide a description of alternate positioning, which should include safe elevation ranges, alternate, bedtime, other positioning as indicated, and as appropriate, non-foundational/individual-specific instructions. ▪ In 23 of 24 (96%) PNMPs, the type of transfer was clearly described, or the individual was described as independent. Individual #17's transfer was not described. ▪ In 12 of 24 (50%) PNMPs (i.e., Individual #418, Individual #26, Individual #55, Individual #411, Individual #86, Individual #253, Individual #142, Individual #392, Individual #385, Individual #493, Individual #3, and Individual #17), bathing instructions were provided. For these individuals, instructions included bathing equipment, strategies, independence, and level of staff assistance required. ▪ In five of 24 (21%) PNMPs, (i.e., Individual #418, Individual #26, Individual #411, Individual #142, and Individual #385), toileting-related instructions were	

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		provided, including check and change. For the remaining 19 individuals, there were no instructions provided to identify the level of independence and level of staff assistance required during toileting. ▪ In 24 of 24 (100%) PNMPs, handling precautions or movement techniques were provided for individuals who were described as requiring assistance with mobility or repositioning. ▪ In 24 of 24 (100%) PNMPs/dining plans, instructions related to mealtime were outlined, including for those who received enteral nutrition. ▪ Fourteen of 24 individuals' (58%) (i.e., Individual #26, Individual #411, Individual #86, Individual #253, Individual #344, Individual #525, Individual #353, Individual #392, Individual #452, Individual #524, Individual #226, Individual #493, Individual #3, and Individual #17) Dining Plans were current within the last 12 months. ▪ Twelve of 24 individuals had feeding tubes with no oral intake (i.e., Individual #378, Individual #55, Individual #443, Individual #253, Individual #33, Individual #452, Individual #7, Individual #255, Individual #226, Individual #385, Individual #297, and Individual #493). o Twelve of 12 (100%) PNMPs/dining plans indicated the individual was to receive nothing by mouth. ▪ In seven of 24 (29%) PNMPs/dining plans (i.e., Individual #418, Individual #86, Individual #344, Individual #525, Individual #392, Individual #3, and Individual #17), position for meals or enteral nutrition was provided via photographs, and the pictures were large enough to show sufficient detail. ▪ In 12 of 12 (100%) PNMPs/dining plans for individuals who ate orally (i.e., Individual #418, Individual #26, Individual #411, Individual #86, Individual #344, Individual #525, Individual #353, Individual #524, Individual #142, Individual #392, Individual #3, and Individual #17), diet orders for food texture were included. ▪ In 12 of 12 (100%) PNMPs/dining plans for individuals who received liquids orally, the liquid consistency was clearly identified. ▪ In 12 of 12 (100%) PNMPs/dining plans for individuals who ate orally, dining equipment was specified in the mealtime instructions section, or it was stated that they did not have any adaptive equipment or used regular equipment, and the rationale was provided. ▪ In 23 of 24 (96%) PNMPs, medication administration instructions were included in the plan, including positioning, adaptive equipment, diet texture, and fluid consistency. Individual #392's PNMP did not include all of these components. ▪ In 24 of 24 (100%) PNMPs, oral hygiene instructions were included, including general positioning and brushing instructions. ▪ Twenty-four of 24 (100%) PNMPs included information related to communication (i.e., how individual communicated, and how staff should	

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		communicate with individual). **Change in Status Update for Individuals' PNMPs Conducted by the IDT/PNMT** For 13 individuals in Sample O.1 (i.e., 13 of 15 individuals: Individual #418, Individual #378, Individual #26, Individual #55, Individual #411, Individual #86, Individual #253, Individual #33, Individual #344, Individual #525, Individual #353, Individual #142, and Individual #392) and eight individuals in Sample O.2 (i.e., eight of nine individuals: Individual #7, Individual #255, Individual #226, Individual # 385, Individual #297, Individual #493, Individual #3, and Individual #17) for whom the IDT and PNMT identified changes needed to be made to the PNMP, none of 21 (0%) individuals had ISPA meeting documentation which noted the PNMP had been reviewed and revised, as appropriate, based on the individual's change in status. For individuals for whom the PNMP was revised, there was supporting documentation that none of the 21 (0%) individuals' revised PNMPs had been implemented. The Monitoring Team did not find evidence in ISPA meetings that the revisions were agreed upon and/or discussed the implementation of these PNMP revisions. Progress had been made since the last review with individuals' PNMPs having more of the necessary components. The Facility had developed and implemented a PNMP audit tool. In addition to further refining PNMPs, work was needed to ensure that IDTs were reviewing, discussing, and revising PNMPs, as necessary, and integrating them into ISPs. The Facility remained out of compliance with this provision.	
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** Staff did not engage in safe mealtime practices for individuals who ate orally and/or received enteral nutrition. Based on the Monitoring Team's observations, none of the 17 (0%) individuals (i.e., Individual #253, Individual #359, Individual #347, Individual #370, Individual #472, Individual #543, Individual #203, Individual #238, Individual #497, Individual #162, Individual #233, Individual #270, Individual #429, Individual #492, Individual #353, Individual #264, and Individual #54) dining plans were implemented as written. Based on observations: ▪ None of 12 (0%) individuals were positioned correctly in their seating systems (i.e., Individual #253, Individual #470, Individual #236, Individual #265, Individual #297, Individual #335, Individual #515, Individual #250, Individual #464, Individual #429, Individual #7, and Individual #353); ▪ None of nine (0%) individuals alternate positioning plans (i.e., Individual #255, Individual #524, Individual #27, Individual #3, Individual #353, Individual #359, Individual #53, Individual #91, and Individual #452) were implemented	Noncompliance

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		as written. ▪ None of one (0%) individual's PNMP (i.e., Individual #385) provided sufficient instructions for personal care in his day program. Staff were not able to discern if the mat table was at the prescribed elevation range. ▪ In none of two (0%) observations of medication administration (i.e., Individual #253 and Individual #236), the nurse followed procedures in the PNMP. The PNMP provides the foundation for health and safety. These observations completed by the Monitoring Team showed that staff were not competent and/or compliant in implementing foundational PNMP strategies. This was concerning in that the staff's failure to implement PNMPs was an overriding issue during the Monitoring Team's last onsite review, and, unfortunately, continued to be of significant concern during this review. The Facility should move forward with a sense of urgency to provide additional support to staff to enhance their competency in the implementation of PNMPs, most importantly, for those individuals at highest risk. In summary, the Facility should place a high priority on staff compliance with individuals' PNMPs. The Facility remained out of compliance with this provision.	
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** NEO orientation should contain the following elements: ▪ Lifting and transfers; ▪ Positioning (e.g., alternate, wheelchair, and bathing/showering); ▪ Adaptive equipment; ▪ PNMP orientation and implementation; ▪ Safe mealtime strategies; and ▪ Basics of dysphagia. At ABSSLC, the PNM related core competencies (i.e., foundational skills) were comprehensive. The Facility reported that new employees from November 2012 through April 2013 completed the following: ▪ 197 of 337 (58%) new employees completed lifting people; ▪ 288 of 337 (85%) new employees completed basic nutrition; ▪ 291 of 337 (86%) new employees completed physical management; and ▪ 292 of 337 (87%) new employees completed Preventing Aspiration. However, the data presented did not identify if these new employees had successfully completed the PNM competency performance check-offs for these classes. The Facility noted that not all of the 337 new employees would be required to take the	Noncompliance

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		PNM part of new employee orientation. However, the Facility did not indicate the number of new employees who would be required to complete PNM performance check-offs. The HT Department and/or staff development did not have a system to record new employees successful completion of the multiple PNM competency performance check-offs. **PNM Core Competencies for Current Staff** ABSSLC reported there was 659 current staff. The Facility reported staff had successfully completed the following PNM foundational training: ▪ 397 of 659 staff (60%) had completed hand care; ▪ 416 of 659 staff (63%) had completed physical management; and ▪ 440 of 659 staff (67%) had completed eating. Nine PNMP Coordinators and nine HT Technicians were approved PNM trainers. Nine of nine PNMP Coordinators (100%) and nine of nine (100%) HT Technicians responsible for training other staff had successfully completed PNM competency-based training and performance check-offs prior to training other staff. **Annual Refresher Training** The following metric could not be assessed: ▪ _____ of _____ current staff that require training have completed annual refresher competency-based training and performance check-offs within the last 12 months. The Facility reported that annual refresher training had not been initiated as the focus of campus-wide staff training had been on the new format for PNMPs. Annual refresher training was scheduled to begin in June 2013 following the completion of the PNMP new format training. The Monitoring Team will assess this during upcoming reviews. **Individual Specific Training** Staff should participate in an in-service to review PNMPs prior to their implementation. This should include all direct support professionals, including pulled/relief staff, responsible for specific individuals with physical or nutritional management problems, providing care that is affected by the PNMP. This review should consist of sharing of information about the core competencies (i.e., foundational skills) that are included in the PNMP. If more individualized supports are needed, further training should be provided, and is discussed in one of the metrics below. At the time of the review, the Facility therapists, PNMP Coordinators and Habilitation Therapy Technicians were focusing on providing PNM foundational competency-based training and performance check-offs for new PNMPs. The HT Department was not	

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		concentrating on individual-specific training. As a result, the following metrics could not be assessed: ▪ For ___ of ____ staff assigned to individuals with PNMPs in Sample O.1 and O.2, (%) there is evidence of exchange of the information included in the PNMP prior to the provision of services. ▪ For individuals in Samples O.1 and O.2, ____ of ____ (%) staff assigned had completed competency check-offs in all specialized components of their PNMPs (i.e., non-foundational skills) prior to the provision of services. Therapy staff responsible for training other staff had not completed competency-based training for the specialized components (i.e., non-foundational skills) of the individuals' PNMPs prior to training other staff on the PNMP/Dining Plan. At the time of the review, the approved trainers for individual-specific (i.e., non-foundational) training were nine PNMP Coordinators and nine Habilitation Therapies Technicians. The Facility did not have a process to validate that staff responsible for training other staff were competent to assess other staff's competency. The Facility had provided PNM foundational training to some new employees and veteran staff. However, additional work needed to be done to ensure all new employees and veteran staff successfully completed PNM foundational training. The Facility had not initiated PNMP individual-specific training. The Facility should ensure that staff working with individuals who require individual-specific PNMP strategies have successfully completed non-foundational competency-based training and performance check-offs. The Facility remained out of compliance with this provision.	
O6	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall monitor the implementation of mealtime and positioning plans to ensure that the staff demonstrates competence in safely and appropriately implementing such plans.	**Facility's System for Monitoring of Staff Competency with PNMPs** At the time of the Monitoring Team review, the Facility did not have a policy to define the monitoring system to test staff's implementation of PNMPs, including their competence. ▪ Monitoring tools did not include adequate indicators to determine whether or not "staff demonstrates competence in safely and appropriately implementing" mealtime and positioning plans. ▪ Monitoring tools did not include adequate instructions. ▪ The staff conducting monitoring were not competent in the areas they were monitoring. The Facility did not present evidence that the monitors had: a) successfully completed individual-specific competency-based training; b) successfully completed training on use of monitoring forms; c) been validated by clinicians on completion of monitoring forms; and d) were periodically revalidated. Moreover, the HT Department indicated during interviews that monitoring data was not	Noncompliance

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		reliable, and as a result, changes had been initiated to the monitoring process. Based on interview with therapists, the high compliance monitoring scores were not reflective of staff performance. A Facility SLP had developed additional indicators to be monitored for meal/snack and positioning compliance. For example, prior to a monitor scoring if staff were implementing a dining plan as written and/or instructed, the monitor had to assess the following seven additional components: ▪ Person positioned correctly and repositioned as needed throughout meal/snack; ▪ Staff positioned correctly; ▪ Correct food and liquid texture/consistency; ▪ Dietary instructions being followed; ▪ Adaptive equipment being utilized as per dining plan; ▪ All mealtime strategies on PNMP/Dining Plan being followed; and ▪ Positioned correctly after meal/snack. In addition, the SLP was working with three monitors to establish inter-rater agreement with the revised meal/snack and positioning indicators on the compliance monitoring form. Based on interview, indicators for medication administration, oral care, bathing, communication, programming, and lifting/transfer indicators were to be expanded. In addition, therapists were to establish inter-rater agreement with all PNM monitors. These revisions to the PNM monitoring process were a positive step in redefining the PNM monitoring system to provide more reliable data. Monitoring tools should have instructions. "Adequate" instructions would describe the methods as well as criteria for monitoring to ensure consistency across staff responsible for monitoring. In addition, the Facility should be able to present evidence that the monitors are competent based on the five indicators discussed above. The HT Department presented multiple documents that reported on monitoring results. For example, overall level of compliance by home and monitor. However, the monitoring data was not sufficient to allow meaningful analysis of monitoring results. The following concerns were noted: ▪ Data was provided for "Overall Level of Compliance by home for Hab Therapies monitoring with a date range of 2/1/13 to 4/19/13." However, this data did not identify what type of monitoring had occurred and/or the frequency of monitoring (i.e., meal/snack, positioning, oral care, bathing, medication administration, lifting/transfers, etc.). ▪ Data was provided for "Overall Level of Compliance by monitor for Hab Therapies monitoring with a date range of 2/1 to 4/19/13." The Facility should present inter-rater agreement scores for monitors to validate the accuracy of their compliance scores. ▪ The report stated: "Overall Level of Compliance for Hab Therapies Monitoring	

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		was 88%." A cumulative compliance score did not provide information to allow the Facility to discern where there were problem areas. ▪ Data was provided for "Overall Level of Compliance for the total PNM audits for each of the ten questions on the compliance monitoring form." The different types of PNM audits were not defined. For example, the HT Department would not be able to discern if there were areas of concern with staff implementation of bathing strategies. The Monitoring Team was not able to assess if the PNMP monitoring process covered all areas that were likely to provoke swallowing difficulties or increase PNM risk. In future reports, the following indicators will be assessed: ▪ ____ of the ____ monitoring forms focused on oral intake (meals and snacks); ▪ ____ of the ____ monitoring forms focused on bathing; ▪ ____ of the ____ monitoring forms focused on medication administration; ▪ ____ of the ____ monitoring forms focused on oral care; and ▪ ____ of the ____ monitoring forms focused on positioning. ▪ ____% occurred during first shift; ▪ ____% occurred during second shift; and ▪ ____% occurred during third shift. In order addresses various types of risk, for the first five indicators, approximately 50 to 60% of monitoring should occur during meals, including individuals that are enterally nourished, with others evenly distributed; and monitoring should occur across all three shifts, with approximately 15% on third shift, and evenly distributed across first and second shifts. The Facility should re-evaluate how monitoring data is displayed and reports developed. **Monitoring for Individuals in Samples** The Monitoring Team was not able to score the following two metrics as the frequency of monitoring was not established in policy and/or assessments did not indicate the frequency of monitoring: ▪ For _____ of the ____ (%) individuals in Sample O.1, did the frequency of PNM compliance monitoring over the past three months occur as per the individuals' assessment and/or the individuals' plans/IHCPs. ▪ For the three months prior to the review, ____ (0%) of the monitoring sessions per policy or the individuals' assessments and/or plans were completed timely. For none of nine (0%) individuals in Sample O.2, did the frequency of PNM compliance monitoring over the past three months occur as per the individuals' PNMT assessment and/or the individuals' plans/IHCPs.	

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		Monitoring should occur according to the schedule identified in policy and/or as individualized in the assessment and/or plan. In cases where the individual's clinical acuity necessitates a higher frequency of monitoring, it should occur at this frequency. Based on interview, the Director of HT and therapists were not confident in the accuracy of monitoring results. For example, monitoring results reviewed for the past three months noted only one compliance score that fell below 80 percent. Individual #353's staff was monitored during presentation of a snack and received a score of 70 percent. The plan was to complete a follow-up observation, which was completed. However, this plan was not adequate. ▪ For the past three months, problems were noted on one of the multiple monitoring forms. ▪ Of these, documentation of adequate follow-up was not provided on the one form for Individual #353 (0%). The Monitoring Team will assess this during upcoming reviews. The Facility should ensure that for individuals whose monitoring scores fall below 80 percent, plans are implemented to address staff noncompliance. "Adequate follow-up" should include plans with specific action steps that are measurable, and can be reasonably expected to correct the deficiency noted. The follow-up documentation should be included on the monitoring form. In addition, the Facility should be able to present cumulative monitoring data to substantiate compliance with these metrics. As noted with regard to Section O.4 and this section, the Monitoring Team and the Facility did not have confidence in Facility's monitoring data. The monitoring data did not accurately reflect staff implementation of PNMP mealtime strategies. Additionally, observations the Monitoring Team completed in dining rooms and residences indicated staff were not correctly implementing dining plans for individuals who received enteral nutrition and/or ate orally, or other PNMP strategies. 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;	

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		▪ Identification of PNM risk factors with high and/or medium risk ranking (i.e., aspiration pneumonia, respiratory compromise, choking) that 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 demonstrate repeated staff non-compliance with PNMPs and therapy programs. In summary, the Facility should develop and implement a PNM monitoring policy, which includes the necessary components listed within this section. The HT Department was monitoring staff PNMP compliance, but additional work was needed. Based on interviews with the HT Director and therapists, there was no confidence in the accuracy of the monitoring data and the Monitoring Team agreed with this assessment. The Facility had made revisions to the monitoring form indicators for meals/snacks and positioning to address these concerns, which was positive. The HT Department planned to expand indicators for all the PNM monitoring areas. In addition, PNM monitors should achieve inter-rater agreement with an established threshold. The Facility remained out of compliance with this provision.	
O7	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement a system to monitor the progress of individuals with physical or nutritional management difficulties, and revise interventions as appropriate.	**<u>IDT and PNMT Monitoring to Assess Individual's Progress and/or Effectiveness of Plans</u>** None of the 24 (0%) individuals' records in Sample O.1 and O.2 contained evidence of indicators integrated as part of the IHCPs to assess the individuals' PNM status. None of the 24 (0%) individuals' records in Sample O.1 and O.2 contained evidence that the progress and status of individuals with PNM difficulties and the effectiveness of the individuals' plans were monitored based on objective clinical data identified in the individuals' IHCPs/risk action plans. For none of the two (0%) individuals (i.e., Individual #392 and Individual #26) receiving direct therapy, the record contained evidence that documentation was reviewed of the plan's effectiveness based on objective clinical data included in the plan. Because plans did not include clinical indicators to alert teams to changes in status, the following metric could not be evaluated, but will be during upcoming reviews: ▪ _____ of the _____ individuals' records showed a change of status based on the	Noncompliance

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		established clinical indicators. Of these, ___ (__%) contained evidence that, as appropriate, the team met and interventions were reviewed and changed, as appropriate in a timely manner. Trigger sheets and supporting documentation was reviewed for individuals in Sample O.2. ▪ None of nine (0%) individuals' records included evidence that the team discussed the need for and developed individualized triggers as appropriate to the clinical needs of the individual. A review of IRRFs and PNMT assessments did not reveal a discussion of the need for individualized triggers for individuals at high risk. ▪ None of nine (0%) individuals' Trigger sheets included individualized triggers as indicated. The trigger sheets reviewed had general triggers, but they were not individualized. In addition, individualized triggers on PNMPs were not reflected on trigger sheets. ▪ None of nine (0%) individuals' Trigger sheets were completed correctly. A review of triggers sheets revealed gaps in documentation on the three shifts. ▪ None of nine (0%) individuals' Trigger sheets were reviewed by the RN on a daily basis. A review of trigger sheets revealed gaps in documentation by nursing. In summary, the Facility should implement an effectiveness monitoring system that includes tracking of individualized clinical indicators and triggers to evaluate and report on the individuals' progress, and revise interventions, as appropriate. The Facility remained out of compliance with this provision.	
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.	**Assessment of Individuals Who Receive Enteral Nourishment** The Facility maintained a list of individuals who received enteral nourishment. However, a Facility policy and/or procedure did not define how the list of individuals who receive enteral nutrition would be maintained and updated as individuals received a feeding tube and/or transitioned to oral eating. Based on a review of the individuals in Sample O.3, eight of eight (100%) individuals (i.e., Individual #378, Individual #55, Individual #443, Individual #253, Individual #33, Individual #184, Individual #454, and Individual #262) who receive enteral nutrition were evaluated at a minimum annually. Individual #467 received her feeding tube in August 2012, and so an annual evaluation was not yet due. None of the eight (0%) individuals evaluated had an appropriate evaluation to determine the medical necessity of the tube. In order to determine medical necessity of enteral nutrition, documentation should include the following areas:	Noncompliance

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		▪ Nutritional assessment of current type of formula and schedule; ▪ Identification of primary medical diagnoses that contributes to the need for non-oral means of nutrition; and ▪ Assessment of Oral Motor status by SLP and/or OT to provide comparative analysis and safety of intake or development of an oral motor treatment plan, as appropriate. Two of the seven individuals (i.e., Individual #233 and Individual #255), admitted since the last Monitoring Team review received enteral nourishment. ▪ None of the two (0%) individuals who received enteral nourishment and were admitted since the last review had a review of the medical necessity of the feeding tube within 30 days. **<u>Pathway to Return to Oral Intake and/or Receive a Less Restrictive Approach to Enteral Nutrition</u>** None of the eight (0%) individuals in Sample O.3 who receive enteral nutrition were appropriately evaluated by the IDT to determine if a plan to return to oral intake was appropriate. All individuals receiving enteral nutrition should be assessed annually by the IDT to determine if improvements can be made to progress towards a less restrictive diet. This means the individual should be: ▪ Assessed by the SLP and/or OT regarding oral motor status with a clear determination of whether the individual is a candidate for an oral motor treatment program to improve potential not only for by mouth (PO) intake but for improved saliva control. Justification for/or against oral motor treatment or potential PO intake should be included as part of assessment findings. ▪ Assessed by the Nutritionist/Dietitian regarding current formula and schedule of feedings and determine if there is a possibility for modification to the least restrictive schedule. Justification for/or against medication of formula/schedule should be included as part of assessment findings. None of the three (0%) individuals (i.e., Individual #184, Individual #262, and Individual #467) who were identified as potentially benefitting from oral motor treatment or cleared to return to some form of oral intake had a comprehensive plan outlining the treatment or return to PO process. Based on information provided by the Facility, none of the three individuals had plans. The plan should include all of the following components: ▪ Staff training required prior to implementation; ▪ Staff roles and responsibilities (e.g., implementation and monitoring); ▪ Time and schedule of interventions; ▪ Specific triggers for when the plan should be stopped; ▪ Milestones for progressing with the plan;	

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		▪ Documentation requirements (i.e., method for tracking progress); and ▪ Frequency of subsequent assessments and staff responsible. As a result, the following metrics were not evaluated, but will be, as applicable, during the upcoming reviews: ▪ ____ of the ____ (%) individuals' plans to return to oral eating were based on the results of the IDTs' discussion and integrated in the IHCP, ISP, and/or an ISPA. The IRRF should provide clinical assessment data to identify an individual's potential to return to oral eating and provide justification for the medical necessity of the feeding tube. Any plan the IDT develops should be memorialized in an IHCP that is part of the ISP, and/or documented in an ISPA. ▪ ____ of the ____ (%) individuals' plans to return to oral eating in the IHCP related to enteral nutrition were implemented in a timely manner. The IHCPs should include timeframes consistent with the clinical needs of the individual. The IHCPs should be implemented according to the timeframes included, unless a reasonable explanation is provided. ▪ ____ (%) of the staff responsible for implementation of these oral intake plans were competent to do so through competency-based training conducted by a licensed clinician with specialized training in PNM. Training conducted by the licensed clinician would include a return demonstration. ▪ ____ of the ____(%) individuals' plans were monitored as outlined in the plan. Individuals' plans should be monitored to meet the frequency and requirements in the plan and should be conducted by monitors with demonstrated competency in the plan. ▪ ____ of ____ (%) individuals' plans were modified by the IDT. For ___ (___%) of these individuals' plans, the IDT met, reviewed and changed interventions, as appropriate, in a timely manner. Individuals' plans should be reviewed by the IDT to determine if the plan is being implemented as written, staff are adequately trained, etc. In addition, if the team determines interventions are not effective, the IDT should revise these interventions. Plans should be revised within 24 hours or sooner if is a critical concern, when a change is indicated such as for a change in status or based on effectiveness monitoring findings. In summary, the Facility remained out of compliance with this provision. The HT Department maintained and updated a list of individuals who received enteral nutrition. However, this process was not captured in Facility policy and/or procedure. Individuals in the sample who received enteral nutrition were reviewed by the IDT, but the annual assessment did not include necessary components. Individuals who were transitioning to oral eating did not have a formal oral intake plan that includes the necessary components described in this section.	

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

1. The Facility PNMT policy should incorporate the necessary components listed in Section O.1. (Section O.1)
2. Individuals' PNMT assessments, action plans/IHCPs, and discharge summaries should include the necessary components discussed with regard to Section O.2. (Section O.2)
3. The Facility PNM policy should define the PNMT process. (Sections O.1 and O.2)
4. The Facility should ensure individuals' PNMPs contain necessary components as discussed with regard to Section O.3. (Section O.3)
5. 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)
6. Per State Office policy, each individual's team should decide which team members should attend the annual meeting. For individuals with therapeutic needs, teams will need to provide clear justification if they decide that therapists involved in the individual's care and treatment do not need to attend. (Section O.3)
7. The PNMT and IDT members should provide additional support to staff to enhance their competency in the implementation of PNMPs, particularly for those individuals at highest risk. (Section O.4)
8. The Facility should ensure staff working with individuals who have individual-specific PNMP strategies (i.e., non-foundational), have successfully completed competency-based, individual-specific training and performance check-offs. (Section O.5)
9. The Facility should assess the success of revisions to the monitoring system. Part of this analysis should assess if the monitoring activities produce valid and reliable data to determine staff competence and compliance in safely and appropriately implementing PNMPs and dining plans. If not, continued revisions should be made to the form(s) and/or instructions, and/or additional training should be provided to those implementing the forms. (Section O.6)
10. The Facility should implement an effectiveness monitoring system to evaluate and report on the individuals' progress, and revise interventions as appropriate. (Section O.7)
11. The Facility should formalize the process and maintain an accurate list(s) of individuals who receive enteral nutrition. (Section O.8)
12. Individuals who receive enteral nutrition should receive an assessment that includes the necessary components discussed with regard to Section O.8. (Section O.8)
13. Individuals who are recommended for and/or are transitioning to oral eating should have a plan developed that includes the necessary components listed in Section O.8. (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 For the following 15 individuals, including individuals identified with PNM concerns, and/or who had experienced a change of status as evidenced by admission to the emergency room, and/or hospital, and/or received direct therapy intervention(s): (i.e., Individual #418, Individual #378, Individual #26, Individual #55, Individual #411, Individual #443, Individual #86, Individual #253, Individual #33, Individual #344, Individual #525, Individual #353, Individual #142, Individual #454, and Individual #392), 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 issues, 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; 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 the Monitoring Team's last onsite visit; o List of individuals who use a wheelchair as primary mobility; o List of individuals with transport wheelchairs; o List of individuals with other ambulation assistive devices; o List of individuals with orthotics and/or braces;

	○ Physical Nutritional Management Maintenance Log; ○ OT/PT Assessments and Updates (templates) with changes made since the Monitoring Team's last review; ○ Tracking Log of completed individual assessments; ○ Wheelchair seating and PNM clinic assessment (templates); ○ Compliance Monitoring form template; ○ Competency-based performance check-off sheets for PNM core competencies and individual-specific PNMPs along with dining plans and other intervention plans; ○ OT/PT assessments for new admissions completed after the submission of the pre-document request; ○ 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, Director of Habilitation Therapies; ○ Amy Gleaton, PNMT Coordinator, PNMT OT and Lead OT; ○ Karen Mayfield, PT, Doctor of Physical Therapy, Lead PT; ' ○ Luke Palmer, PT, DPT; ○ Lindsey Tierce, PT, DPT; ○ Sherri Ryan, OTR Contract; and ○ Leslie Riggins, SLP Assistant; ▪ **Observations of**: ○ Individuals in the Infirmary, residences and dining rooms.
	Facility Self-Assessment: Facility Self-Assessment: The Facility submitted a Self-Assessment for Section P, dated 4/13/13. In its Self-Assessment, for each subsection, 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: ▪ Based on a review of the Facility Self-Assessment, various monitoring/audit templates and instructions/guidelines, a sample of completed monitoring/audit tools, inter-rater reliability data, as well as interviews with the Director of HT, Section P Lead, and Program Compliance Monitor: ○ The Facility recently had developed a new monitoring tool for Section P. This monitoring tool incorporated some of the compliance indicators/metrics used in the Monitoring Team's previous reports. The HT Department had used the revised tool during the past month. The revision of the monitoring tool was a positive development. The Facility is encouraged to review the Monitoring Team's report to identify additional indicators/metrics that are relevant to making compliance determinations. ○ The monitoring tool included adequate methodologies, such as observations, record review, and staff interview. ○ The Self-Assessment identified the sample(s) sizes. However, the Self-Assessment did not identify how the sample was chosen. The Facility Self-Assessment should identify how sample sizes were chosen for each of the subsections, including sample sizes adequate to

	consider them representative. o The monitoring/audit tool did not have adequate instructions/guidelines to ensure consistency in monitoring and the validity of the results. On a positive note, the Director of HT and staff stated they would develop guidelines for the revised monitoring tool. o The following staff/positions were responsible for completing the audit tool: the Director of HT, therapy staff, and the PCM. o Adequate inter-rater reliability had not been established between the Director of HT, therapy staff, and the PCM. ▪ The Facility used other relevant data sources, including, for example, information from the HT Department database. ▪ The Facility presented some data in a meaningful/useful way, but in other instances more work was needed. Specifically, the Facility's Self-Assessment: o Presented 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 in compliance with none of the subsections in Section P. This was consistent with the Monitoring Team's findings. ▪ The Facility data identified areas in need of 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: With one exception, individuals newly admitted to the Facility received an OT/PT assessment within 30 days. However, individuals who had experienced a change in status had not received an assessment update. Overall, individuals' OT/PT assessments were missing many of the components necessary to fully assess an individual's OT/PT functional status, provide an analysis of whether or not current supports and services were effective, and as appropriate, recommend new services or skill acquisition programs to improve the individual's functioning, health, and/or independence. The OT/PT assessment template and audit tool should be reviewed to ensure the essential components for OT/PT assessments are incorporated. Individuals receiving direct OT/PT interventions did not have plans. As a result these plans and/or programs were not integrated into individuals' ISPs. In addition, there were no monthly progress notes reviewing the effectiveness of programs/interventions and the individuals' progress with direct and/or indirect OT/PT supports. As discussed with regard to Section O.6 and O.7, the Facility did not have an adequate monitoring system for OT/PT services. The Facility did not have a policy to define the monitoring system. A database for Assistive Equipment Work Orders had been developed to track the completion of work orders. The development of this database was step in the right direction to assess the timeliness of work orders. However, the database results had not been analyzed to identify the total number of work orders

	and the number of work orders that had been completed by the due date, and/or identify and resolve problematic areas in the completion of adaptive equipment work orders.

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P1	By the later of two years of the Effective Date hereof or 30 days from an individual's admission, the Facility shall conduct occupational and physical therapy screening of each individual residing at the Facility. The Facility shall ensure that individuals identified with therapy needs, including functional mobility, receive a comprehensive integrated occupational and physical therapy assessment, within 30 days of the need's identification, including wheelchair mobility assessment as needed, that shall consider significant medical issues and health risk indicators in a clinically justified manner.	**Definition of Samples** ▪ **Sample P.1** is the same as Sample O.1 that consisted of a non-random sample of 15 individuals (i.e., Individual #418, Individual #378, Individual #26, Individual #55, Individual #411, Individual #443, Individual #86, Individual #253, Individual #33, Individual #344, Individual #525, Individual #353, Individual #142, Individual #454, and Individual #392) who were chosen from a list provided by the Facility of individuals they identified as being at a medium or high risk of PNM related issues [i.e., aspiration, choking, falls, fractures, respiratory compromise, weight (over 30 or under 20 BMI), enteral nutrition, GI, and/or osteoporosis], required mealtime assistance, and/or were prescribed a dining plan, were at risk of receiving a feeding tube, and/or who had experienced a change of status in relation to PNM concerns (i.e., admitted to the Facility Infirmary, if applicable, emergency room and/or hospital). Individuals within this sample might have met one or more of the preceding criteria. ▪ **Sample P.2** consisted of two of the five individuals (i.e., Individual #26 and Individual #392) who received direct OT/PT services. **Timeliness of Assessments** Six of seven (86%) newly admitted individuals (i.e., Individual #211, Individual #233, Individual #239, Individual #248, Individual #255 and Individual #256) since the last review received an OT/PT assessment within 30 days of admission or readmission. Individual #222's OT/PT assessment had not been completed within 30 days of admission. None of 15 (0%) individuals' OT/PT assessments and/or updates were dated as having been completed at least 10 days prior to the annual ISP. Eleven of 15 (73%) (i.e., Individual #378, Individual #26, Individual #55, Individual #411, Individual #86, Individual #344, Individual #525, Individual #353, Individual #142, Individual #392, and Individual #452) individuals had received an assessment that was current within 12 months for individuals who were provided PNM supports and services. **OT/PT Assessment** Based on review of the sample of assessments for individuals in Sample P.1, the	Noncompliance

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		comprehensiveness of the OT/PT assessments was as follows: ▪ Twelve of 15 (80%) individuals' OT/PT assessments (i.e., Individual #418, Individual #378, Individual #26, Individual #55, Individual #253, Individual #33, Individual #344, Individual #525, Individual #353, Individual #142, Individual #392, and Individual #452) were signed and dated by both the OT and PT clinicians upon completion of the written report. ▪ None of 15 (0%) assessments included medical diagnoses and relevance to functional status. ▪ None of 15 (0%) assessments included medical history and relevance to functional status. The medical history refers to medical conditions that would impact the provision of OT and PT supports and services. ▪ One of 15 (7%) assessments (i.e., Individual #378) addressed health status over the last year. ▪ None of 15 assessments (0%) included a comparative analysis section that clearly analyzed the individuals' level of health status with previous years or assessments. The OT/PT assessment should provide an overview of an individual's health status over the past year and discuss the type of supports and services that have been implemented to minimize the impact on the individual's functional status. ▪ Ten of 15 (67%) (i.e., Individual #418, Individual #378, Individual #26, Individual #253, Individual #33, Individual #344, Individual #525, Individual #353, Individual #142, and Individual #392) assessments included a section that reported health risk levels that were associated with PNM supports. This information should be utilized for planning interventions and supports and for recommendations related to changes in the existing risk levels. ▪ Two of 15 (13%) (i.e., Individual #378 Individual #452) assessments listed medications and potential side effects relevant to functional status. ▪ Nine of 15 (60%) individuals' OT/PT assessments (i.e., Individual #418, Individual #378, Individual #26, Individual #344, Individual #525, Individual #353, Individual #142, Individual #392, and Individual #452) included individual preferences, strengths, and needs. The preferences listed should be derived from the Preferences and Strengths Inventory (or other relevant documents) developed by the individual's team. ▪ Four of 15 (27%) assessments (i.e., Individual #378, Individual #525, Individual #353, and Individual #142) included evidence of observations by OTs and PTs in the individuals' natural environments (i.e., day program, home, work). ▪ Fifteen of 15 (100%) individuals' OT/PT assessments 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 15 assessments (0%) included discussion of the current supports and	

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		services or others provided throughout the last year and effectiveness, including monitoring findings. ▪ Four of 15 (27%) assessments (i.e., Individual #26, Individual #525, Individual #353, and Individual #142) included a comparative analysis of current functional motor and activities of daily living skills with previous assessments that clearly analyzed the individuals' level of functional status with previous assessments. The OT/PT assessment should provide an overview of the past assessment results with the current assessment data for functional motor and activities of daily living skills. The assessment analysis should discuss the individual's performance and present data to support if the individual has remained the same, has improved, and/or has regressed within the areas of functional motor and activities of daily living. ▪ One of 15 (7%) assessments (i.e., Individual #26) included discussion of the individual's potential to develop new functional skills. The OT/PT assessment should discuss how an individual's current abilities could be enhanced by direct and/or indirect interventions, including skill acquisition programs. ▪ Fifteen of 15 (100%) assessments identified the need for direct or indirect OT and/or PT services, and provided recommendations for direct interventions and/or skill acquisition programs as indicated for individuals with identified needs. The OT/PT assessment analysis section should provide clinical justification related to recommendations for direct therapy interventions and/or skill acquisition programs. ▪ None of 15 (0%) assessments included a monitoring schedule. The OT/PT assessment should recommend a monitoring schedule for the upcoming year as these individuals had PNMPs. The therapist should describe the monitoring form(s) to be utilized. ▪ None of 15 (0%) assessments included a reassessment schedule. ▪ Fifteen of 15 (100%) individuals' OT/PT assessments made a determination about the appropriateness of transition to a more integrated setting. As required by State Office, therapists had included their opinion about whether or not the individual could effectively be supported in the community. If the therapist believed the individual could not be supported in the community, the therapist identified what supports the individual needs were missing in the community. ▪ None of 15 (0%) assessments recommended ways in which strategies, interventions, and programs should be utilized throughout the day. At the time of the review, the OTs and PTs were completing comprehensive assessments and assessment updates (i.e., assessment of current status). The Monitoring Team requested both. There were eight individuals (i.e., Individual #55, Individual #411, Individual #86, Individual #253, Individual #33, Individual #344, Individual #353, and	

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		Individual #142) who had experienced a change in status (i.e., hospitalization related to PNM concerns, fracture, skin breakdown, and/or unexplained weight loss) after the completion of these individuals' comprehensive OT/PT assessments. These individuals should have received an assessment update, but they did not. More specifically: ▪ Individual #55 was admitted to the hospital on 11/29/12 with an admitting diagnosis of respiratory distress and low oxygen saturation level of 88%. She had experienced a change in her health status, but an assessment update had not been completed. ▪ Individual #411 was discharged from the hospital on 10/23/12 with a fracture. He had not received an assessment update to address his change of status. ▪ Individual #86 was discharged from the hospital on 10/25/12 with multiple diagnoses and "mild" aspiration pneumonia. She did not receive an assessment update. ▪ Individual #253 was hospitalized from 2/24/13 to 3/5/13 with a discharge diagnosis of aspiration pneumonia. He had not received an assessment update. ▪ Individual #33's admitting diagnosis to the hospital on 2/22/13 was aspiration pneumonia. She had not received an assessment update. ▪ Individual #344 was admitted to the hospital on 11/23/12 with the diagnosis of aspiration pneumonia. He had not received an assessment update after his hospitalization. ▪ Individual #353 had been admitted to the hospital twice (i.e., 1/6/13 and 1/11/13) for skin integrity issues and respiratory distress. She did not have an assessment update after these hospitalizations. ▪ Individual #142 experienced a choking incident on 3/27/13. She had not received a mealtime assessment update to address this choking incident. The following metric could not be assessed due to the fact that assessment updates had not been completed: ▪ For _____ of ___ (0%) individuals for whom updates were completed, the updates provided the individuals' current status, a description of the interventions that were provided, and effectiveness of the interventions, including relevant clinical indicator data with a comparison to the previous year, as well as monitoring data. In summary, individuals newly admitted to the Facility received an OT/PT assessment within 30 days with the exception of one individual. Individuals' OT/PT assessments required additional work to ensure essential components were present. The OT/PT assessment template and audit tool should be reviewed to ensure the essential components for OT/PT assessments are incorporated. Individuals who had experienced a change in status had not received an assessment update. The Facility remained out of compliance with this provision.	

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P2	Within 30 days of the integrated occupational and physical therapy assessment the Facility shall develop, as part of the ISP, a plan to address the recommendations of the integrated occupational therapy and physical therapy assessment and shall implement the plan within 30 days of the plan's creation, or sooner as required by the individual's health or safety. As indicated by the individual's needs, the plans shall include: individualized interventions aimed at minimizing regression and enhancing movement and mobility, range of motion, and independent movement; objective, measurable outcomes; positioning devices and/or other adaptive equipment; and, for individuals who have regressed, interventions to minimize further regression.	**Direct OT/PT Interventions** At the time of the review, there were five individuals receiving direct therapy intervention. Sample P.2 was comprised of two of these individuals (i.e., Individual #26 and Individual #392). The records of these individuals were reviewed resulting in the following findings: ▪ None of two (0%) individuals' direct intervention plans were implemented within 30 days of the plan's creation, or sooner as required by the individuals' health or safety. It could not be determined from a review of these individuals' plans if they had been implemented within these timeframes. ▪ For none of two (0%) individuals' records reviewed, the current OT/PT assessment identified the need for direct intervention with rationale. The OT/PT assessment did not include an analysis of assessment data to provide justification for initiation of the direct therapy intervention. ▪ For none of two (0%) individuals' records reviewed, there were measurable objectives related to functional individual outcomes included in the ISP or ISPA. The following metric was not applicable to Individual #26 and Individual #392. However, it will be assessed during upcoming reviews. ▪ For ____ of _____ individuals' records whose therapies had been terminated, termination of the intervention was well justified and clearly documented in a timely manner. The therapist should provide clinical justification for the termination of a direct intervention plan. The team should discuss the recommendation to terminate the program within 10 working days, and the team's decision should be documented through an ISPA meeting. **Indirect OT/PT Programs** The implementation of these plans is discussed under Section O.4 for PNMPs and in Section S for skill acquisition plans. **Integration of OT/PT Direct Intervention(s) and Indirect OT/PT Program(s) in the ISP** Five of the 15 individuals' annual ISPs in Sample P.1 (33%) (i.e., Individual #26, Individual #443, Individual #253, Individual #525, and Individual #353) noted that the OT or PT attended the ISP or ISPA meeting, or there was adequate justification was provided in the Pre-ISP meeting documentation. OTs attended for Individual #443, Individual #253, and Individual #525. PTs attended for Individual #26, Individual #443, and Individual #353. Per current State Office policy, each individual's team should decide which team members should attend the annual meeting. For individuals with therapeutic needs, teams will need to provide clear justification if they decide that therapists involved in the individuals' care and treatment do not need to attend.	Noncompliance

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		Generally, for individuals receiving direct therapy, the therapist should attend the meeting. No OT and/or PT attended the ISP meeting for Individual #392 who received direct therapy. In assessing this requirement, the Monitoring Team reviewed the ISP Preparation Meeting documentation that should have included such information, as well as the ISP sign-in sheets. Pre-ISP meetings were completed for eight of the 15 individuals. Four of the eight individuals' OTs and PTs (i.e., Individual #418, Individual #411, Individual #142, and Individual #392) were not required to attend, but there was not adequate justification provided. Four individuals' OTs and PTs were required to attend (i.e., Individual #443, Individual # 33, Individual #353, and Individual #452). However, an OT and PT did not attend for Individual #33 and Individual #452. Individual #443's OT and PT attended, but only the OT attended for Individual #353. For individuals receiving OT/PT supports and services, 15 of 15 (100%) PNMPs were developed within 30 days of the date of the assessment/update, or sooner as indicated by need. Eleven individuals in Sample P.1 had their PNMPs revised after the annual ISP meeting, but there was not an assessment update and/or adequate ISP/ISPA meeting documentation to address these revisions. For example, there was ISPA documentation for four individuals who had their PNMPs revised, but the ISPA simply stated the PNMP had been revised. There was no explanation and/or rationale for the proposed changes that had been accepted by the IDT and/or a date for the implementation of the revised and approved PNMP. None of 15 (0%) individuals' ISPs or ISPAs integrated the OT/PT interventions (i.e., PNMPs). Although ISPs often referenced portions of PNMPs, they were not fully integrated into the ISPs. In none of the fifteen (0%) ISPs or ISPAs reviewed, skill acquisition programs that had been recommended in the OT/PT assessment were present. For none of the two individuals in Sample P.2 (0%), the ISP/ISPAs contained measurable objectives related to functional individual outcomes. None of the two (0%) individuals receiving direct OT/PT Services was provided with comprehensive progress notes (IPNs) at least monthly. The progress notes should: ▪ Contain information regarding whether the individual showed progress with the stated goal including clinical data to substantiate progress and/or lack of progress with the therapy goal(s); ▪ Describe the benefit of the goal to the individual; ▪ Report the consistency of implementation; ▪ Identify recommendations/revisions to the OT/PT intervention plan as indicated related to the individual's progress or lack of progress; and	

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		▪ Be completed on at least a monthly basis. Based on the therapist's monthly data, if a lack of progress is noted, team review should occur to determine if the plan is being implemented as written, staff are adequately trained, etc. However, if the team determines interventions are not effective, the IDT should revise these interventions. For individuals with PNMPs or SAPs, for none of the 15 individuals (0%), there was evidence that their progress was reviewed and documented based on the action plan in the ISP/ISPA at least monthly. For individuals who received indirect OT and/or PT programs (i.e., PNMPs), monthly documentation from the OT and PT and/or QDDP should include: ▪ Information regarding whether the individual showed progress with the stated goal(s), including clinical data to substantiate progress and/or lack of progress with the therapy goal(s); ▪ A description of the benefit of the program; ▪ Identification of the consistency of implementation; and ▪ Recommendations/revisions to the indirect intervention and/or program as indicated in reference to the individual's progress or lack of progress. Individuals receiving direct OT/PT intervention did not have plans developed. There were continuing concerns regarding OT/PT attendance at ISP meetings for individuals with PNM plans. OT/PT assessments that recommended skill acquisition programs had not been integrated in the ISP. The Facility remained out of compliance with this section.	
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.	The requirements for this section were discussed in detail with regard to Section O.5.	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	**Monitoring System** The Facility did not implement a system for the adequate monitoring of PNMPs. Monitoring of PNMPs is discussed in detail with regard to Section O.6. The Facility submitted the following policies: ▪ State Supported Living Center policy for Occupational/Physical Therapy Services, effective date 10/7/09;	Noncompliance

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	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.	▪ Facility Occupational Therapy, undated; ▪ Thickening Food and Liquids, undated; ▪ Mealtime Monitoring, undated; ▪ Physical Therapy, undated; ▪ Orthotics, undated; ▪ Purchasing of Equipment and Supplies, undated; ▪ Orthotics/Wheelchair Shop, undated; ▪ Wheelchair Use and Adaptive Equipment Repairs, undated; ▪ Wheelchair and Wheelchair Seat Cleaning, undated; ▪ Policy for Lifting Individuals, undated; and ▪ Policy Regarding Positioning Individuals, undated. Based on interview with the Facility Director, these policies had not been updated and did not consistently reflect current practices in the HT Department. The Director stated that these policies would be reviewed and updated over the next six months. The Facility comprehensive OT/PT policies when finalized should include the following elements: ▪ Description of the role and responsibilities of OT/PT; ▪ Referral process and entrance criteria; ▪ Discharge criteria; ▪ Definition of the monitoring process for the status of individuals with identified occupational and physical therapy needs; ▪ Definition of the process for monitoring the condition, availability, and effectiveness of physical supports and adaptive equipment; ▪ Identification of monitoring of the treatment interventions that address the occupational therapy, physical therapy, and physical and nutritional management needs of each individual; ▪ Identification of monitors and their roles and responsibilities; ▪ Definition of a formal schedule for monitoring to occur; ▪ Process for re-evaluation of monitors on an annual basis by therapists and/or assistants; ▪ Requirement that results of monitoring activities in which deficiencies are noted are formally shared for appropriate follow-up by the relevant supervisor; ▪ Identification of the frequency of assessments; ▪ Definition of how individuals' OT/PT needs will be identified and reviewed; and ▪ Requirements for documentation expectations for individuals receiving direct services. Individuals in Sample P.1 had individual-specific PNMP check sheets that included the following fields: reporting period, ISP date, adaptive equipment, eating equipment,	

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		communication/hearing equipment, and positioning equipment. Staff were responsible for initialing the location and use of the adaptive equipment on a daily basis and per shift. However, a review of these check sheets identified the following concerns: ▪ The condition of adaptive equipment was not monitored; ▪ The check sheet did not require staff to document if adaptive equipment was not available; ▪ There was no system to determine the effectiveness of the equipment; ▪ The PNMP check sheets did not identify all the prescribed equipment from an individual's PNMP; and ▪ Individuals' equipment was not monitored on a monthly basis; For none of 15 (0%) individuals, routine maintenance checks were conducted to ensure that positioning devices and other adaptive equipment identified in the PNMP were clean and in proper working condition. Routine maintenance meant that therapists or designated staff reviewed equipment at least monthly. A database for Assistive Equipment Work Orders had been developed to track the completion of work orders. The following fields were tracked: category, work order number, name, case number, home, originator of work order, technician, work requested, report on status, resources/barriers, priority, date entered, due date, date completed, met/did not meet timeline, if not identified the number of days, and validation date. The development of this database was a step in the right direction to assess the timeliness of work orders. However, the database results had not been analyzed to identify the total number of work orders (N) and the number of work orders that had been completed by the due date (n). In addition, this analysis should identify where there are barriers to completing work orders. This analysis should provide information to identify and resolve problematic concerns with the completion of work orders. The Facility should define through protocols what information will be presented in reports taken from this database and how plans of correction will be developed to resolve problems. These reports should provide information to substantiate compliance within this section. During upcoming monitoring visits, the following metric will be measured: ▪ ___ of ___ individuals for whom adaptive equipment was noted to be in disrepair or needing replacement (%), equipment was repaired or replaced within 30 days unless justification is provided, or unless the issue impacts the individual's health or safety, then action was taken within 48 hours. The Facility Self-Assessment for Section P noted that protocols were to be developed for standard wheelchair cleaning and maintenance; standard wheelchair maintenance schedule; and definition of seating system priority levels. In addition, a list of individuals without an adequate seating system was developed to prioritize individuals	

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		receiving a comprehensive seating assessment. As discussed with regard to Section O.6, the development and implementation of a monitoring system to 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 support professionals of these interventions should be a high priority. In summary, as discussed with regard to Section O.6, the Facility did not have an adequate monitoring system for individual OT/PT needs. The Facility did not have a policy to define the monitoring system. On a positive note, the Facility had developed a database to track the timeliness of the completion of adaptive equipment work orders. However, the Facility was not yet generating this report, and using this data to assist in determining barriers or areas in which action needed to be taken.	

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

1. The Facility should review the revised OT/PT assessment template and content guidelines to ensure essential components are addressed. The OTs and PTs should consider each of these elements as they complete assessments to ensure they are comprehensive as required by the Settlement Agreement. In addition, the OT/PT assessment audit form should include these components. (Section P.1)
2. For adequate integration of OT/PT direct interventions and/or indirect therapy programs, the individuals' ISP meetings should include attendance by an OT and/or PT unless the team provides justification. In addition, ISPs should identify the direct intervention and/or OT/PT program(s); integrate, as appropriate, skill acquisition programs to promote reinforcement of new skills learned; and as appropriate, integrate skills learned from the direct interventions and/or OT/PT programs into the individual's daily routine. (Section P.2)
3. The Facility should ensure the development and implementation of direct therapy intervention plans for individuals receiving direct therapy. (Section P.2)
4. The Facility should ensure the completion of comprehensive progress notes related to OT/PT direct interventions and indirect programs, including:
    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/indirect intervention, or OT/PT program as indicated, related to the individual's progress or lack of progress. (Section P.2)
5. The Facility comprehensive OT/PT policies when finalized should include the following elements:
    a. Description of the role and responsibilities of OT/PT;
    b. Referral process and entrance criteria;
    c. Discharge criteria;
    d. Definition of the monitoring process for the status of individuals with identified occupational and physical therapy needs;
    e. Definition of the process for monitoring the condition, availability, and effectiveness of physical supports and adaptive equipment;
    f. Identification of monitoring of the treatment interventions that address the occupational therapy, physical therapy, and physical and

nutritional management needs of each individual;

g. Identification of monitors and their roles and responsibilities;
h. Definition of a formal schedule for monitoring to occur;
i. Process for re-evaluation of monitors on an annual basis by therapists and/or assistants;
j. Requirement that results of monitoring activities in which deficiencies are noted are formally shared for appropriate follow-up by the relevant supervisor;
k. Identification of the frequency of assessments;
l. Definition of how individuals' OT/PT needs will be identified and reviewed; and
m. Requirements for documentation expectations for individuals receiving direct services. (Section P.4)

6. The HT Department should analyze the work order database results to identify the total number of work orders and the number of work orders completed by the due date. In addition, this analysis should identify where there are barriers to completing work orders. This analysis should be used to identify and resolve problematic concerns with the completion of work orders. The Facility should define through protocols what information will be presented in reports taken from this database and how plans of correction will be developed to resolve problems. (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, including updated policies/ procedures/protocols, with any areas of approved changes highlighted; o List of staff in the Dental Department, including names, title/role, and degrees; o List of staff in the Dental Department and their CPR certification status; 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; ▪ 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 documented confirmation of 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 and other dental visits in prior six months for one individual from each residence, copy from dental office's record of visit and copy from active record of same visit, including source of documentation for each record provided for: Individual #413, Individual #393, Individual #321, Individual #30, Individual #282, Individual #540, Individual #7, Individual #95, Individual #295, Individual #373, Individual #269, Individual #276, Individual #364, Individual #224, Individual #434, Individual #502, Individual #524, Individual #231, Individual #461, Individual #537, and Individual #14; o Five most recent off-site oral surgery consults and progress notes for the past six months: Individual #196, Individual #212, Individual #408, Individual #384, and Individual #510; 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.), name, reason for appointment, dates of refusals and date of completion; 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 on-site visit, and those who have become edentulous since that time; o List of other reasons for missed appointments per date for past six months (including reason for appointment – prophylaxis, annual, etc.); o List of no shows/missed appointment other than refusals per residence per month for the last six months; o List of refusals per residence per month for the last six months; o List of interventions per individual for missed appointments (i.e., follow-up appointment scheduled, whether follow-up completed, any correspondence to QDDP, home manager, team, etc.); o QDDP, IDT minutes that review, assess, develop, and implement strategies for dental visit refusals and no shows last six months, including any ISPAs that documented discussion/action plans concerning dental refusals and other dental missed appointments; o For five most recent emergency exams, integrated progress notes from start of emergency to closure, and copy of Dental Department evaluation and treatment, including time and date of first symptom/concern, and time and date first seen in dental office, for: Individual #178, Individual #105, Individual #410, Individual #17, and Individual #206; 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, IPN on date of procedure, etc., for: Individual #321, Individual #232, Individual #318, Individual #88, Individual #408, and Individual #384; o For the past six months, copies of any correspondence concerning restraint and sedation use at office visit (e.g., to QDDP, team, psychologist, etc.); o Copy of complete dental records for prior three years at SSLC (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, as well as table format with name, dates of annual exams, prophylactic exams, and dates of other treatment. Records for following individuals were

	submitted: Individual #393, Individual #7, Individual #295, Individual #98, and Individual #498; o For 10 individuals given dental pre-treatment sedation, copies of progress notes/vital sign logs, other pre-appointment assessments from active record and dental office from start of sedation in residence (if applicable) to release from monitoring (including pre-treatment sedation sheets). Information was provided for the following individuals: Individual #427 10/26/12 and 3/22/13, Individual #276, Individual #318, Individual #198, Individual #363, Individual #248, Individual #527, and Individual #304; o Current list of HRC approved dental medical restraints with sedation, including type of sedation, such as PO sedation, IV or general anesthesia; o Copy of any restraint and sedation tracking list/system used by the Dental Department [i.e., type of restraint, reason, sedation plan, drug used and dosage, effectiveness of restraint, trial of less restrictive approach (lower dosage, less mechanical restraint duration, etc.)]; o For the past six months, per month, percentage of individuals utilizing general anesthesia/IV sedation for dental exam and treatment; o For the past six months, per month, percentage of individuals utilizing oral sedation for dental visits; o For the past six months, per month, percentage of individuals utilizing mechanical restraints for dental visits; o For most recent five extractions in the past six months, copy of initial evaluation for this, second opinion, and subsequent documentation until closure, for: Individual #247, Individual #525, Individual #233, Individual #136, and Individual #510; 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 (e.g., 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: Individual #7, Individual #480, Individual #373, Individual #145, Individual #99, Individual #342, Individual #365, Individual #344, Individual #177, and Individual #304; 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 (including odontogram); o Copy of 10 most recent annual dental summaries provided for the ISP submitted for the following individuals: Individual #393, Individual #123, Individual #230, Individual #500, Individual #361, Individual #509, Individual #366, Individual #231, Individual #50, and Individual #63; o The most recent/current Facility oral hygiene data for all individuals in the past year,

	including numbers and percentages of good, fair, poor ratings, with date of data, including a list of individuals for whom an oral hygiene rating was not obtained during this time; 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 individuals that brush their own teeth but do not floss, for each individual, any documentation of reason for not flossing their own teeth, documentation of skill acquisition plan development and/or implementation for flossing; o For those that are edentulous, list of those with dentures; o For those edentulous without dentures, list of reasons with documentation as indicated; o Summary information on desensitization plans since Monitoring Team's last visit, including evidence of implementation of plan, progress, logs, etc.; o For those undergoing Total Intravenous Anesthesia (TIVA), any incident of injury in 24 hours following TIVA administration in prior six months; o For those with documented pneumonia, for each individual, date pneumonia documented, date of last dental visit prior to pneumonia with description of dental visit prior to the pneumonia, including type of procedure/visit completed, and type of anesthesia (i.e., TIVA, oral, local, none, etc.) in past six months; o For the self-assessment process: A list of monitoring /audit tools used; for each tool, documentation of the total number of the eligible population to be sampled, the number in the sample, clarification of the methodology in choosing the same, the frequency of data collection, the staff that completed the audit/monitor survey/review, and any inter-rater reliability data from the audit/monitoring review, and analysis of the inter-reliability data. o For the self-assessment process: A list of databases utilized (other than audit information), including title of each database/chart/table with date range of each database, and frequency of data collection (if not continuous); and o Presentation Book for Section Q. ▪ **Interviews with**: o Jerry Griffin, DDS, Dental Director; and o Pamela Acevedo, Registered Dental Hygienist (RDH), regarding campus oral hygiene programs and desensitization.
	Facility Self-Assessment: For Section Q, in conducting its self-assessment: ▪ The Facility used a monitoring/auditing tool. 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: "ABSSLC Texas Health Monitoring Instrument," dated 11/1/2012. o These monitoring/audit tools included some of the indicators needed to allow the Facility to determine compliance with the Settlement Agreement. The Facility is encouraged to review the Monitoring Team's report to identify other indicators that are relevant to

	making compliance determinations (e.g., assessment of pain and pain treatment for an emergency visit, post-procedure documentation and follow-up the next business day, current consent tracking for procedures and sedation, tracking oral hygiene scores for those that have self-tooth brushing skills, etc.). o The monitoring tools included adequate methodologies, such as record reviews. o The Self-Assessment identified the sample(s) sizes, including the number of individuals/records reviewed per month in comparison with the number of individuals/records in the overall population (i.e., n/N for percent sample size). This sample size was adequate to consider them representative samples. o The monitoring/audit tools did not include instructions/guidelines to ensure consistency in monitoring and the validity of the results. However, reference was made to meetings with the PCM indicating the Facility was working to review/develop instructions and interpretation of the indicator with guidelines developed. o The following staff/positions were responsible for completing the audit tools: dentist and PCM. o Adequate inter-rater reliability had been established between the various Facility staff responsible for the completion of the tools. ▪ The Facility used some other relevant data sources and/or key indicators/outcome measures to show whether or not the intended outcomes of the Settlement Agreement are being reached. This included information from both an old and new database. The new database had limited utility at the time of the Monitoring Team's visit. The old database was able to provide complete reports over a breadth of dental service areas. The quality of the data maintained in the old databases was noted to be complete and accurate. The new database remained incomplete. Accuracy of the new database was not determined. Examples of databases/data sources that were not considered included dates of most recent consent from family/LAR, date of HRC approval, periodontal probe results over time, and oral hygiene scores rates of improvement/rates of worsening, as examples. ▪ The Facility presented most data in a meaningful/useful way. Specifically, the Facility's Self-Assessment did not provide meaningful data related to training the individual or DSP on oral hygiene while at the dental office. In addition, training documentation used terms to describe the in-services that needed interpretation. However, on a positive note, the Facility: o Presented findings consistently based on specific, measurable indicators. o Consistently measured the quality as well as presence of items. o Distinguished data collected by the QA Department versus the program/discipline. ▪ The Facility rated itself as being in compliance with the following sub-sections of Section Q.1. This was not consistent with the Monitoring Team's findings.
	Summary of Monitor's Assessment: The Dental Department had continued to progress in many dental service areas. The Dental Policy and Procedure was extensive and well written. There appeared to be continued collaboration with the Psychology Department in the current program for improving compliance with dental services/desensitization. Documentation showed some progress. The Dental Department was available to provide an oral exam after the individual returned from the hospital for those at risk of aspiration, to determine whether oral health was a potentially contributing factor.

	Concerns included how to provide information and training to direct support professionals regarding the level of individuals' dental health, which might focus staff on ensuring the development of good tooth brushing skills, or the provision of necessary assistance to individuals in tooth brushing. There was no information concerning the competency-based training component for direct support professionals, or what training occurred at the dental office with both the individual and the direct support professionals. A quarterly review process was needed for the desensitization/improved dental compliance program, including review of data and analysis of trends. The role of psychology in reviewing this data also was not clear.

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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.	<u>Staffing</u> Two dentists, two registered dental hygienists, two dental assistants (one registered), and an administrative assistant staffed the Dental Department. CPR certification was submitted for the Dental Department staff. For six clinical dental staff, six (100%) were current in CPR. <u>Annual Assessments</u> The Annual Dental Assessment Record was revised to include a review of whether the individual had osteopenia or osteoporosis, as well as whether a bisphosphonate or Prolia were prescribed. Specifically, there was a yes/no response to "any contraindication to start/continue bisphosphonate or Prolia therapy." This revision was included on the Annual Dental Assessment Record for individuals with teeth as well as those that were edentulous. As treatment of osteopenia or osteoporosis may include medications linked to the complication of osteonecrosis, this provided important information to the PCP and IDT in determining the need for further dental consultation prior to starting the medication. A list of those individuals having annual examination appointments was submitted from 2011 to 4/16/13 in a document entitled "Annual Exam Report 2013 3 year." This was reviewed to determine timeliness of annual examination completion. The most recent two dates were taken from this list. The list included 395 individuals. Seven of these had database errors/typographical errors and were removed. Ten were new admissions or were temporarily placed at another state facility, but still on the census at ABSSLC. Of the remaining 378 individuals, all 378 (100%) were listed with a prior annual examination date. Of these 378, 369 (98%) had an annual examination date completed within 365 days of the prior annual exam. There were nine overdue annual examinations. The Dental Department demonstrated substantial compliance with the	Noncompliance

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		timely completion of annual dental assessments. The Dental Department documented that there were zero individuals residing at ABSSLC who had not seen a dentist in the prior 365 day time period (4/1/12 to 3/31/13). Separately, copies of ten annual dental assessments that were completed in the 30 days prior to the Monitoring Team's visit along with the prior year's completed assessments. For nine of 10 (90%) of these individuals, an annual dental assessment had been completed within 365 days of the prior annual dental assessment. Additionally: ▪ Ten of the 10 (100%) submitted assessments had an entry concerning cooperation, behavioral issues, and need for sedation/restraint use. ▪ Ten of the 10 (100%) submitted assessments had entries for oral hygiene ratings. ▪ Eight of the eight (100%) submitted assessments for individuals with teeth had entries for teeth restorations, and periodontal condition. Two were edentulous. ▪ Nine of the 10 (90%) submitted assessments had entries for oral cancer screening (intra-oral exam and extra oral exam screening)/soft tissue exam. ▪ Ten of the 10 (100%) submitted assessments included a dental treatment plan. ▪ Ten of the 10 (100%) submitted assessments documented oral hygiene recommendations. ▪ Zero of the 10 (0%) submitted assessments documented risk rating. ▪ Ten of the 10 (100%) submitted assessments documented community transition preparedness. The annual dental assessment forms should include a risk rating assessment. Additionally, during the time period from 10/1/12 through 4/23/13, there were seven new admissions. Six out of seven (86%) had completed an initial dental exam in the first month (from nine to 21 days). For one new admission, the admission exam was completed 61 days from the admission date. This individual refused two appointments (on 1/28/13 and 1/31/13), which would have attained the goal of a completed admission exam within 30 days of admission. Following the second refusal, the Dental Department developed a dental restraint plan, which was discussed and agreed upon by the IDT on 2/22/13. The dental restraint plan was then forwarded to HRC for approval, which occurred on 2/26/13. Consent from parent/guardian was received on 3/8/13. A third appointment was then made and completed. This occurred on 3/19/13. Another new admission also refused an initial appointment, but the residence provided additional encouragement and participation in walking the individual to the appointment. This individual completed the exam within 30 days. An ISPA of 5/8/13 described the steps for a successful visit for this individual. The Dental Department demonstrated substantial compliance with the timely completion of admission dental	

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		exams. 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. Five records were submitted, and the following findings were based on the review of this material: ▪ For five of five (100%), the most recent annual dental assessment was within 365 days of the prior assessment. ▪ For five of five (100%), there were multiple IPN entries. There were one to four dental IPNSs recorded per individual in 2013, and 11 to 13 dental IPNs recorded per individual in 2012. ▪ Zero of five were edentulous. (This is a descriptor and not a compliance indicator.) ▪ For those with teeth, a periodontal chart or periodontal screening/probe record was completed/documented in five of five (100%) records. ▪ Five of five (100%) included a permanent dentition chart. ▪ The dental treatment plan was documented in five of five (100%) records. ▪ One of five individuals had undergone tooth extraction in the prior three years. (This is a descriptor and not a compliance indicator.) ▪ One of five individuals had undergone restorative dentistry in the prior three years. (This is a descriptor and not a compliance indicator.) ▪ Zero of five had undergone TIVA/ general anesthesia in the prior three years. (This is a descriptor and not a compliance indicator.) ▪ Two of five had dental emergencies. One individual had an emergency and a follow-up visit in 48 hours. One individual had four separate emergency visits. (This is a descriptor and not a compliance indicator.) ▪ Zero of five (0%) had a current annual dental summary submitted (utilized by the IDT). As the annual dental summaries appeared to be a completed computerized printout, it was not clear if this was available in the record or only through a shared drive on the computer network. ▪ Zero of five (0%) had annual dental summaries for the three prior years. ▪ Four of five had information submitted documenting completion of dental x-rays within the prior year. This is a descriptor and not a compliance indicator. ▪ Five of five (100%) had information submitted concerning the completion of dental x-rays within the prior three years. ▪ The level of cooperation and need for sedation/restraint in the prior year was documented in five of five (100%) records. ▪ The current oral hygiene rating was recorded in five of five (100%) records ▪ The level of risk for dental needs was recorded in zero of five (0%) records for the most recent year. ▪ The recommendations for oral hygiene instruction (e.g., tooth brushing	

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		recommendations/ flossing, etc.) were recorded in five out of five (100%) records. ▪ One of five individuals missed appointments. This individual missed two appointments, both for medical illness. (This is a descriptor and not a compliance indicator.) ▪ A statement of preparedness for community transition was recorded in five out of five (100%) records. This area needs further work to meet substantial compliance, specifically with the need for dental risk to be assessed, and assurance of the completion of dental summaries. <u>Oral Hygiene</u> An oral hygiene index was completed on each individual (that had teeth) at the time of the annual exam. The most recent oral hygiene scores were submitted for the entire campus, in a document entitled "Oral Hygiene most recent values for all individuals ABSSLC 4-2012 to 3-2013." According to this document, for a census of 409 individuals (annual exams completed from April 2012 through March 2013), 307 (75%) had a good oral hygiene score, 61 (15%) had a fair oral hygiene score, and 41 (10%) had a poor oral hygiene score. From a separate list dated 4/16/13, entitled "ABSSLC Clinical Summary Annual Exam data with oral hygiene rating," the most recent oral hygiene ratings were listed from the annual exams completed in the prior six months. Of these, 246 individuals completed the appointment and allowed an oral hygiene rating to be completed. To determine the condition of those with teeth, these were then separated from those having an edentulous state. There were 148 individuals with teeth. Of these, 87 out of 148 (59%) had an oral hygiene rating of good, 47 of 148 (32%) had an oral hygiene rating of fair, and 14 (9%) had a score of poor. All 98 edentulous individuals had good oral hygiene ratings. This more recent list provided more current information, and separated out the edentulous ratings, as they tended to skew the values due to the large number of edentulous individuals residing at ABSSLC. If not already in place, it is recommended that a quarterly report be created in which those with teeth are tracked separately for oral hygiene index ratings from those that are edentulous. The large number of edentulous individuals otherwise could hide any trend related to the oral hygiene ratings of those with teeth. *Oral Hygiene Training* Three trainings were identified: ▪ Vacuum Brushing System: Use and care of vacuum machine and vacuum toothbrush. ▪ ABSSLC Intermediate oral hygiene training. According to the Dental Policy and Procedure Manual, this was the course provided to all DSPs.	

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		▪ ABSSCL Basic oral hygiene training. No information was provided concerning the target population. Submitted was an "Active Employee Course Participation Report" from 10/1/12 to 4/24/13 for "Basic Oral Hygiene Refresher Course." Ninety-nine percent of 1346 staff completed training. The Dental Policy and Procedure Manual indicated that Dental Department staff were responsible for training the DSPs on the dental services policy. There did not appear to be any training document or tracking of this training. The Dental Policy and Procedure Manual also indicated that there were both informational and skill components of the oral health training. It was not clear if this was part of the "Intermediate Oral Hygiene Training" or the "Basic Oral Hygiene Training." There was no data to determine which DSPs completed the presentation section of the training, and which completed a skills component. It was not clear if the skills component was a demonstration by dental staff, or competency-based training by DSPs. There was no information concerning training of individuals in oral hygiene care. There was no tracking of training of individuals in the dental office. There was no tracking of training of DSPs while in the dental office. It is recommended that the training components of dental services be reviewed. The titles of the training programs were confusing (e.g., the reason for naming the training for DSPs as intermediate was not clear). There appeared to be many gaps in documenting training and a need for an improved system of training documentation that included the following: training of DSPs while in the dental office with the individual, training of the individual in oral health care, and documenting competency based training in oral health care by the DSPs. *Suction Tooth brushing* As part of preventive oral care, suction tooth brushing was provided to those with one or more of the following indications for this procedure: risk for aspiration, history of aspiration, silently aspirate, cannot manage thin liquids safely, cannot spit, and cannot brush independently. A list submitted indicated 147 individuals received suction tooth brushing, which was 147 out of 393 (37%) of the population. As of 4/5/13, no additional individuals were identified as qualifying for suction tooth brushing. ABSSLC demonstrated substantial compliance with the provision of suction tooth brushing to individuals that required it.	

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		Individuals with self brushing plans Sixty-three individuals had care plans/ISPs that included brushing one's own teeth. The oral hygiene scores of these 63 individuals were submitted for the prior two ratings completed at the time of the annual exams. For four individuals, only one oral hygiene rating was listed, and these were removed from the total, leaving 59 individuals who self-brushed and for whom progress and maintenance in oral hygiene ratings could be determined. Thirty-two remained in the same category of oral hygiene rating. There were 21 that maintained a good oral hygiene rating. For seven, the individuals maintained a fair oral hygiene rating. For four, the individuals continued to have poor oral hygiene ratings. For these four individuals, it was not determined whether the IDT and/or the Dental Department had identified the need for additional assistance/steps or to meet to review the plan for brushing one's own teeth. For 12 individuals that brushed their own teeth, there was improvement in the oral hygiene ratings. For one individual, the rating improved from poor to fair. For seven individuals, the ratings improved from fair to good. For four individuals, the ratings improved from poor to good. For 15 individuals that brushed their own teeth, the oral hygiene ratings worsened. For five individuals, the rating changed from good to poor. For six individuals, the ratings changed from good to fair. For four individuals, the ratings changed from fair to poor. It was not determined whether the IDT and/or Dental Department had identified this worsening in oral hygiene rating and whether steps had been taken to address this decline. *Flossing* The Dental Department listed zero individuals that flossed their own teeth. A list of those individuals with independent tooth brushing skills was provided, along with the reasons for those individuals not being able to floss independently or with assistance. The list of those with independent tooth brushings skills included 64 individuals. This list was undated. Of these, nine were listed as off campus (which was not otherwise defined), and the remainder were listed as not being self–flossers. A tooth brushing skill acquisition plan was in place for 15 of these individuals. A flossing skill acquisition plan was listed for two individuals, but further information indicated the individuals had not completed the brushing or proxy brush skill acquisition plan. Two individuals were currently being assessed for self-flossing skills. For eight individuals, the RDH had trained the individual, but this appeared to be a potential goal for some, as they were still completing the brushing skill acquisition plan. There	

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		appeared to be four individuals for whom a flossing SAP was recommended. Reasons were provided for not flossing and for having proxy brush potential (the ability to use an interdental brush), but the phrases were not always easily interpreted. Reasons preventing self-flossing included behavioral concerns, tremors, and dexterity. For the proxy brush potential skill acquisition, information was entered for each individual who currently self-brushed. It could not be determined if these entries were potential goals for the individuals who self-brushed, or whether this was the current status of proxy brushing potential. For example, some were listed as self/some assistance, and others "stay with brushing SAP" or "brushing first then decide." Overall, it appeared that some individuals were considered candidates for a flossing SAP, but it was not clear whether any individual had started or completed a flossing SAP, according to the chart. A document was submitted, entitled "Dates of floss training per each individual at ABSSLC." This listed 82 individuals that had from one to four dates of training on use of floss. It could not be determined whether the site of floss training was at the dental office or during a residential visit. <u>Pneumonia</u> The Facility submitted a list of those with a diagnosis of pneumonia from 9/24/12 through 2/25/13, along with the date of the prior dental appointment and the procedure completed during that appointment. Of a list of 11 individuals that had pneumonia (either bacterial or aspiration pneumonia), zero individuals had dental appointments within eight days prior to the date of the pneumonia diagnosis. <u>Preventive, Restorative, Emergency Dental Services</u> The Dental Department provided the breadth of services required to care for the individuals at ABSSLC. Submitted was a document entitled "Clinical Summary Preventative Procedures." From 10/1/12 through 3/15/13, 687 individuals (duplicated count) were seen for prophylactic care. These visits occurred as prophylactic care only treatment or as a combination of other dental services (i.e., annual assessments, x-rays, topical fluoride treatment, etc.). The following was the breakdown per month of the number of prophylactic care treatments completed: **Month** — **# Prophylactic Care Treatments** October 2012 — 118 November 2012 — 123 December 2012 — 98 January 2013 — 111	

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February 2013	96
March 2013	106
April 2013 (through 4/15/13)	35
Total	687

Twenty-four individuals underwent restorative care during 26 appointments. Two individuals completed two appointments each during which restorations occurred. For four individuals, community oral surgeons were consulted. The following was the number of restorations completed at each visit, along with the number of visits in which this occurred:

# Restorations per visit	# Visits
1	14
2	6
3	2
6	1
8	1
9	1
19	1
Total: 48 restorations	26 visits

Forty-three individuals were examined and/or treated for dental emergencies. Thirteen were identified as having no dental pathology. For these 43 dental emergencies, 17 individuals complained of pain. The dentist identified pain in 13 individuals. Fifteen individuals underwent dental extractions. The number of teeth extracted per individual ranged from one to four per visit. Eight individuals had one tooth extracted. Two individuals had two teeth extracted. Four individuals had three teeth extracted. One individual had four teeth extracted.

As there appeared to be relatively high rates of edentulousness at ABSSLC, further review of those with extractions is recommended. This should include a historical chart review to determine whether extractions were associated with new admissions, or were associated with poor oral hygiene scores, individuals who brush their own teeth, those with numerous refusals or missed appointments, trauma/fractured teeth, impacted teeth, etc. Given that the need for tooth extraction might be a late treatment option due to mobility of teeth, periodontitis, and severe decay leading to non-restorable teeth, it is important to identify steps to prevent the need for extraction whenever possible. Although certain conditions might not be preventable, such as trauma or impacted teeth, ABSSLC needs to demonstrate preventive steps to minimize chronic conditions leading to extraction.

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<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>
From a submitted document entitled "Clinical Summary Data Annual Exam," printed 4/16/13, 234 individuals completed an annual dental exam from 10/1/12 through 4/15/13. These annual exams were done as the only procedure, or were completed in combination with prophylactic treatment, x-rays, consultations, etc. The following number of annual exams were completed per month:
<table>
<tr><th>Month</th><th># of Completed Annual Exams</th></tr>
<tr><td>October 2012</td><td>42</td></tr>
<tr><td>November 2012</td><td>33</td></tr>
<tr><td>December 2012</td><td>34</td></tr>
<tr><td>January 2013</td><td>33</td></tr>
<tr><td>February 2013</td><td>41</td></tr>
<tr><td>March 2013</td><td>38</td></tr>
<tr><td>April 2013 (through 4/15/13)</td><td>33</td></tr>
<tr><td>Total</td><td>254</td></tr>
</table>
X-rays
The Dental Department confirmed each individual with teeth had "at least a current left and right oblique radiograph of teeth within 18 months." Of these, all but two had them completed within 12 months. A new digital x-ray system was installed and was operational. This added improved clarity to the extra-oral oblique films ordered. This equipment had allowed for all individuals to be x-rayed extra-orally with improved diagnostic accuracy.

The Dental Department listed several concerns and risks associated with intra-oral dental films and the reasons they are not obtained routinely:

Movement by the individual while the films are placed and exposed;
Risk of gagging and aspirating;
Increase in uncooperative behavior even among those normally cooperative;
Increased salivation with risk of aspiration; and
Risk of aspirated or swallowed dental films, broken film holders, and lacerations from the broken film holders.

Five individuals completed the equivalent of a full mouth set of films during general anesthesia (from August 2012 through February 2013).

ABSSLC demonstrated substantial compliance with the completion of x-rays.
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		Edentulous individuals/dentures A document was submitted entitled "ABSSLC Individuals Without Teeth." This was printed on 4/1/13. This document listed 150 individuals. It also listed when these individuals became edentulous: **Time period in which became edentulous** / **# Individuals** Admitted with edentulous status: 14 Prior to year 2000: 36 From 2000 through 2004: 59 From 2005 through 2009: 39 2010: 1 2011: 0 2012: 1 **Total**: 150 The Facility submitted a second document entitled "ABSSLC Edentulous with reason why no dentures," which provided response to the requested information: "For those edentulous without dentures, list reasons with documentation as indicated." This document was undated. This information indicated that 151 individuals residing at ABSSLC were edentulous, for a rate of 151 out of 393 (38%). One hundred and fifty individuals that were edentulous did not have dentures. Reasons given were: • Fifty-seven refused dentures or had inadequate cooperation for denture fabrication to be completed. Of these, one individual had dentures in the past but refused to wear them and repeatedly lost them. • One hundred seventeen had complex oral anatomy such as poor ridges or macroglossia. • Nine had inadequate muscle coordination, uncontrolled muscle movements, or excessive gag reflex. • Two had a prior poor dental experience. • Additionally, two appeared to be having dental procedures, which might lead to dentures in the future. • One individual had dentures and was "doing well." • Some individuals had more than one reason listed for not having dentures. The Facility submitted a document entitled "ABSSLC Individuals with dentures/partial dentures." This included one individual with partial dentures and 11 individuals with full dentures. This did not agree with the former list. The former list indicated four of the 11 were not candidates for dentures. The one individual with dentures on the former list also was listed on this document. The other six individuals were not listed on the former list. It is recommended that further research be done to ensure	

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		documents agree in content concerning the use of dentures at ABSSLC. *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 of 10 (100%) confirmed nothing by mouth (NPO) status or nothing per G-tube at the time of the dental visit. Zero individuals were documented to not need NPO status. ▪ Ten of 10 (100%) listed the medication administered, the dose, and the route. ▪ Ten of 10 (100%) listed pre-procedure vital signs in the home. ▪ Zero of 10 (0%) had submitted an examination/operative IPN/dental progress note (DPN) on the date of the visit. ▪ Ten of 10 (100%) documented pre-procedure vital signs at the dental office. ▪ Ten of 10 (100%) documented intra-procedure vital signs or attempts at vital signs. ▪ Ten of 10 (100%) documented post-procedure vital signs. ▪ Adequate documentation regarding effectiveness of sedation was found in 10 of the 10 (100%) of the active records. ▪ Zero of 10 (0%) submitted documentation of Dental Department follow-up (phone or visit) the next business day. ▪ Zero of 10 (0%) documented a post-dental procedure IPN note. ▪ Zero of 10 (0%) included documentation of current sedation consent from guardian/LAR. ▪ Zero of 10 (0%) included documentation of HRC review and approval. ▪ Ten of 10 (100%) included a restraint checklist. Several components of the oral sedation process and related documentation were not submitted or appeared incomplete in the record. *General Anesthesia/TIVA* The Dental Department submitted the general anesthesia/TIVA appointment schedule for the time period from September 2012 through October 2013. The number of appointments utilizing general anesthesia/TIVA completed per month follow:	

Month	# Completed visits with general anesthesia /TIVA	# Scheduled visits with general anesthesia/ TIVA not completed	Utilized oral surgery or other dental specialty consult	Procedure completed at area hospital

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September 2012	4	2	2	0
October 2012	6	0	3	1
November 2012	4	0	0	0
December 2012	4	0	0	0
January 2013	3	0	3	3
February 2013	4	1	3	2
March 2013	6	1	4	1
April 2013	6	0	2	2

For those that had appointments that were not completed, one individual was cancelled twice due to medical illness and/or risk outside of a hospital setting. This individual was scheduled at the local hospital for May 2013. For one individual, an attempt under general anesthesia at the local hospital failed. For one individual, the guardian cancelled the appointment.

The active record was submitted for six individuals who had undergone general anesthesia/TIVA from 9/14/12 through 3/21/13. The procedures under general anesthesia/TIVA included one or more aspect of dental care. The list varied in each case, and included one or more of the following: bridge procedure, cleaning, x-rays, restoration, tongue biopsy, removal of implants, and mandibular surgery to remove mass. Three of these procedures occurred at the local hospital. 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 six of six (100%).
- A copy of the HRC review and approval was submitted in zero of six (0%).
- A pre-operative medical clearance was completed and submitted in six of six (100%) cases.
- An operative note by the dentist was recorded in six of six cases (100%).
- The operative anesthesia record was completed in six of six (100%).
- The post anesthesia care "Respiration, Energy, Alertness, Circulation, and Temperature (REACT)" score or Aldrete Score was submitted in four of five (80%) of applicable cases. One individual remained in the hospital post-operatively.

The intent of this section was to determine pre-procedure, intra-procedure, and post-procedure care with general anesthesia/TIVA at ABSSLC. As three of the submitted cases occurred in the hospital setting, this did not provide sufficient cases to allow the Monitoring Team to review ABSSLC's use of general anesthesia. In the past, submitted cases were generally from ABSSLC. The Facility's rationale for the change in interpretation or sampling was not provided. In the future, to ensure evidence of

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		compliance, records submitted should reflect general anesthesia/TIVA cases at ABSSLC. The Monitoring Team will review its document request to ensure this is clear. Additionally, evidence of HRC review and approval should be submitted. The Facility provided information concerning injuries reported within 24 hours of general anesthesia/TIVA administration. It was noted that only gas anesthesia was utilized at ABSSLC. For the six months prior to the Monitoring Team's visit, there was one incident of injury in the following 24-hour time period. The injury occurred on the same day as the procedure. The individual sustained a small cut beneath the right great toenail. This was identified as a minor injury. *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 dental IPN/DPN indicating the need for extractions was documented in five of five (100%) individuals (either completed pre-operatively or at the time of exam under general anesthesia/TIVA). ▪ For the five individuals, there were six appointments. One individual had extractions eight days apart. ▪ For two of the six appointments, general anesthesia was used. Four of the six had only a local anesthetic. For one, a combination of general anesthesia and local anesthesia was documented. These descriptors are informational only. ▪ From one to four teeth were extracted at a visit. This is informational only. ▪ Pain medication was provided in six of six cases (100%). ▪ A follow-up dental note the following workday morning (at the Infirmary if applicable) or a phone call to the residence (when not admitted overnight to the Infirmary) was documented in zero of six (0%) cases. ▪ A follow-up visit was documented in six of six (100%) cases to determine healing or complications. For five individuals that underwent oral surgery consultation, the dental record was submitted. Reasons for consultation included: care of condylar fracture, second opinion of 3rd molar impaction, mandibular mass resection, removal of dental implants, and extraction. ▪ There were one or more IPNs/consult notes for each of the five cases (100%). ▪ For two of five, there was a post visit/procedure oral surgery note in the IPN section of the active record ▪ For two of five, there was a post procedure note by an ABSSLC dentist (40%). ▪ For one of five, the second opinion indicated there was no need for surgery. ▪ There were three oral surgeries of these five cases. One of three had an	

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		operative report included in the submitted information. ▪ No prior IPNs/DPNs were submitted to determine the length of time the Dental Department had been following each case prior to referral to the oral surgeon (0%). ▪ No copies of consents were submitted for the three oral surgeries (0%). ▪ For the one individual undergoing extraction, one tooth was extracted. *Emergency Treatment* Emergency treatment was reviewed for five individuals. The reasons for the emergency were as follows: biting on things, broken filling, abscess of tooth, chapped lips, fever, and anorexia. The following findings are made based on this review: ▪ One of five records (20%) documented the presence or not of pain. ▪ Pain was treated in one of one (100%) case in which pain was documented. There was no information documenting pain in the remaining four. ▪ Follow-up occurred for two of five (40%) individuals. ▪ There was documentation of closure of the dental emergency (either no further visit required or scheduled for procedure) in five of five (100%) cases. ▪ The length of time from the identification of the dental emergency in the home to completion of the Dental Department visit varied from 0.25 hour to 23 hours. The Dental Department should clearly identify whether pain is present or not during the emergency examination, and complete and document follow-up. As the Dental Department strives towards 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 recommended risk ratings, and annual summaries should be completed for submission to IDTs. ▪ Oral hygiene should be tracked for the total population, and separately for those that are edentulous, and for those that have teeth. ▪ Clear evidence was needed regarding training of DSPs while in the dental office with the individual, training of the individual in oral health care, and successful completion of competency-based training in oral health care by the DSPs. ▪ 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 and/or worsening of oral hygiene ratings, additional plans should be implemented to improve oral hygiene, or provide additional assistance in tooth brushing. ▪ Identifying individuals who could floss and teaching individuals to floss their own teeth was an area in which work remained. ▪ Several components of the oral sedation process and related documentation	

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		needed improvement. ▪ Several components of the documentation related to extractions needed improvement. ▪ For dental emergencies, the Dental Department should clearly identify whether pain is present or not during the emergency examination, and complete and document follow-up.	
Q2	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement policies and procedures that require: comprehensive, timely provision of assessments and dental services; provision to the IDT of current dental records sufficient to inform the IDT of the specific condition of the resident's teeth and necessary dental supports and interventions; use of interventions, such as desensitization programs, to minimize use of sedating medications and restraints; interdisciplinary teams to review, assess, develop, and implement strategies to overcome individuals' refusals to participate in dental appointments; and tracking and assessment of the use of sedating medications and dental restraints.	This section of the report includes a number of sub-sections that address the various requirements of this provision of the Settlement Agreement. These include the development of dental policies and procedures, provision of dental records to IDTs, refusals and missed appointments, tracking of use of sedating medications and restraints, and interventions to minimize the use of sedating medications. <u>Policies and Procedures</u> The Dental Policy and Procedures Manual was revised, and on 3/26/13, it was approved. Numerous areas were updated, including the following subsections: ▪ Purpose; ▪ Definitions (focus on medical restraint plan); ▪ Dental Department organizational chart; ▪ Dental Professionals Participation in the IDT process; ▪ Individual Support Plan Attendance; ▪ Standards of Care; ▪ Quality Assurance; ▪ Forms; ▪ Medical Restraint; ▪ General Anesthesia and Oral Sedation Policy and Procedures; ▪ Informed Consent; ▪ Radiation Control; and ▪ Appendix of current forms utilized by the Dental Department. It was noted that the above manual was extensive and appeared to be well written. When the role of the Dental Department in desensitization is clarified, this might be an additional area for further written guidance in the manual. Written guidance in tracking of training as well as content of training of direct support professionals, nurses, and other staff would assist in ensuring this ongoing activity is formally completed and recorded. <u>Provision of Dental Records to IDTs</u> Copies of the most recent comprehensive exams from the active record were requested for one individual from each residence along with the copy from the dental office	Noncompliance

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		records. This was used to assist in determining whether the IDTs received adequate/complete dental information for the individuals. For the 21 submitted records, identical information was available in the active record (as part of the IPN section and/or Dental Department section of the active record) and dental office record in 94 of 95 (99%) submitted documents. Copies of 10 Annual Dental Summaries were submitted. These were available to the IDT. Information from the annual dental assessment was entered into a computerized datasheet. It included the following components: dates of missed appointments, date of last annual assessment, date of last prophylaxis, oral hygiene rating, level of behavior, need for restraint/oral sedation, TIVA/general anesthesia, number of teeth, number of caries, degree of periodontal health, presence of bruxism, presence of mobile teeth, work completed during the visit, work remaining, the number of restorations, extractions, crowns/bridges in the past year, whether a desensitization program was in place, positioning requirements for dental evaluation, and tooth brushing recommendations. ABSSLC demonstrated substantial compliance with the provision of up-to-date dental information to IDTs. Although addressed with regard to Section T, it is important to note that there was no information concerning readiness for community placement, or the steps needed for a successful transition in dental care to the community. <u>Refusals/Missed Appointments</u> A review of information from a document entitled "Absence Tracking for ABSSLC Dental Refusals" for dental appointments for the prior six months indicated that 42 appointments were refused. Thirty-one individuals refused these 42 appointments. Follow-up appointments were subsequently completed for all but seven appointments. For seven follow-up appointments for six individuals information remained pending (the document scan date was 4/16/13). The document did not include pending appointments. Pending appointments for these six individuals might have been scheduled to occur after the document scan date. For one individual, it appeared that one of the seven follow-up appointments had been refused, because a reschedule date had also been made, but there was no further information for either of these appointments. Eight individuals refused more than one appointment. Two individuals refused four appointments and six individuals refused two appointments. Reasons for the scheduled appointments that were refused included: prophylaxis (21 appointments), admission	

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		exam (two appointments), annual exam (six appointments), exam and prophylaxis (five appointments), restoration (four appointments), consultations (two appointments), follow-up not further defined (one appointment), and one for which the abbreviation listed was not in the ABSSLC Dental Abbreviations Master List and could not be determined. The refused appointments occurred from 14 residences. Refused appointments occurred during the following time period: **Month** / **# Refused Appointments** October 2012 — 10 November 2012 — 6 December 2012 — 4 January 2013 — 5 February 2013 — 8 March 2013 — 7 April 2013 (to 4/16/13) — 2 **Total** — 42 For the 42 appointments that were refused by 31 individuals, 25 follow-up appointments were completed. Some individuals refused more than one appointment prior to completion of an appointment (for example, a refused appointment twice before a completed appointment). ▪ For 14 individuals, the completed appointments occurred from one to 15 days after the refused appointment. ▪ For three individuals, the completed appointments occurred from 16 to 30 days after the refused appointment. ▪ For five individuals, the completed appointment occurred from 31 to 60 days after the refused appointment. ▪ For three individuals, the completed appointment occurred more than 60 days after the refused appointment. ▪ For one individual, the completed appointment date could not be determined due to typographical error. ▪ As mentioned above, six individuals had a refused appointment (one individual had two refused appointments), for which a completed appointment had not yet occurred by the time of the printing of the document. According to the submitted document entitled "Absence Tracking for ABSSLC Missed Appointments Non-refusals," for the time period 10/1/12 through 3/31/13, there were 31 missed/no show appointments, which were not categorized as refusals. Reasons for the scheduled appointments that were missed included prophylaxis (15 appointments),	

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		annual exam (one appointment), annual exam and prophylaxis (seven appointments), discharge exams (two appointments), and six, which used an abbreviation not listed in the "Dental Abbreviations Master List." The missed/no show appointments occurred in 15 residences. The major reasons identified for missed appointments included: ▪ Not scheduled on calendar – 17; ▪ Schedule conflict – 7; ▪ Staff shortage – 3; ▪ Cancelled by supervisor – 2; ▪ Furlough – 1; and ▪ Medical resident illness – 1. The majority of these indicated lack of communication between departments such as schedule conflict, furlough, and not scheduled on calendar. This latter reason was responsible for over half of the missed non-refusal appointments, and appeared to be a training issue or a system issue with scheduling documentation. It would be appropriate to target these areas for resolution. For the 31 appointments that were missed, a follow-up appointment was documented in 31 cases. All 31 follow-up appointments were completed. ▪ For 20 individuals, the completed appointments occurred from one to 15 days after the missed appointment. ▪ For six individuals, the completed appointments occurred from 16 to 30 days after the missed appointment. ▪ For three individuals, the completed appointment occurred from 31 to 60 days after the missed appointment. ▪ For two individuals, the completed appointment occurred more than 60 days after the missed appointment. For one individual, the missed appointment was due to a schedule conflict. However, the follow-up completed appointment did not occur for 146 days. **Month** / **# Missed Appointments (Non-refusal)** October 2012 – 10 November 2012 – 4 December 2012 – 2 January 2013 – 8 February 2013 – 4 March 2013 – 3 **Total** – 31 The Dental Department submitted "Absence Tracking" logs that provided the reasons	

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		for the missed appointment, and procedure. Attached were copies of memos to the QDDP/homes requesting the teams to meet and discuss the reason in order to develop resolution steps. If applicable, emails also were attached communicating the Dental Department's request for a meeting with the IDT. If it was determined that the cause for the missed appointment was staff error, etc., then the QDDP was informed of the missed appointment, but a request for a team meeting was not required in most instances. "Absence Tracking" logs were submitted for October 2012, November 2012, December 2012, January 2013, and February 2013. The Dental Department submitted information concerning whether the refused and missed/no show appointments were followed by an IDT meeting with an ISPA created to address the no show appointment. There were 34 ISPAs submitted to address refused or missed appointments that were non-refusals. Of these, the dentist was referenced in discussion or there was a signed attendance roster including the dentist for 24 of the 34 ISPAs. (Few ISPAs had attached attendance sheets for verification). Although data from attendance rosters was often not submitted, it appeared the Dental Department took an active role in developing a resolution to the missed appointments. As the total refused appointments was 42 and the 34 ISPAs included both refused and missed non-refused appointments, it was not clear if ISPAs had occurred for the other refused appointments. It is recommended that the Dental Department develop a tracking system (or the current tracking log expanded) to provide the needed monitoring to ensure the IDTs respond to refused and missed non-refused appointments by developing ISPAs or other action steps to prevent another missed appointment. It was also noted that the IDT often did not provide concise next steps or actions to assist in resolution. As one example, for Individual #126, the team noted that the individual "should be encouraged by staff to attend his scheduled dental appointments. The team agreed that he cannot be forced to attend appointments. It is apparent that the individual may refuse on certain days, but will attend at a later date. The reason for the refusal is unknown." There were several areas of concern noted. There was no information as to how the staff should encourage the individual to attend. There was no information as how the team could assist the individual to make a positive choice for improved dental care, rather than just stating he could not be forced to attend the appointments. As there were times the individual completed the appointment and other times not, a review of what was different on these days might have provided clues as to when the individual would be most accepting of the appointment (i.e., sufficient rest, minimal noise in the home in the morning, did better in the afternoon, etc.). <u>Interventions to Minimize the Use of Sedating Medications and/or Restraints</u>	

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		Information was submitted concerning use of restraints for dental procedures. For the prior six months (October 2012 through March 2013), there were 1408 completed appointments and the dental office did not use mechanical restraints. Eleven of 1408 (0.78%) of completed appointments utilized oral sedation. Twenty-six of 1408 (1.85%) completed appointments utilized general anesthesia/TIVA. The Dental Department submitted copies of "Dental Medical Restraint Plan" forms, which were completed for chemical, physical, or mechanical restraint consent, or a combination of these. The contents included the following areas: preventive actions to avoid restraint, description of behaviors/rationale for restraint, restraint (sedation, etc.) needed, types of restraint (i.e., sedation, etc.) most effective, how to carry out restraint/sedation safely and reporting, criteria for releasing the restraint and follow-up evaluation, direct support professionals instructions given by the dental office or nurse, documentation, post-restraint procedures implemented to reduce the need for sedation, IDT signatures, legal guardian consent, and authorization of HRC with signatures. The Dental Department submitted a copy of a document entitled "Restraint and Sedation Log by Person." This was printed on 4/1/13. The log included restraint and sedation use from 10/1/12 through 3/31/13. For each individual listed, it included the type of restraint utilized (i.e., chemical, physical, etc.), the type of medication, dosage, and dosage route if chemical, the procedure for which the restraint had been used, the reason for the use, and whether it was effective. If a medical restraint plan had been implemented, this was noted. If a reduction strategy was in place, this was also noted. *Desensitization* A document entitled "ABSSLC Desensitization Tracking Worksheet" was submitted providing current information concerning desensitization and other dental behavioral programs to improve individual cooperation and compliance with dental visits. ▪ Seventy individuals were listed as having participated in the desensitization/behavioral programs. ▪ Sixty-nine individuals were listed as having been evaluated for dental desensitization and dental behavioral plans. ▪ Twenty-one formal plans were written. ▪ Twenty-one strategies were written. ▪ Ten were removed from the program for various reasons (e.g., moved to the community, death, LAR declined consent, psychology decision, IDT decision, etc.) ▪ Twenty-three were in the assessment phase or recently had begun implementation of the plan. ▪ Four were discontinued due to successful completion of the goals. It was not	

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		clear whether additional programs would be developed or needed after success of the initial behavioral plans for these individuals. ▪ Seventeen were considered to have improved compliance in cooperation/compliance with dental care. ▪ Fourteen were considered to have slight improvement in cooperation/compliance with dental care. ▪ This was a 35/70 = 50 percent rate of positive response to the behavioral strategies and plans that were implemented. ▪ Two showed no improvement in cooperation/compliance with dental care. ▪ Twenty-seven of the desensitization/behavior plans or strategies were revised since the start of the plans/strategies. ▪ Submitted information for fifty-two individuals included the following, as applicable: dental desensitization assessment or dental desensitization plan/strategy, monthly desensitization summary, monthly desensitization reports, and data collection. ▪ Data showed that for those with formal dental desensitization plans/strategies that were implemented, documentation indicated it was implemented consistently. ▪ The process developed allowed for a written monthly review/analysis of progress by the dental hygienist. ▪ There was information submitted for one individual that indicated periodic analysis by the Psychology Department. ▪ There was no quarterly dental report that included analysis of progress of the desensitization program, including strengths and challenges. It is recommended that a quarterly report summarize the activity/progress/lack of progress by the desensitization program. Identification of those who would benefit from this desensitization and or other strategies, but who were not in the program also was needed. <u>Quality Assurance/Improvement Initiatives</u> The QA/QI Department used the "Texas Health Monitoring Instrument," revised 5/1/12, to audit the quality of dental services. This instrument had 18 indicators, and several of these had subcomponents. Results of review of dental services for the time period from 10/1/12 to 3/28/13 were provided for 40 individuals. Each month a computer generated random sample provided 10 names for review. In addition, the PCM monitored three individuals from the monthly sample. However, the time period from 10/1/12 to 3/28/13 covered six months, for which 60 individuals would have been reviewed. If the March 2013 sample had not been complete or results entered into the database, that would still indicate 50 individuals would have been monitored from	

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		October through February. The reason for having only the results of 40 individuals during this time period was not clear. Inter-rater reliability extended through February 2013, which suggested five months of results were available. The following information was provided for the results of the 40 individuals submitted. The results indicated four of 40 scored less than 100% on the monitoring tool. It was noted that the numbered indicators of the "Texas Health Monitoring Instrument" did not match the numbers of the indicators listed on the form "Compliance by Monitoring Tool." For instance, the "Health Monitoring Instrument" only listed one component for Indicator #16, but the data results of "Compliance by Monitoring Tool" list #16a and #16b. The reason for the discrepancy was not identified. From the "Compliance by Monitoring Tool," indicators with less than a 100% score included the following: ▪ #11.a "reviewed the incident(s) of refusal" ▪ #11.b "assess the reason(s) for the refusal" ▪ #11.c "developed strategies to overcome the individual's refusals to participate in dental appointments" ▪ #11.d "implemented the strategies that were developed" ▪ #14 "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" ▪ #16.a "addressing safe positioning for dental procedures" ▪ #16.b "incorporating safe positioning for dental procedures" Indicators #11.a, #11.b, #11.c, #11.d, and #14 scored below 80%. At the 5/6/13 QA/QI Leadership Council, the Dental Department reviewed these concerns. There appeared to be ongoing challenges with the new dental database. No specific steps were outlined to address these areas at this meeting, but reference was made to the expectation that the updated Dental policy would assist in improving #11.a and #11.b. However, the implementation steps of the updated policy to address these issues were not outlined. Indicators #11 and #14 were considered priorities. Two auditors completed the monitoring, a dentist from the ABSSLC Dental Department, and a member of the QA Department. Inter-rater reliability was submitted for each of the indicators in the survey tool for the time period from 10/1/12 through 3/28/13. For inter-rater reliability, Indicator #6 ("preventative care was provided, including but not limited to cleaning, root planning, sealant, and fluoride application") scored 78%. Indicator #16.a ("addressing safe positioning for dental procedures") scored 78%. Indicator #16.b ("incorporating safe positioning for dental procedures") had the lowest agreement, at 67%. Eight other indicators scored less than 100% but above 80%. For 30 indicators, agreement was 100%.	

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

1. A quarterly report should be created in which those with teeth are tracked separately for oral hygiene index ratings from those that are edentulous. (Section Q.1)
2. The Dental Department should create an improved system of training documentation that includes the following: training of DSPs while in the dental office with the individual, training of the individual in oral health care, and successful completion of competency-based training in oral health care by the DSPs. (Section Q.1)
3. The IDTs, including the Dental Department should meet to discuss poor or worsening oral hygiene ratings in those with self-brushing skills/plans, to determine the next appropriate intervention in order to improve oral health. (Section Q.1)
4. Further research should be done to ensure documents agree in content concerning the use of dentures at ABSSLC. (Section Q.1)
5. Whether pain is present or not during the emergency examination should be clearly identified. (Section Q.1)
6. Further review of individuals with extractions is recommended. This should include a historical record review to determine whether extractions were associated with new admissions, or were associated with poor oral hygiene scores, individuals who brush their own teeth, those with numerous refusals or missed appointments, trauma/fractured teeth, impacted teeth, etc. As the need for tooth extraction might be a late treatment option due to mobility of teeth, periodontitis, and severe decay leading to non-restorable teeth, it is important to identify steps that prevent the need for extraction whenever possible. Although certain conditions might not be preventable, such as trauma or impacted teeth, ABSSLC needs to demonstrate preventive steps to minimize chronic conditions leading to extractions. (Section Q.1)
7. The Dental Department should develop a tracking system (or expand the current tracking log) to provide the needed monitoring to ensure the IDTs respond to refused and missed non-refused appointments by developing ISPAs or other action steps to prevent another missed appointment. (Section Q.2)
8. The Unit Director/QDDP Coordinator/QA Department, or other appropriate department(s) should review ISPAs for missed/refused appointments to ensure they provide clear instruction, and resolve the concern identified, with steps clearly identified. (Section Q.2)
9. A quarterly report should summarize the activity/progress/lack of progress of the implementation of the desensitization program. Identification also should occur of those who would benefit from desensitization or other strategies, but who are not in the program. (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 The following documents: Communication Comprehensive assessment; Update and Assessment of Current Status; 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, or monthly reviews by SLP; alternative and augmentative communication (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), for 20 individuals who had communication deficits, AAC system(s), and/or received direct communication supports, including: Individual #83, Individual #409, Individual #138, Individual #119, Individual #281, Individual #530, Individual #545, Individual #224, Individual #318, Individual #325, Individual #150, Individual #94, Individual #17, Individual #327, Individual #137, Individual #297, Individual #377, Individual #92, Individual #156, and Individual #196; o Policy and procedures addressing the provision of speech and/or communication services and supports, including changes since the Monitoring Team's last visit; o Continuing education and other training completed by SLPs with certificates of completion, since the Monitoring Team's last visit; 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 List of 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; o Minutes for Communication committee meetings held since the Monitoring Team's last review;

	○ Minutes for Speech Department meetings held since the Monitoring Team's 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, including: Individual #193, Individual #184, Individual #440, and Individual #344; ○ 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 the Monitoring Team's last review; and ○ American Speech Hearing Association (ASHA) certification for SLPs. ▪ **Interviews with:** ○ Bobbie Holden, OTR, Director of HT; ○ David Feemster, MA, CCC/SLP; ○ Donna Boulette, MS, CCC/SLA-A; ○ Carolina Rodriguez, MS, SLP; and ○ Leslie Riggins, SLP Assistant. ▪ **Observations of:** ○ Individuals in residences and day programs.
	Facility Self-Assessment: Facility Self-Assessment: The Facility submitted a Self-Assessment for Section R, dated 4/14/13. In its Self-Assessment, for each subsection, 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 used monitoring/auditing tools. Based on a review of the Facility Self-Assessment, various monitoring/audit templates and instructions/guidelines, a sample of completed monitoring/audit tools, inter-rater reliability data, as well as interviews with the Director of HT and therapists: ○ The monitoring/audit tool the Facility used to conduct its self-assessment included: the Compliance Monitoring tool and various Facility-developed audit tools to assess compliance with some of the indicators presented in Monitoring Team's reports. The Director of HT stated that the Section R monitoring tool was not being used. As discussed in interviews, the Compliance Monitoring Tool did not accurately assess the Facility's current compliance status in each of the sections. The Director of HT, SLPs, and SLP-A were planning to revise the monitoring tool to incorporate the indicators/metrics from the Monitoring Team's report that more accurately assessed the status of compliance within each of the sections. ○ The data presented in the self-assessment reflected the completion of activities/audits completed outside of the scope of the Monitoring Tool for Section R. These Facility-based audits provided a positive move forward in monitoring compliance with Section R. The

	Facility is encouraged to review the Monitoring Team's report to identify additional indicators/metrics that are relevant to making compliance determinations. o The monitoring tool did include adequate methodologies, such as observations, record review, and staff interview. o The Self-Assessment identified the sample(s) sizes. However, the Self-Assessment did not identify how the sample was chosen. The Facility Self-Assessment should identify how sample sizes were chosen for each of the subsections, including sample sizes adequate to consider them representative. o The monitoring/audit tool did not have adequate instructions/guidelines to ensure consistency in monitoring and the validity of the results. On a positive note, the Director of HT and the PCM continued to revise the monitoring tool guidelines. o The following staff/positions were responsible for completing the audit tool: The Director of HT, SLPs, and PCM. o Adequate inter-rater reliability had not been established between the Director of HT, SLPs and the PCM. ▪ The Facility used some other relevant data sources, including, for example, a communication assessment audit tool, which incorporated essential components from the Monitoring Team's previous report, and the HT Department database. ▪ The Facility presented some data in a meaningful/useful way, but more work was needed. Specifically, the Facility's Self-Assessment: o Presented 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 noncompliance with all subsections of Section R. This was consistent with the Monitoring Team's findings. ▪ The Facility data identified areas in need of 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 Facility had four SLPs, but there was not a reasonable process to determine what an appropriate caseload would be for SLPs at ABSSLC. Four of the seven individuals newly admitted to ABSSLC had communication assessments completed within 30 days. The Facility continued to make progress on improving individuals' communication assessments. Although further work was needed to include all of the necessary components, the assessments had begun to provide some important information to teams. ISPs generally provided some description of individuals' communication skills. However, more work was needed to include communication goals and objectives into ISPs, as appropriate, and/or integrate communication strategies into other goals and objectives. For individuals learning to use AAC devices or receiving direct therapy, goals or objectives also needed to be developed and included in ISPs to structure

	skill acquisition, and provide a mechanism to measure progress. Observations of individuals with AAC systems revealed the systems were not present and/or being used. Staff did not understand how to engage individuals with the systems. It could not be determined if individuals who received direct SL therapy interventions had their plans initiated in a timely manner. Progress notes did not include necessary components. Competency-based training and performance check-offs had not been developed and implemented for new employee orientation. Individual-specific training and performance check-offs had not been developed and implemented for individuals with AAC systems. The Facility did not have a policy for monitoring communication supports. Individuals with AAC systems had not been monitored using the Compliance Monitoring form. In addition, the Facility had identified that the monitoring data it was collecting was not reliable.

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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:** Individuals identified by the Facility with severe expressive or receptive language disorders with assessments completed in the last 12 months, including the following ten individuals: Individual #83, Individual #409, Individual #530, Individual #138, Individual #119, Individual #156, Individual #196, Individual #318, Individual #150, and Individual #94. ▪ **Sample R.2:** Two individuals receiving direct speech interventions including: Individual #83 and Individual #409; ▪ **Sample R.3:** Eight individuals with a PBSP and communication deficits, including: Individual #327, Individual #17, Individual #156, Individual #545, Individual #196, Individual #150, Individual #318, and Individual #137; ▪ **Sample R.4**: Ten individuals with AAC devices including: Individual #138, Individual #281, Individual #530, Individual #545, Individual #224, Individual #325, Individual #94, Individual #297, Individual #377, and Individual #92. This paragraph of the Settlement Agreement includes a number of requirements that are addressed in subsequent sections within Section R. This section of the report addresses compliance with current staffing, staff qualifications, adequate number of speech language pathologists, and continuing education. The SLP assessment process and the development and implementation of programs are discussed with regard to Section R.2. Staff training is addressed with regard to Section R.3, and the Facility's monitoring system is discussed with regard to Section R.4. **<u>Staffing</u>**	Noncompliance

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		The Facility had not developed or implemented a reasonable process to determine what an appropriate caseload would be for SLPs at ABSSLC. A "reasonable process" to determine an adequate number of SLPs would include an analysis of SLPs' responsibilities, including consideration of the acuity of individuals' speech and communication needs, and assistance from speech assistants. Such responsibilities would include, but not be limited to conducting assessments, developing and implementing programs, providing staff training, and monitoring the implementation of programs. The current caseloads for the four SLPs were 117, 79, 107, and 90 individuals. The Facility had not initiated an analysis to determine an adequate caseload for SLPs at ABSSLC. The Facility should complete an assessment to include consideration of the various requirements of the job, as well as the acuity of the individuals in relation to SLP needs. In addition, an adequate SLP caseload should be related to the Facility's ability to successfully implement the requirements of Sections R.1 through R.4. The Facility had one SLP vacancy. During the on-site review the Director of HT indicated an SLP had accepted the vacant SLP position. **Qualifications:** ▪ Four of four SLPs (100%) were licensed to practice in the state of Texas. ▪ Four of four SLPs (100%) had evidence of ASHA certification. **Continuing Education** Four of the SLPs and one Speech Language Assistant (SLA) staff (100%) had completed continuing education directly related to communication and transferrable to the population served. Attendance rosters, course certificates of completion, and agendas were submitted and reviewed. The continuing education the clinicians attended included the following topics: ▪ Annual Habilitation Therapies Conference (9/20/12 to 9/21/12); ▪ Comprehensive Dysphagia Interventions: The Esophagus, Acid Reflux Disease, Oral Hygiene and Free Water (9/29/12 to 9/30/12); ▪ Normal Aging and Hearing: An Update for SLPs (1/6/13); ▪ Picture Exchange Communication System Level 1 Training: Basic (1/28/13 to 1/29/13); ▪ Video Technology: Reinventing Pragmatic Therapy (2/2/13); ▪ Designing Optimal Learning Environments for Children with Developmental Disabilities, Autism, or other Behavior Challenges (2/2/13); ▪ Equipment and Positioning DADS Webinar (2/7/13); ▪ Swallowing Screening: How and Why (3/9/13); ▪ Performing a Clinical Swallow Evaluation (3/9/13);	

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		▪ AAC: Demystifying the "Assessment Process" (3/9/13) ▪ Hearing Aids 2010: A Review of Our Favorite Publications (3/10/13); ▪ Ethics in Audiology (3/10/13); ▪ Ethics in Hearing Healthcare – The Basics (3/10/13); and ▪ Equipment Webinar (3/14/13). **Facility Policy** The Facility submitted the following policies: ▪ State Supported Living Center policy for Communication Services, effective 10/7/09; and ▪ ABSSLC Specific Policy/Procedure for Speech-Language Pathology in addition to adherence to the State Communication Services policy, undated. Based on interview with the Facility Director, these policies had not been updated and did not consistently reflect current practices in the HT department. The Director stated that these policies would be reviewed and updated over the next six months. The State policy only addressed some, but not all of the components necessary for a comprehensive SLP policy. The components contained in the State policy are underlined below. When finalized, the Facility policy should address the components that are not underlined: ▪ Roles and responsibilities of the SLPs (meeting attendance, staff training etc.); ▪ Outline of the assessment schedule; ▪ Frequency of assessments/updates; ▪ Timelines for completion of new admission assessments (within 30 days of admission or readmission); ▪ 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 essential components of a monitoring policy are addressed with regard to Section	

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		R.4. In summary, the Facility had four SLPs, but there was not a reasonable process to determine what an appropriate caseload would be for SLPs at ABSSLC. All the SLPs and one SLA had completed continuing education. The Facility did not have a SLP policy that reflected current practices and expectations. The HT Department should ensure revised policies include the elements listed within this section. The Facility remained out of compliance with this section.	
R2	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall develop and implement a screening and assessment process designed to identify individuals who would benefit from the use of alternative or augmentative communication systems, including systems involving behavioral supports or interventions.	**Communication Assessments Provided** Four of seven individuals newly admitted since the last review (i.e., Individual #211, Individual #222, Individual #233, and Individual #239) (57%) received a communication screening or assessment within 30 days of admission. Individual #255 and Individual #256's communication assessments were not completed within 30 days. The therapist had not dated the assessment for Individual #248. Consequently, the Monitoring Team could not determine if the assessment had been completed within the timeframe. **Communication Assessment** Based on review of the individuals in Sample R.1, the comprehensiveness of the communication assessments were as follows: ▪ Nine of 10 individuals' SL assessments (90%) (i.e., Individual #530, Individual #83, Individual #409, Individual #138, Individual #119, Individual #156, Individual #196, Individual #318 and Individual #94) were signed and dated by the clinician upon completion of the written report; ▪ Five of 10 individuals' SL assessments (50%) (i.e., Individual #83, Individual #138, Individual #156, Individual #318, and Individual #94) were dated as completed at least 10 working days prior to the annual ISP; ▪ Five of 10 individuals' SL assessments (50%) (i.e., Individual #83, Individual #138, Individual #196, Individual #318, and Individual #94) included diagnoses and relevance of impact on communication; ▪ Ten of 10 individuals' SL assessments (100%) included individual preferences, strengths, and needs. Preferences listed were derived from the Preferences and Strengths Inventory (or other relevant document) developed by the individual's team, as well as information obtained from staff interviews; ▪ Ten of 10 individuals' SL assessments (100%) included medical history and relevance to communication. The medical history refers to medical conditions that would impact the provision of SLP communication supports and services; ▪ Three of nine individuals' SL assessments (33%) (i.e., Individual #138, Individual #119, and Individual #196) listed medications and discussed side effects relevant to communication. Individual #14 did not take any medication;	Noncompliance

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		▪ Ten of 10 individuals' SL assessments (100%) provided documentation of how the individual's communication abilities impacted his/her risk levels; ▪ None of 10 individuals' SL assessments (0%) incorporated a description of verbal and nonverbal skills with examples of how these skills were utilized in a functional manner throughout the day; ▪ Nine of 10 individuals' SL assessments (90%) (i.e., Individual #530, Individual #83, Individual #409, Individual #119, Individual #156, Individual #196, Individual #318, Individual #150 and Individual #94) provided evidence of observations by the SLPs in the individuals' natural environments (e.g., day program, home, work); ▪ Two of nine individuals' SL assessments (22%) (i.e., Individual #119 and Individual #196) 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 #14 communicated verbally; ▪ Nine of 10 individuals' SL assessments (90%) (i.e., Individual #530, Individual #83, Individual #409, Individual #138, Individual #119, Individual #156, Individual #196, Individual #318, and Individual #94) included discussion of the expansion of the individuals' current abilities. For these individuals, the SLP assessment discussed how an individual's current abilities could be enhanced; ▪ Eight of 10 individuals' SL assessments (80%) (i.e., Individual #530, Individual #83, Individual #409, Individual #138, Individual #119, Individual #156, Individual #318, and Individual #94) provided a discussion of the individuals' potential to develop new communication skills. For these individuals, the SLP assessment provided an analysis of the individual's current communication deficits with suggestions for direct interventions and/or skill acquisition programs; ▪ None of 10 individuals' SL assessments (0%) included the effectiveness of current supports, including monitoring findings. The SLP assessment should present clinical data to support the effectiveness of the individual's current supports. This clinical data should include the results of individual-specific compliance and effectiveness monitoring; ▪ Seven of the 10 individuals' SL assessments (70%) (i.e., Individual #530, Individual #83, Individual #409, Individual #138, Individual #119, Individual #156, and Individual #94) assessed AAC or Environmental Control (EC) needs, including clear clinical justification and rationale as to whether or not the individual would benefit from AAC or EC; ▪ None of 10 individuals' SL assessments (0%) offered a comparative analysis of health and functional status from the previous year. The SLP assessment should provide an overview of an individual's health status over the past year. The	

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		therapist should discuss the type of supports and services that have been implemented to minimize the impact on the individual's functional status; ▪ Seven of 10 individuals' SL assessments (70%) (i.e., Individual #530, Individual #83, Individual #409, Individual #138, Individual #119, Individual #156, and Individual #94) gave a comparative analysis of current communication function with previous assessments. The SLP assessment should provide an overview of the past assessment results with the current assessment data for communication function. The assessment analysis should discuss if the individual's communication performance has remained the same, has improved, and/or has regressed; ▪ 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; ▪ Seven of 10 individuals' SL assessment (70%) (i.e., Individual #83, Individual #409, Individual #119, Individual #156, Individual #196, Individual #318, and Individual #94) had specific and individualized strategies outlined to ensure consistency of implementation among various staff; ▪ Ten of 10 individuals' SL assessments (100%) had a reassessment schedule; ▪ None of the 10 individuals' SL assessments (0%) supplied a monitoring schedule. The SLP assessment should discuss monitoring results from the previous year and recommend the implementation of a monitoring schedule for the upcoming year. The therapist should describe the monitoring form(s) to be utilized; ▪ Ten of 10 individuals' SL assessments (100%) had recommendations for direct interventions and/or skill acquisition programs, including the use of AAC or EC devices/systems, as indicated for individuals with identified communication deficits. For these individuals, the SLP assessment analysis section provided clinical justification related to recommendations for direct therapy interventions and/or skill acquisition programs; ▪ Ten of 10 individuals' SL assessments (100%) made a recommendation about the appropriateness for community transition. As required by State Office, for these individuals, therapists included their opinions about whether or not the individual could effectively be supported in the community. If the therapist believed the individual could not be supported in the community, the therapist identified what supports the individual needs were missing in the community; and ▪ Seven of the 10 individuals' SL assessments (70%) (i.e., Individual #83, Individual #409, Individual #119, Individual #156, Individual #196, Individual #318, and Individual #94) defined the manner in which strategies, interventions, and programs should be utilized throughout the day. The SLP assessment should provide suggestions for direct support professionals and other IDT members, as appropriate, to implement an individual's indirect	

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		programs (i.e., PNMP) and reinforce skills being learned in direct therapy interventions. The SLPs continued to make progress in including necessary elements in comprehensive SLP/communication assessments. However, additional work was needed to ensure comprehensive SLP assessments included all the necessary assessment elements. **SLP and Psychology Collaboration:** Based on review of individuals in Sample R.3 with Positive Behavior Support Plans the following was noted: ▪ Two of eight individuals' communication assessments and PBSPs reviewed (i.e., Individual #196 and Individual #150) (25%) addressed the connection between the PBSP and the recommendations contained in the communication assessment. ▪ Two of eight individuals' communication assessments (i.e., Individual #196, and Individual #150) (25%) contained evidence of review of the PBSP by the SLP. Based on review of the Facility Behavior Support Committee meeting attendance sheets from 10/3/12 to 1/9/13, participation by a SLP was noted in eight of the nine meetings (89%). In summary, some individuals newly admitted to ABSSLC had not had communication assessments completed within 30 days. Individuals' communication assessments continued to improve. However, the Facility is encouraged to focus on the remaining components that were not yet included or consistently included in the assessments. Some SLPs were not collaborating with psychologists and/or were not documenting collaboration. The Facility remained out of compliance with this section.	
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 ten individuals in Sample R.4, the following was noted: ▪ Seven of the 10 individuals' SLPs (70%) (i.e., Individual #281, Individual #530, Individual #545, Individual #224, Individual #325, Individual #297, and Individual #377) attended the annual ISP meeting. Per current State Office policy, each individual's team should decide which team members should attend the annual meeting. For individuals with therapeutic needs, team should provide clear justification if they decide that therapists involved the individuals' care and treatment do not need to attend. For the individuals in the sample, the ISP Preparation Meeting documentation indicated that: o Six of the ten individuals did not have an ISP Preparation meeting. o Three of the remaining four individuals' (i.e., Individual #224, Individual #377 and Individual #92) ISP Preparation Meeting documentation did	Noncompliance

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		not indicate that the SLP was required to attend the ISP meeting. The rationale provided to not require SLP attendance was not adequate for these individuals: Individual #224 (i.e., "hab tech will suffice"), and Individual #377 (i.e., "assessment will suffice"), and Individuals #92 i.e., "assessment will suffice"). However, SLPs did attend the annual ISP for Individual #224 and Individual #92. A review of Individual #377's communication assessment and PNMP indicated that she had communication needs and consequently, a SLP should be required to attend her annual ISP. The expertise of the SLP would be helpful in assisting IDT members to understand how to imbed her AAC system in daily activities. ▪ Seven of 10 ISPs reviewed (70%) (i.e., Individual #138, Individual #281, Individual #530, Individual #325, Individual #297, Individual #377, and Individual #92) included a description of how the individual communicated and how staff should communicate with the individual, including the AAC system if he/she had one. These ISPs contained information on how staff could improve communication with the individual. The types of AAC and/or communication supports (including, but not limited to, the Communication Dictionary and strategies for staff use) were identified. ▪ Two of 10 ISPs reviewed (20%) (i.e., Individual #281 and Individual #530) included how communication interventions were to be integrated into the individual's daily routine. ISPs should contain information on how communication strategies can be integrated throughout the day and throughout the other selected goals. Information should be consistent with the communication assessment and provide detailed descriptions to ensure staff consistency. ▪ Two of 10 ISPs reviewed (20%) (i.e., Individual #281 and Individual #530) contained skill acquisition programs to promote functional communication. As appropriate to the individual's needs, ISPs should contain a program (direct or indirect) that is aimed at improving functional communication. Individuals with AAC systems should have skill acquisition programs and/or other specific staff supports to promote the generalization of the use of the AAC system in multiple environments. ▪ None of 10 ISPs reviewed (0%) included information regarding the individual's progress on goals/objectives/programs, including direct or indirect supports/interventions involving the SLP. The ISPs should provide information on status of goals/programs and recommendations for the future. This information should include data as appropriate.	

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		Development and Implementation of Functional Individual-Specific Assistive Communication Systems Observations were conducted in the homes of two individuals (i.e., Individual #119 and Individual #297) with AAC systems in Sample R.4. Findings included the following: ▪ One of two observations (i.e., Individual #119)) (50%) found individuals' AAC devices present in each observed setting and readily available to the individual. ▪ AAC systems for none of two individuals (0%) were noted to be in use in each observed setting. ▪ AAC systems for one of two individuals (50%) were portable. Staff could not locate Individual #297's AAC systems. ▪ AAC systems for none of the two individuals (0%) were functional. The systems were not functional for the individual to interact with a communication partner. For example, Individual #136 could not identify icons and/or answer simple questions using his communication board. In addition, there were no established measurable outcomes developed for these systems to support interaction with a communication partner. ▪ For none of two individuals (0%), staff instructions/skill acquisition plans related to the AAC system were available. Staff were not able to show and/or explain the staff instructions and/or skill acquisition programs for the systems. **General Use AAC Devices** The Facility indicated the intent of all common area devices was to promote communication skills and encourage incidental learning in the context of daily living activities. The Facility provided a communication equipment list that identified shared AAC devices that included the location and type of device. The Monitoring Team observed the presence of general-use AAC devices during observations of individuals in their residences and workshops. These devices included staff instructions. However, the Monitoring Team did not observe staff and/or individuals utilizing these generic devices. **Direct Communication Interventions** Two individuals were receiving direct speech interventions. Sample R.2 included these two individuals (i.e., Individual #83 and Individual #409). Review of these individuals' records found the following: ▪ None of two individuals' direct intervention plans (0%) was implemented within 30 days of the plan's creation, or sooner as required by the individual's health or safety. The Monitoring Team's review of plan documentation did not provide a development date. Consequently, it could not be determined if the direct intervention plan was implemented within 30 days of its creation. ▪ For two of two individuals' records (100%) reviewed, the current SLP assessment identified the need for direct intervention with rationale. ▪ For none of two individuals' records (0%) reviewed, there were measurable	

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		objectives related to individual functional communication outcomes included in the ISP. ▪ For one of two individuals (50%) (i.e., Individual #83), information was present regarding whether the individual showed progress with the stated goal. ▪ For none of two individuals (0%) a description was found of the benefit of the device and/or goal to the individual. The therapist should have reported on a monthly basis through the provision of clinical data how the goal was supporting communication for the individual in their daily activities. ▪ For one of two individuals (50%) (i.e., Individual #83), a report was found regarding the consistency of implementation. ▪ For one of two individuals (50%) (i.e., Individual #83), recommendations/ revisions were made to the communication intervention plan as indicated related to the individual's progress or lack of progress. Based on the therapist's monthly data, if a lack of progress is noted, team review would be necessary to determine if the plan is being implemented as written, staff are adequately trained, etc. However, if the team determines interventions are not effective, the IDT should revise these interventions. **Competency-Based Training and Performance Check-offs:** The Facility reported that none of the new employees have received communication training. **Individual-Specific Competency-Based Training** None of the ten individuals' staff (0%) in Sample R.4 had received individual-specific training. To meet the standard of competency-based training, the performance check-offs should include a demonstration component for individual-specific communication programs. In addition, the Facility should present data that identifies the total number of staff that would require individual-specific training for an individual's AAC systems (N) and the total number of staff that have successfully completed performance check-offs. The Facility did not have a process to validate that staff responsible for training other staff were competent to assess other staff's competency. Staff responsible for training other staff should have the requisite skills to train staff and complete performance checklists. In summary, ISPs generally provided some description of individuals' communication skills. However, more work was needed to include communication goals and objectives into ISPs, as appropriate, and/or integrate communication strategies into other goals and objectives. For individuals learning to use AAC devices or receiving direct therapy, goals or objectives also needed to be developed and included in ISPs to structure skill acquisition, and provide a mechanism to measure progress. Observations of individuals	

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		with AAC systems revealed the systems were not present and/or being used. Staff did not understand how to engage individuals with the systems. It could not be determine if individuals who received direct SL therapy intervention had their plans initiated in a timely manner. Progress notes did not include necessary components. Competency-based training and performance check-offs had not been developed and implemented for new employee orientation. Individual-specific training and performance check-offs had not been developed and implemented for individuals with AAC systems. The Facility remained out of compliance with this section.	
R4	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall develop and implement a monitoring system to ensure that the communication 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** As noted above, the Director of HT indicated that the policies did not reflect current practice, and they were under revision. The Facility's revised policy and/or procedures should include the following essential components related to monitoring: ▪ Monitoring for the presence of communication adaptive equipment or other AAC supports/materials; ▪ Monitoring for the working condition of communication adaptive equipment; ▪ Monitoring for the use of communication adaptive equipment in multiple environments (home, day program, work); ▪ The frequency of monitoring for individuals within the established Master Communication Plan priority levels; ▪ 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 (individual and systemic). **Monitoring of Implementation of Communication Supports** The last three months of Compliance Monitoring forms for implementation of communication supports for individuals in Sample R.3 were reviewed, and the following was found: ▪ The Monitoring Team requested documentation of AAC equipment monitoring for the past three months. For none of the ten individuals with AAC systems (0%), had the Speech AAC and Electronic Aides to Daily Living Equipment Monitoring been completed consecutively over the past three months. Seven individual's AAC systems (i.e., Individual #138, Individual #281, Individual #92, Individual #281, Individual #94, Individual #224, and Individual #297) had only been monitored in April 2013; one individual's AAC system was monitored in February and April 2013; and two individual's AAC systems were not monitored during the three months (Individual #545 and Individual #377). ▪ None of the ten individuals' staff (0%) had been monitored using the Compliance Monitoring form. Additional information on the status of expanding the scope	Noncompliance

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		for compliance monitoring is discussed with regard to Section O.6. In summary, the Director of HT planned to revise, over the upcoming six months, outdated SLP and communication policies that did not reflect current practices. The Facility policies/procedures should incorporate the elements presented within this section. As discussed with regard to Section O.6, the Facility had identified that the monitoring data it was collecting was not reliable. In addition, individuals with AAC systems had not been monitored using the Compliance Monitoring form. The Facility remained out of compliance with this section.	

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

1. The Facility should complete an analysis to determine an appropriate caseload for SLPs at ABSSLC, 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. As the Facility's revises and updates its policies and procedures to reflect current practices, it should incorporate the following components:
    a. Roles and responsibilities of the SLPs (meeting attendance, staff training etc.);
    b. Outline of the assessment schedule;
    c. Frequency of assessments/updates;
    d. Timelines for completion of new admission assessments (within 30 days of admission or readmission);
    e. Timelines for completion of comprehensive assessments (within 30 days of identification via screening);
    f. 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);
    g. A process for effectiveness monitoring by the SLP;
    h. Criteria for providing an update (Assessment of Current Status) versus a Comprehensive Assessment;
    i. Methods of tracking progress and documentation standards related to intervention plans; and
    j. 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 review the revised SL assessment template and content guidelines to ensure the necessary 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 audits should assess these elements. (Section R.2)
4. 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)
5. Individuals' ISPs should include: attendance by a SLP for individuals with communication needs unless the team provides adequate justification; 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)
6. The Facility's monitoring policy for communication devices should include:
    a. Monitoring for the presence of communication adaptive equipment or other AAC supports/materials;

b. Monitoring for the working condition of communication adaptive equipment;
c. Monitoring for the use of communication adaptive equipment in multiple environments (home, day program, work);
d. The frequency of monitoring for individuals within the established Master Communication Plan priority levels;
e. The process for identification, training, and validation for monitors;
f. The process of inter-rater reliability; and
g. A process for data trend analysis and utilization of findings to drive training and problem resolution (individual and systemic). (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, held on 5/6/13; o Section S Presentation Book; o Guidelines for Monitoring the Quality of Functional Skills Assessments; o Individual Notebook (I-Book) Guidelines; o Roster of Individual Support Plan dates; o Individual Support Plan for: Individual #87, Individual #126, Individual #280, Individual #123, Individual #282, Individual #517, Individual #61, Individual #220, Individual #26, Individual #478, Individual #489, Individual #239, Individual #505, Individual #545, Individual #197, Individual #315, Individual #89, Individual #355, Individual #168, Individual #97, Individual #24, Individual #465, Individual #255, Individual #285, Individual #46, Individual #273, Individual #430, Individual #287, Individual #215, Individual #222, Individual #397, Individual #525, Individual #37, Individual #233, Individual #527, Individual #324, Individual #211, Individual #80, Individual #182, Individual #414, and Individual #399; o Preferences and Strengths Inventory for: Individual #87, Individual #126, Individual #280, Individual #123, Individual #282, Individual #61, Individual #220, Individual #26, Individual #478, Individual #239, Individual #505, Individual #545, Individual #197, Individual #315, Individual #89, Individual #355, Individual #97, Individual #46, Individual #273, Individual #430, Individual #287, Individual #215, Individual #222, Individual #397, Individual #525, Individual #233, Individual #324, Individual #211, Individual #80, Individual #182, Individual #414, and Individual #399; o Skill Acquisition Programs for: Individual #118, Individual #418, Individual #207, Individual #122, Individual #282, Individual #295, Individual #518, Individual #478, Individual #237, Individual #521 (two SAPs), Individual #234, Individual #212, Individual #412, Individual #403, Individual #287, Individual #447, Individual #326, Individual #297, and Individual #386; o Community Skill Acquisition Programs for: Individual #6, Individual #156, Individual #460, Individual #481, Individual #453, Individual #82, Individual #46, Individual #191, Individual #430, and Individual #447; o Vocational Skill Acquisition Programs for: Individual #517 and Individual #544; o Skill Acquisition Programs, Data Sheets, and Graphs developed by K. Theiss for implementation in Activity Center 5923 for: Individual #32, Individual #239, Individual #507, Individual #50, and Individual #144; o Training Documentation Reports for: Individual #87, Individual #126, Individual #220, Individual #478, Individual #505, Individual #197, Individual #315, Individual #355, Individual #168, Individual #24, Individual #465, Individual #46, Individual #273,

	Individual #324, Individual #80, Individual #182, Individual #414, and Individual #399; o I-Books (on site) for: Individual #87, Individual #263, Individual #543, Individual #123, Individual #95, Individual #518, Individual #478, Individual #464, Individual #92, Individual #545, Individual #265, Individual #315, Individual #538, Individual #318, Individual #268, Individual #99, Individual #301, Individual #410, Individual #465, Individual #255, Individual #320, Individual #256, Individual #8, Individual #541, Individual #94, Individual #112, Individual #447, Individual #83, Individual #312, Individual #327, Individual #211, Individual #80, Individual #291, Individual #182, Individual #100, and Individual #14; o Functional Skills Assessment for: Individual #87, Individual #126, Individual #220, Individual #478, Individual #168, Individual #97, Individual #24, Individual #465, Individual #46, Individual #527, Individual #182, and Individual #414; o Functional Skills Assessment Summary for: Individual #280, Individual #282, Individual #517, Individual #61, Individual #489, Individual #239, Individual #505, Individual #545, Individual #197, Individual #315, Individual #89, Individual #355 (draft), Individual #255, Individual #285, Individual #273, Individual #430, Individual #287, Individual #215, Individual #222, Individual #397, Individual #525, Individual #37, Individual #233, Individual #324, Individual #211, Individual #80, and Individual #399; o Vocational Assessments for: Individual #87, Individual #280, Individual #517, Individual #26, Individual #478, Individual #489, Individual #505, Individual #197, Individual #89, Individual #355, Individual #46, Individual #273, Individual #430, Individual #215, Individual #397, Individual #527, Individual #324, and Individual #182; o Vocational Services, Case Management, updated 3/27/13; o Vocational Services – Job Explorations; and o List of Individuals with Visual Impairment. ▪ **Interviews with**: o Direct Support Professionals, on 5/6/13; o Candia Hallford, Vocational Services Director, on 5/7/13; o Kristin Wyrick, QDDP Coordinator; Jeff Branch, Director of Active Treatment; Jolene Willis, Assistant Director of Programs; and Linda Lothringer, DADS SSLC Director of Compliance, on 5/7/13; o Shae Butts, Human Rights Officer, on 5/7/13; o Jeff Branch, Active Treatment Coordinator; Kristin Wyrick, QDDP Coordinator; and Jolene Willis, Assistant Director of Programs, on 5/8/13; o Ron Manns, Director of Behavioral Services, and Dr. George Zukotynski, DADS Coordinator of Behavioral Services, on 5/8/13; and o Erin Lomasney, Associate Psychologist/Counselor, on 5/8/13. ▪ **Observations of**: o Residence 5961, Residence 5962, Residence 5971, Residence 5972, Residence 6330, Residence 6350, Residence 6360, Residence 6370, 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, and Activity Center 6700; o Workshop 1, Workshop 2, and Workshop 3; o 5th Street Diner; o Human Rights Committee meeting, on 5/7/13; o ISP meeting for Individual #241, on 5/8/13; o Behavior Support Committee meeting, on 5/8/13; and o Restraint Reduction Committee meeting, on 5/9/13.
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section S, dated 4/22/13. In its Self-Assessment, for each sub-section, the Facility had identified: a) activities engaged in to conduct the self-assessment; b) the results of the self-assessment; and c) a self-rating. For Section S, in conducting its self-assessment: ▪ The Facility used monitoring tools. Based on a review of the Facility Self-Assessment, the monitoring templates and guidelines, a sample of completed monitoring tools, inter-rater reliability data, as well as interviews with staff: o The monitoring tools the Facility used to conduct its self-assessment included: a) the "Section S" monitoring tool; b) a PLACHECK monitoring tool; and c) a skill acquisition implementation monitoring tool (Skill Acquisition Competency-Based Training Tool SAP). o These monitoring tools included adequate indicators to allow the Facility to determine compliance with the Settlement Agreement. o The monitoring tools included adequate methodologies, such as record review, observation, and staff interview. o The Self-Assessment identified a sample size of 84 individuals whose records were reviewed using the Section S monitoring tool. A total of 644 audits using the PLACHECK monitoring tool, and a total of 41 audits of staff implementing skill acquisition programs were completed. o The monitoring tools had adequate guidelines to ensure consistency in monitoring and the validity of the results. The guidelines for the new SAP data sheet appeared to be a draft. This should be presented in a clearer format. o The following staff were responsible for completing the monitoring: a) the Section S monitoring tool was completed by the QDDP Coordinator, the QDDP Educator, and two QDDPs; and b) the PLACHECK and skill acquisition implementation monitoring tools were completed by Home Supervisors, QDDPs, Home Activity Specialists, and Day Program Managers. A Program Compliance Monitor from the Quality Assurance Department assessed inter-rater reliability using the Section S monitoring tool. Inter-rater reliability was not assessed on the PLACHECK or skill acquisition implementation monitoring tools. o Adequate inter-rater reliability had not been established between the various Facility staff responsible for the completion of the Section S tool. ▪ The Facility did not use other relevant data in its Self-Assessment. Other relevant data sources

	related to Section S would be an analysis of individual progress on identified SAPs. This should include data on community-based training. ▪ The Facility consistently presented data in a meaningful way. Total compliance on each indicator in each of three tools was reviewed in the text of the Self-Assessment report. The monitoring data for the Section S monitoring tool was presented on individual indicators in both table and graphic format. Overall engagement data was presented in graphic format. o In the table format, the Facility distinguished data collected by the QA Department versus the program or discipline on the Section S monitoring tool. ▪ The Facility rated itself as being out of compliance with all sub-sections of Section S. This was consistent with the Monitoring Team's findings. ▪ In its Self-Assessment, the Facility did not identify areas of need or improvement.
	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: ▪ The Facility had introduced a Pre-Individual Support Plan meeting during which necessary staff and required assessments were identified for the ISP meeting. ▪ The new Skill Acquisition Plan format included triggers to address frequent refusal to participate in training activities, and increasingly addressed maintenance and generalization of newly acquired skills. ▪ The Facility had begun monitoring staff's understanding and implementation of Skill Acquisition Plans. ▪ The Facility had begun monitoring active engagement of the individuals served. ▪ Evidence of interdisciplinary efforts to improve habilitation services was evident in the introduction of discrete trial training for a small number of individuals in one of the activity centers. Areas in which continued work was necessary included the following: ▪ Although the Preferences and Strengths Inventory identified individual-specific qualities, the analysis used to guide future planning was often quite limited and shortsighted. ▪ The Functional Skills Assessment Summary included information found in other documents (e.g., preferences and strengths), but did not focus on the primary purpose that was to review the individual's abilities across a broad array of skill domains, with corresponding recommendations for programming. ▪ Training objectives remained limited in scope and schedules of training. Access to community-based training remained infrequent. ▪ Engagement remained quite limited, particularly in the residential areas and activity centers.

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S1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide individuals with adequate habilitation services, including but not limited to individualized training, education, and skill acquisition programs developed and implemented by IDTs to promote the growth, development, and independence of all individuals, to minimize regression and loss of skills, and to ensure reasonable safety, security, and freedom from undue use of restraint.	A total of 41 Individual Support Plans were reviewed. These had all been completed between 10/12 and 4/13. A summary of findings is provided below. ▪ All of the plans (100%) included a review of the individual's preferences and strengths. The breadth of these reviews varied across individuals. o A few examples of more thorough descriptions were found in the ISPs for Individual #24, Individual #287, and Individual #222. o An example of a poor description of strengths was found in the ISP for Individual #355. He was about to graduate from high school and had held a competitive job the previous summer, yet neither of these was identified as a strength. o Looking at family photos was identified as a preference for Individual #80 who was blind. This issue was apparently raised in discussion. The explanation was that staff talked to the individual about his family. This might be a better descriptor. ▪ All of the plans (100%) included the Integrated Risk Rating Form. The ISPs for Individual #505, Individual #46, and Individual #211 included an older version of this rating form, which did not provide the same quality of information as the newer form. For each of the identified risk areas, staff were now expected to document the individual's history, current supports, current status, proposed recommendations/rationale, team deliberation and final recommendations, and risk rating. While most of the completed forms appeared to assign appropriate risk ratings to Behavioral Healthcare, there were a few exceptions. o Behavioral Healthcare was noted as a medium risk for Individual #430, but due to a chemical restraint applied in 8/12, he should have received a rating of high. o There was no information included under the Behavioral Healthcare rating for Individual #233, although there was a note that he was prescribed medication and had a behavior support plan. o Behavioral Healthcare was rated to be a medium risk for Individual #26, although it was noted that he often refused to participate in check and change (addressed in his BSP). Due to the health concerns raised by this refusal, it is suggested that a high rating would have been more appropriate. o Individual #505 was assigned a medium risk with regard to Behavioral Healthcare, yet the Team recommended against community placement due to his serious behavioral needs. Again, a rating of high risk would appear to be more appropriate for this individual. o Conversely, Individual #355 received a medium risk rating in Behavioral Healthcare although he had not displayed any targeted problems for the past year. ▪ Thirty-nine of the 41 ISPs (95%) included training objectives ranging from one	Noncompliance

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		to eight in total. This computed to an average of 3.63 objectives per individual. No training objectives were listed for Individual #489 or Individual #123, whose plan was identified as a draft. ▪ None of the ISPs (0%) included training objectives that were written in observable and measurable terms. Many were written in one to two word descriptors (e.g., bathing, dining, lotion rubs). For some individuals, there were additional concerns. Individual specific feedback is provided below: o For some individuals, there was clearly an attempt to address some of their expressed interests. Individual #211 was going to expand her writing skills, work on improved reading abilities, and learn to use a computer. Individual #87 was learning to cook. o Individual #126 had only one training objective identified in his ISP. It was identified as "Possible SAP for appropriate interaction/socialization." This terminology suggested that he might not have any training objectives, as this was only a possibility. o Individual #197 had expressed an interest in learning to cook and crochet. None of her three objectives addressed either of these skills. o The ISP for Individual #525 indicated that he would have a new SAP at the activity center that would include a vocational assessment to be completed. This assessment should have been completed prior to the meeting, and its completion certainly did not address the individual's learning a new skill. o Similarly, the ISP for Individual #517 identified a "SAP for telephone usage/after assessed." Again, this skill should have been assessed prior to the meeting. o Even when individuals had noted strengths in academic areas (e.g., reading, writing, math), there were no identified goals to strengthen or expand these skills to enhance one's leisure and/or work skills (examples included Individual #517, Individual #197, and Individual #222). Individual #211 had expressed an interest in expanding her reading skills and using the Internet, but neither of these was addressed in her ISP. ▪ A schedule of implementation was identified for at least one objective in only 19 of the 41 ISPs (46%). For 14 of these individuals, the schedule was noted to be daily, three to five days per week, or weekly. Other schedules were less clear as these were described as ongoing, continuous, monthly, quarterly, or annually or as needed (PRN). ▪ The community was identified as a possible training site in 19 of the 41 ISPs (46%). For some individuals, the objective specified that he/she would learn to make a purchase in the community (examples included Individual #505 and Individual #273). Other objectives were less clear:	

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		o Individual #285 was to learn to unbuckle the positioning belt on his recliner (a skill he was reported to already have) and water the plants outside. Community was listed as a possible training site for both of these skills. o The community was identified as a possible training site for two objectives for Individual #239. While one was appropriate for the community (i.e., shaking hands), the other was a skill that was better reserved for one's home (i.e., rinsing mouth for good oral hygiene). o The community was identified as a possible training site for all three of the objectives for Individual #355. The community appeared to be an inappropriate training site for learning to floss or identifying one's medications. Staff should carefully proof all documents. The ISP for Individual #399 contained information related to Individual #525. In summary, the Facility had made substantial improvements to the Integrated Risk Rating Form. The forms included in more recent ISPs reflected more thoughtful discussion with clear reference to recorded events and data, particularly with regard to behavioral health. Efforts should continue to present comprehensive reviews in the ISPs of the individual's preferences and strengths, and these should be related to the goals and objectives outlined in the plan. Training objective should be identified to meet the needs of the individual as determined by comprehensive interdisciplinary assessment, should address a broad range of skill areas, 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. Found in each residence were I-Books for each person residing in that home. These books were used as quick references for staff. While touring the Facility, the Monitoring Team reviewed a total of 36 I-Books across 11 residences. One section of the I-Book was the ISP Action Plans. None of the 36 books contained this information, and 10 of the I-Books did not include a tab for this section. Also contained in the I-Book were the SAPs for the individual. In the 36 books reviewed, there were zero to seven SAPs included, with an average of three SAPs per individual. As these books are used as guides for staff when supporting and implementing habilitation services, it is essential that these be kept current. Feedback from staff indicated that the I-Book was a helpful reference, but staff suggested that the information or risk card should be re-introduced as it provided a quick reference to critical information. The Facility had provided a total of 32 Skill Acquisition Plans in the Section S	

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		Presentation Book. The format had been revised slightly since the Monitoring Team's last visit. There was a lesson plan that included the following components: a) specific target behavior; b) general instructions; c) a table that provided information on the chaining method and definition, the data sheet, and the step sequence; d) a rationale; e) communication information; f) prerequisites; g) necessary materials; and h) the step sequence and teaching method. This was accompanied by a two-page data sheet that included the following: a) identified skill; b) teaching schedule and location, and times to document the individual's performance; c) the ISP date and implementation date; d) the teaching strategy; e) the prompting sequence; f) the instruction or other discriminative stimulus; g) consequences for correct and incorrect responding; h) plans for maintenance and generalization; i) the contact or responsible person; j) the assessment source; and k) a data recording grid. The second page of this document allowed staff to record comments and the QDDP to provide a monthly review of progress. All but five of the SAPs that were included in the Presentation Book followed this new format. Ten of the SAPs were identified as community SAPs and two were identified as vocational SAPs. A summary of the review of these 32 SAPs is provided below: ▪ Although 27 of the 32 SAPs (84%) included objectives that identified conditions under which an observable and measurable behavior was to occur, none (0%) met the standards of a behavioral objective, because the criterion for mastery was not clear. Twenty-five of the 32 SAPs (78%) designated a number of correct trials, but the time frame was identified as "within one reporting period" or something similar. If the reporting period were clearly identified (e.g., within 30 days), the criterion for mastery would be better indicated. ▪ Sixteen of the 32 SAPs (50%) noted that correct responding needed to occur over a consecutive number of trials. Caution is advised, because this criterion might impede progress. It might provide more room for slight errors in performance if the criterion was established as percentage of consecutive trials (e.g., for 10 of 12 consecutive trials). ▪ In 31 of the 32 SAPs (97%), a type of behavioral chain was identified under general instructions or teaching strategy. Fifteen of these 31 SAPs (48%) identified backward chaining as the teaching strategy, while 16 of these 31 SAPs (52%) identified forward chaining as the teaching strategy. It should be noted that in this second group of SAPs, five of the skills to be learned were not behavioral chains. Individual #418 was learning a discrete skill of pressing the button on a remote, Individual #282 and Individual #212 were both learning to make a simple choice, Individual #521 was learning to maintain a switch in the on position for increasingly longer periods of time, and Individual #544 was learning to use sign language. All of the programs in which a behavioral chain was the targeted skill suggested training only on the identified or current step in the chain. As noted previously, chaining techniques allow one to learn complex skills as smooth routines, with each link in the chain serving as the	

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		discriminative stimulus for the next link in he chain. These chains should be taught in sequence with fading of prompts determined by the type of chaining technique chosen for instruction. As there was no identified criterion for increasing the individual's independence by moving to the next step in the teaching sequence, it was unclear how and when the entire sequence or chain would be taught. ▪ Where appropriate, a task analysis was identified 100% of the time. ▪ Schedules of training varied across SAPs: o Thirteen of the 32 SAPs (41%) indicated that training was to occur one time each week. The SAP for Individual #295 suggested that five trials would be conducted during this training. The SAP for Individual #453 indicated that training could occur on either Wednesday or Saturday. o Six of the SAPs (19%) indicated that training should occur five days each week. o Five of the SAPs (16%) indicated that training should occur daily. The SAP for Individual #82 noted that training should occur before and after every meal. o Two SAPs were to be trained four times a week and one was to be trained three times per week. Two SAPs identified a training schedule of twice per week, with the SAP for Individual #430 noting that one training day could be on campus, and the other should be in the community. o The remaining three SAPs did not clearly identify a training schedule. Individual #478 was to work on her identified skill "when she needed a treatment." Individual #481 was to work on pedestrian safety skills "at various times." Individual #447 was to learn her identified skill "when she is about to make a purchase." Schedules should be clearly identified to ensure that training occurs. ▪ Training opportunities remained quite limited. Only the SAP for Individual #295 and Individual #82 identified or implied multiple trials per training session. Their training sessions were once weekly or daily, respectively. Therefore only the SAP for Individual #82 suggested adequate opportunities for learning. ▪ Twenty-one of the 32 SAPs (66%) identified praise alone as the reinforcer to be provided contingent upon correct responding. Seven of these suggested that the reinforcer was to be delivered regardless of the level of prompting required to produce a correct response. The remaining 11 programs paired praise with a purchased/preferred item or social interaction. ▪ A clear description of staff response to refusals or incorrect responding was found in 23 of the 32 SAPs (72%). The best example of this was found in the SAP for Individual #430 in which an example was provided. It should be noted that none of the older formatted SAPs included this component. Most of the	

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		correction strategies incorporated more intrusive prompting to achieve successful performance. o Several programs (e.g., those for Individual #478, Individual #237, and Individual #297) suggested that correction trials should be implemented by using the next less intrusive prompt. It is unclear how this would result in correct responding. The program for Individual #403 included guidelines for responding to incorrect performance by simply repeating the trial. Again, it is unclear how this would result in correct responding. ▪ Adequate and appropriate plans for maintenance and generalization of newly learned skills were found in 20 of the 32 SAPs (63%). This represented a marked improvement since the Monitoring Team's last visit. ▪ Of the 10 community SAPs, six (60%) clearly indicated that training was to occur in the community. The four remaining plans suggested that training could take place on campus or in the community. ▪ All of the SAPs (100%) noted the ISP meeting date. In twenty of the SAPs (63%) the date of implementation was not identified, although the ISP had been held between 8/12 and 3/13. Where implementation dates were identified, these ranged from the same day as the ISP meeting to eight months later. The SAP for Individual #544 suggested that his SAP had been implemented approximately one month before his annual meeting. As noted previously, SAPs should be developed and introduced in a timely manner following the ISP meeting to ensure ongoing access to habilitation services. As noted in the past, SAPs should include the following: a) a behavioral objective consisting of the conditions under which the behavior is to occur, the response described in observable and measurable terms, and the criterion used to determine mastery; b) training guidelines that are clear and comprehensive; c) training schedules, including number of trials per session, that ensure sufficient opportunities for learning to occur; d) guidelines for the application of individually identified reinforcers following correct responding; e) clear guidelines for error correction; and f) plans to ensure maintenance and generalization of newly acquired skills. To assist in the appropriate design and implementation of SAPs, the State and Facility are encouraged to recruit staff who have training and experience in the delivery of special education services. Further, with 91 individuals identified as having a severe visual impairment, the Facility should provide services of an Orientation and Mobility Specialist to ensure that habilitation services are carefully planned and implemented to meet the needs of this population. The Facility had begun monitoring staff to ensure their understanding and appropriate implementation of all SAPs. The use of the Skill Acquisition Monitoring Tool SAP was a good step in enhancing the support and training provided to the staff directly responsible	

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		for teaching the individuals new skills. A review of a sample of completed forms revealed limited documentation of positive feedback and constructive training to the staff who were observed. Monitoring provides an excellent opportunity to reinforce staff for good performance while also giving them suggestions for ways to improve training. This is also important as direct support professionals with whom the Monitoring Team met reported that they would appreciate more positive feedback from supervisors, other professional staff, and administrators. Three months of Training Documentation Reports were reviewed for 18 individuals. It should be noted that the Facility was changing over to an alternative form for data recording, but this had not yet been completed. With a total of one to eight training programs per person, this resulted in a review of 58 programs. A summary of findings is presented below: ▪ The date of program initiation was included in 57 of the 58 programs (98%). Thirty programs had been initiated in 2013, 12 had been introduced in 2011, 11 had been introduced in 2010, three had been introduced in 2009, and one had been introduced in 2008. Concerns were raised when individuals had been working on the same step of a program for several years without apparent progress or revisions to the program. Examples are provided below: o Individual #80 was still on the first step of all three programs reviewed (leisure, dressing, grasping an object), all of which had been introduced in 2/11. o Individual #273 was still on the first step of two of the three programs reviewed, one of which had been introduced in 2/11 (oral hygiene), the other having been initiated in 2/10 (eating). o Individual #24 remained on the first step of two programs (self-medication and inform staff of needs), both of which had been introduced in 1/10. ▪ Data was recorded on the days identified at least 50% of the time in 56 of the 58 programs reviewed (97%). ▪ In every case (100%) where data was recorded, there was a single data point, suggesting that the program was implemented only once that day. As noted previously, the number of trials per session should be clearly indicated with multiple opportunities offered to ensure that learning occurs. ▪ Refusals to participate in 50% or greater of the training opportunities were noted for eight individuals. These included: Individual #478 (dining and exercise), Individual #315 (reaching, exercise, and snack), Individual #168 (tooth-brushing), Individual #24 (participation and purchasing), Individual #46 (money skills), Individual #80 (leisure, dressing, and grasping an object), and Individual #414 (pedestrian safety). Individual #126 also was included in this list, because he refused to participate in training or refused to transition to the	

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		activity center. Frequent or repeated refusal to participate in an activity should trigger a review with revisions to the program as appropriate. This should be better addressed when the new SAP format is fully implemented. ▪ 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 individual program specific concerns are noted below: ▪ Individual #478 had a medication knowledge program, the first steps of which were to teach her to identify her B12 vitamin. Data recording had occurred between 12/12/12 and 1/2/13, but did not begin again until 2/12/13. A note from 1/25/13 indicated that she "did not receive" B12 vitamins. The result was that previous training was not applicable for this woman and that no training had occurred for over one month. It is concerning that this error was not detected earlier. ▪ This same individual had a work objective in which she was to learn to clean her glasses. Each time a new step was introduced, she was able to independently perform the skill. Baseline measures should be collected prior to formal training to determine whether the individual already possesses the identified skill. ▪ Individual #126 had a leisure program in which he was learning to transition to a room following staff instruction. The first step indicated he would do so within 10 verbal prompts. Across seven steps, he was to learn to make this transition in response to fewer and fewer verbal prompts, eventually making the transition upon arrival to the building. This represented very poor teaching methodology, because there was no change in prompting levels to ensure successful performance. Repeating a verbal instruction multiple times without compliance is, in effect, nagging. Similarly, Individual #465 was to make a choice in response to fewer and fewer verbal prompts, and Individual #46 was to transition to the medication room following fewer and fewer verbal prompts. Improved prompting strategies would prove to be a more effective and efficient way to teach each of these behaviors. ▪ As noted above, Individual #168 demonstrated repeated refusals to perform the first step (rinsing his mouth and spitting) of his tooth-brushing program. Over three months of data recording, he had refused participation in 40 of 50 documented trials. As he had been working on this program for 10 months, it would appear that some revision should be made to ensure that he learns to brush his teeth. ▪ Individual #182 had a name writing program in which there was no data recorded between 1/26/13 and 2/21/13. No explanation for this omission was noted. ▪ Individual #24 had five programs all of which contained a note that data was not	

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		recorded for 12 days, because there were no SAPs in her book. ▪ Individual #87 and Individual #197 both had money skills programs in which they were learning to identify coins and their values. Considering that these women were 30 and 37 years old, respectively, teaching them about money following a typical developmental sequence might not be the most functional or efficient way to develop their skills and greater independence. At the time of the Monitoring Team's visit, graphic display of progress on SAPs was still not evident. Graphs provide a very clear analysis of an individual's 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. <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 41 PLACHECKS were conducted across the home environments. Engagement ranged from 0% to 100% with an average engagement score of 36.73%. As noted in the past, engagement was greater in homes with fewer individuals present and in homes where the individuals experienced greater independence. Homes in which a greater number of individuals resided and in which individual needs were significant proved to have lower engagement scores. One staff member could have been providing supervision to 10 or more individuals, while other staff attended to self-care or medical needs for an individual. Engagement was also compromised when individuals were sitting, waiting for a meal. The highest engagement scores were observed during meals. ▪ A total of 20 PLACHECKS were collected across the activity centers. Engagement ranged from 0% to 100% with an average score of 36.25%. Activities were similar to those observed in the past. While individuals were present in most of the centers, a visit to Activity Center 6700 revealed only one man using a stationary bike with three staff present. Staff explained that the center was primarily used between 9:30 am and 11:30 am and then again from 2:30 pm to 4:30 pm. While individuals were welcome to attend at other times, this proved to be a very limited use of an area that is equipped with a range of exercise equipment and other materials. Similarly, the kitchen area located near Activity Centers 5721, 5722, and 5723 appeared to be underutilized. Cooking classes might be an area of interest for many of the individuals served. ▪ The workshop areas maintained the highest engagement rates. A total of 11	

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		PLACHECKS were conducted. Engagement ranged from 75% to 100% with an average rate of 91%. One promising practice that had been implemented since the last visit of the Monitoring Team was the introduction of discrete trial training in Activity Center 5923. The BCBA clinical supervisor in the Behavioral Services Department had introduced SAPs for five individuals who attended this center. Staff had been trained to work one-to-one with each individual to develop his leisure or communication skills. Data was collected during each training session and the BCBA reviewed and graphed progress. The plan was to have the BCBA train other Behavioral Services Department staff to extend this service to additional centers. Vocational Services had initiated job exploration for identified individuals. Much of this consisted of introducing individuals to different jobs available on campus. There had also been visits to a local Business Exposition and different stores in the community. The staff member responsible for job exploration documented each of these activities, often noting the individual's response. This was a good beginning to expanding work opportunities to areas beyond the workshops. Vocational services had expanded to include an additional janitorial enclave working at the local Veterans of Foreign Wars (VFW). Discussion was underway to explore additional work in this location, possibly assisting with lunch or larger banquets. Another development was the plan to begin helping the Facility's food service department prepare snacks for distribution on campus. Additionally, a greater number of individuals were working part-time in the 5th Street Diner, and one individual was helping to bus tables during lunch in two of the homes on campus. A review of the roster of Vocational Services – Case Management indicated that 119 individuals were employed for between two and 36 hours, averaging 17.48 hours per week. Eight of these individuals were involved in off campus employment. One additional individual was identified as working varied hours each week. Supported employment in inclusive settings in the community remained elusive. This section of the Settlement Agreement requires the Facility to provide habilitation to: "promote the growth, development, and independence of all individuals, to minimize regression and loss of skills, and to ensure reasonable safety, [and] security…" In order to accomplish this, it will be important for staff to consider not only age-appropriate and varied activities that are interesting to or preferred by the individual, but also to engage in respectful interactions that promote the dignity of the individual. While most staff displayed this understanding, there were a few occasions that suggested the need for greater familiarity with the Principle of Normalization, and its impact on creating an environment that promotes growth and development and minimizes regression. The following are examples of situations that did not provide such an environment: ▪ One individual was observed one morning sitting in the dirt outside of his home.	

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		He was sifting dirt over his clothing and body. A staff member exited the home with two other individuals. This staff member called over to the individual in the dirt, telling him to dust himself off and join the group as they transitioned to the activity center. With dirt on his clothes, face, and hands, this was completely unacceptable manner for him to engage in his daily schedule. The staff's action did not promote growth and development, support the individual to learn appropriate hygiene skills, or present himself in a way that would encourage integration with his peers, particularly non-disabled peers. ▪ In one of the activity centers, a woman was observed standing in the hallway with her pants down around her ankles. As she was approached, her underpants fell to her ankles. It was soon after that a staff member came to her assistance. In order to promote individual's independence, minimize regression, and ensure reasonable safety and security, clothing should fit properly, it should be clean, and it should be in good condition. Anything less suggests a lack of respect for the individual. ▪ In one home, men were repeatedly observed crouching, sitting, or lying on the floor of the living room with little to keep them appropriately engaged. The carpet did not look comfortable or clean. It is highly unlikely that any staff member or visitor to this home would choose to spend his/her time similarly. Again, failing to intervene to provide meaningful activities and encourage the men to engage in normalized behavior resulted in missed opportunities to promote growth and development, as well as independence. Unless there is a clear understanding of and adherence to the Principle of Normalization, there is an implied perception that the individuals served at the Facility will not be able to grow, develop, recognize improved living conditions, or benefit from habilitation. The Facility was employing the ABSSLC PLACheck Monitoring Form, revised on 10/12/12, to measure active engagement. The two-page form consisted of the following three parts: a) engagement of individuals in a group incorporating a momentary time sample or PLACHECK; b) an active treatment probe, including staff interview, that examined the quality of the activity and environment and staff interactions with the individuals; and c) a description of the coaching that was provided and any staff concerns or suggestions. A sample of completed monitoring forms was reviewed for completeness. All addressed the components of the first and second sections of the form, but the best were those that documented encouragement and suggestions to staff to improve the overall quality of the habilitation services offered to the individuals. Although the Facility continued in its efforts to improve habilitation services, for the reasons noted above, it remained out of compliance with this provision of the Settlement Agreement.	

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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.	Prior to the ISP meeting, the Team was expected to complete the Preferences and Strengths Inventory (PSI) for the individual. The first part of this form required the Team to record responses to a range of questions related to living options, employment activities, relationships, leisure skills, and independence. The Team also was expected to record the method used by the individual to identify his/her preferences. The second section required the Team to summarize the individual's preferences and strengths. The final analysis section posed questions to help develop goals to meet the individual's preferences for future living options employment, relationships, leisure skills, and independence. The PSIs for 32 individuals were reviewed. Findings are summarized below. ▪ The completion date was identified in 30 of the 32 PSIs (94%). ▪ Twenty-six of the PSIs (81%) were completed before the individual's annual ISP meeting. Three were completed on the same day and one was completed after the annual meeting. ▪ The person guiding the process, his/her role, and signature were found in 22 of the 32 PSIs (69%). Concerning was the PSI for Individual #397, in which the signature date preceded the completion date by almost three months. ▪ Information was provided for all areas under consideration in the first part of the PSI in 17 of the PSIs reviewed (53%). The remaining 15 PSIs (47%) included sections that were incomplete or left blank. ▪ The method used to identify the individual's preferences was clearly identified in 15 of the 32 PSIs (47%). Staff should indicate the sources of information, be they the individual's verbal report (or some other form of communication), observations by staff, or information provided by those who know the individual best. ▪ Although fairly comprehensive summaries of individual preferences and strengths were provided in 26 of the 32 PSIs (81%), these varied considerably across individuals. Examples are provided below: o Although the first section of the PSI for Individual #282 was incomplete, there were fairly good summaries of his preferences and strengths. o Similarly, the summary section for Individual #197, Individual #525, and Individual #399 provided a fairly good profile of the individual's preferences and strengths. o There was no summary of strengths provided for Individual #123. o The PSI for Individual #355 provided no summary of his preferences or strengths. o The PSI for Individual #397 listed only foods under preferences and did not address his strengths at all. Throughout the inventory there was almost a negative tone, because the individual was noted to have answered "beer" to many questions, even when this answer did not make any sense. To make this assessment useful, further inquiry with	Noncompliance

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		the individual or those who knew him would have been appropriate. ▪ The final section guided teams to consider future planning for the individual. Here, too, the quality of these analyses varied greatly with only 15 of the 32 (47%) approximating comprehensive planning. This is an opportunity for the team to explore options for individuals that will enrich their lives and address their preferences. Many of the remaining PSIs were very shortsighted with regard to future planning. Examples included the following: o The team for Individual #280 identified his current home and current job as the recommended goals for his residence and employment, respectively. When guided to indicate the preferences and strengths that supported these proposed goals, the team indicated these were not applicable. His leisure goal was "working." Similarly, the PSI for Individual #239 and Individual #505 suggested no substantive changes from their current situations. o Four of the five questions in the analysis section of the PSI for Individual #123 were not addressed. None of the questions regarding barriers and necessary action plans were addressed. o The analysis section for Individual #61, Individual #355, Individual 397, and Individual #324 was blank. o Although the PSI for Individual #26 was fairly comprehensive, the analysis section provided no recommendations for future planning. o In the analysis section for Individual #315, staff were quoted as stating that they "… do not feel that she would like to be more independent." ▪ The PSIs for Individual #280, Individual #239, and Individual #505 were almost identical in their content. The PSI should be specific to the individual. As noted previously, the team should engage in a thoughtful discussion of all areas outlined in the PSI, with input from the individual and those who know him/her well, to ensure that the outcome is a comprehensive profile of the individual's preferences and strengths. This should then be used to guide for future planning, with barriers to goals and accompanying action plans clearly outlined. Given that all of individuals should have the opportunity to grow and develop as reflected in the language of Section S.1, accepting the current living, working, and leisure environments as the preferred goal for the individual does not reflect any effort to provide the individual with an improved quality of life and greater independence. The Facility continued to employ the Functional Skills Assessment to determine an individual's strengths and needs across 13 broad areas, including: dressing, restroom, 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 FSA, including summary and	

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		recommendations, was reviewed for 12 individuals. A report summarizing the results of the FSA was reviewed for an additional 27 individuals. The results of this document review are outlined below: ▪ The date of completion of the FSA was identified in 37 of the 39 reports (95%). ▪ Thirty-two of the 37 dated FSAs (86%) had been completed prior to the individual's identified annual ISP date. (The FSA for Individual #414 was dated 10/19/13 and while it may have been completed before his ISP meeting, it was not included in this calculation). For three individuals, the FSA date and the ISP date were the same. The master list of ISP dates did not reflect the current ISP date for Individual #489, however, her FSA completion date was recorded as 1/1/13. ▪ None of the summary reports (0%) included a comprehensive list of the individual's strengths across the 13 areas assessed. As noted previously, the purpose of completing an assessment of skills is to develop a comprehensive understanding of the individual's strengths and needs in order to best guide treatment planning. ▪ Between two and six skill acquisition programs were recommended in the 37 summary reports. On average, 3.85 skill acquisition programs were recommended. Similar to the summary description of an individual's strengths and needs, it would be beneficial to treatment planning if recommendations across all areas assessed were considered. ▪ The person completing the summary and his/her title were identified in all of the reports (100%). Thirty-one of the summary reports (79%) were signed. As noted in the last report and repeated here, 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. When working with individuals who are beyond school-age, staff are encouraged to consider truly functional skills and not rely on the typical course of skill development (e.g., learning to match to sample to use a vending machine is a more functional skill than first learning the value of coins, learning to choose between two articles of clothing is more functional than first learning to identify colors, etc.). As noted previously, the Facility utilized an expanded vocational assessment to outline an individual's vocational vision, work preferences, education/work history, strengths, barriers to achieving the vocational vision, supports necessary to overcome these barriers, ideas for the future, and finally recommendations. Eighteen assessments were reviewed. A summary of findings is provided below. ▪ All of the reports (100%) identified the person completing the assessment and his/her role. All of the reports (100%) were signed and dated. ▪ Ten of the assessments (56%) had been completed or updated since 10/12.	

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		▪ Only six assessments (33%) identified the most current ISP date. ▪ Nine of the assessments (50%) had been completed on or prior to the identified ISP date. ▪ Twelve of the assessments (67%) identified a vocational vision. These were often shortsighted, consisting of the individual's involvement in other contracts at the workshop or in similar environments on campus. The vision for Individual #489 and Individual #89 indicated that each was to continue in her current job. Individual #505 was identified as not having a work vision. Individual #324 clearly indicated that she did not want to work. As this woman was only 29 years of age, it would seem appropriate to try to find an area of interest and then explore vocational activities related to this interest. However, the exploration recommended for her was to visit the workshop areas for a tour. ▪ Recommendations regarding further assessment and/or job exploration were identified for 15 individuals (83%). Again, these were limited to campus-based employment and often referenced exploring other contracts within the workshop areas. Expected dates of completion for future assessment and/or job exploration were not included. o Individual #87, Individual #26, Individual #355, and Individual #397 all clearly indicated an interest in working in the community, but there were no clearly identified plans to pursue work opportunities beyond the campus. o Individual #355 had indicated he wanted a job in the community involving lawn care, but the only recommendation for exploration was for him to visit the workshop areas for a tour. It would seem that outdoor activities, even if on campus, might have better addressed his preferences. ▪ Six of the assessments (33%) identified job exploration that had been completed. In every case, the exploration took place on campus, often in the same workshop area. In five of these six reports, the individual's response to the job was described. For Individual #527, his job exploration led to part-time employment at the 5th Street Diner. This was the only definitive positive outcome that was described. As the Vocational Services Department continues to expand the variety of jobs available to individuals, recommendations should be made to focus on individual-specific interests with greater emphasis on activities beyond the workshop and in the community. Based upon the information reviewed above, the Facility remained out of compliance with this provision of the Settlement Agreement.	

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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 should be reviewed by the Facility, because much of it remains relevant. While assessment of an individual's preferences, strengths, and needs was ongoing, the quality of these assessments remained inconsistent across individuals. The information gleaned through these assessments was not always summarized in full, nor was the information used to provide recommendations for habilitation across all skill domains. Habilitation programs remained limited in scope, were often redundant from one year to the next, and were poorly implemented. Opportunities for instruction were severely limited, reinforcement for correct responding was not individualized, and guidelines for error correction were often not clear. During the tour of the Facility, observation of teaching on individual-specific plans occurred infrequently. Engagement remained quite poor. 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 comments provided in the last report remain relevant and are repeated here. The Facility continued to make efforts to increase training in the community, most notably in vocational services, although these remained quite limited. Direct support professionals reported that recreational trips to the community were also limited. The community-based SAPs provided by the Facility continued to reflect limited opportunities for actual training due to limited scheduling (i.e., once per week) or options for campus-based training. Programs were limited to making a purchase or pedestrian safety. While this reflected a slightly broadened view of community-based training, staff are again encouraged to consider the vast array of activities that could be learned outside of the campus. These include, for example, job opportunities, trips to the library or post office, participation in local leisure or church-based groups, among others. Greater emphasis was needed on expanding habilitation services to the community across a range of activities, and in an individualized manner. The Facility remained out of compliance with this provision of the Settlement Agreement.	Noncompliance

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 Preferences and Strengths Inventory should be completed to ensure that the individual's strengths, preferences, and needs are clearly identified. Goals for the future and necessary action plans should encourage continued expansion of skills, access to a greater variety of environments, and enhanced quality of life. Assessment of individual risk should be clearly identified and explained in the IRRF. (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. Results of all audits should be provided to the staff who are monitored to ensure that positive feedback is provided whenever appropriate and supportive training is provided as needed. (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 Principle of Normalization and how this applies to these very basic rights. (Section S.1)
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, since the Monitoring Team's last visit, updated 5/9/13; o List of individuals referred for community transition with current status, undated; o In response to a request for a list of individuals requesting community placement, but not referred, a statement indicating the data could not be pulled, but the Facility was attempting to correct the issue; o List of individuals for whom Legally Authorized Representative (LAR) preference is to remain at SSLC regardless of preference of individual, dated 4/8/13; o List of individuals transitioned to community, since the Monitoring Team's last onsite review, updated 5/8/13; o List of individuals who have had a Community Living Discharge Plan (CLDP) developed during the last six months; o Discharge summary and related assessments, and sign-in sheet for Individual #81; o List of individuals who have transferred to other SSLCs, undated; o Response to request for list of alleged offenders: "There have been no Alleged Offenders committed to the facility since the last on-site review," undated; o In response to request for description of how Facility assesses individual for placement: ISP Meeting Guide, undated; o In response to a request for the last 12 months, a list of individuals who have been assessed for placement, date of assessment, and resulting recommendations, the following statement: "All individuals are assessed for placement during the annual ISP process. Sometimes, an individual is reassessed for placement as part of a Living Options discussion through an ISP Addendum" with a list of individuals referred for placement in the last 12 months, and the ISP schedule for the last 12 months; o In response to request for list of individuals that returned to the Facility following transition to the community: "Since the last onsite review, no individuals have returned from a community residential placement"; o In response to request for list of all deaths if any that occurred following transition to the community: a list including Individual #402 and Individual #41, as well as related documentation related to the deaths; o Community Placement Report, dated 4/16/13; 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 List and material related to training provided to individuals, families, and LARs; o Summary of data from March 23, 2013 Provider Fair evaluations; o Training documentation and materials for staff related to most integrated setting, various dates; o List of obstacles identified in ISP meetings for the past one-year period; o Workbook for Supporting Visions Tier 2 and 3: Personal Support Planning; o Individual Support Plans, Sign-in Sheets, Assessments, Individual Support Plan Addenda (ISPAs), Preferences and Strengths Inventory (PSI), Community Living Options Information Process (CLOIP) worksheet, skill acquisition and teaching programs, Rights Assessment, monthly reviews, and ISP Preparation Meeting documentation for: Individual #255, Individual #447, Individual #418, Individual #218, and Individual #374; o CLDP, any associated assessments, and most recent ISPs for the following: Individual #194, Individual #179, Individual #197, Individual #274, Individual #107, Individual #50, and Individual #396; o ISPAs related to transition for Individual #111; o In response to State Office reviews of CLDPs, the following statement: "There are no state reviews for the CLDPs submitted"; o Since the previous review, a list of all post-move monitoring visits, including the dates for each of the completed visits and due dates for upcoming visits; o Pre- and Post-Move Monitoring Checklists for the following individuals: Individual #179, Individual #450, Individual #194, Individual #274, Individual #163, Individual #48, and Individual #107; o Monthly Meeting Notes Section T: Placement, dated 9/5/12, 10/9/12, 11/7/12, 12/6/12, 1/28/13, 3/13/13, and 4/30/13; o List of individuals/guardians with whom transition specialists are working, undated; o Sample of Section T quality assurance monitoring tools the QA Department completed, and the Admissions/Placement Department completed, various dates; and o In response to requests for analyses of data: ▪ Annual Report on Obstacles to Transition, completed November 2012; ▪ Section T Action Plans, updated 4/12/13;

	▪ Quarterly Obstacles Report for 1st Quarter of FY 2013, presented 12/17/12; and ▪ Quarterly Section Reviews of Progress, dated 10/15/12, 12/17/12, and 3/11/13. ▪ **Interviews with**: o Kerry Loveland, Admissions/Placement Coordinator; o Kristin Wyrick, QDDP Coordinator; o Heather Vivoda, Post-Move Monitor; and o Diane Jackson, Transition Specialist. ▪ **Observations of**: o Post-move monitoring visit for Individual #107, on 5/8/13; and o Community Living Discharge Plan meeting for Individual #50, on 5/9/13.
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section T, dated 4/22/13. 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: o 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. o 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. As one example, 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. 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. o 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. It did not seem like the correct sample was even being drawn.

	For example, some of the indicators for T.1.a should have been applied to individuals in the transition process as opposed to a random sample of ISPs. 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) 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. 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 Transition Specialist 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 programmatically competent in the relevant areas. o Adequate inter-rater reliability had not been established between all of the various Facility staff responsible for the completion of the tools. This is discussed in detail with regard to Section T.1.f. ▪ The Facility used some other relevant data sources. 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 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 a number of subsections for which the Monitoring Team did not find substantial compliance. Largely, it appeared that 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. However, the Facility is encouraged to review the Monitoring Team's report in comparison with its self-assessment to further identify the discrepancies. ▪ The Facility data identified areas in need of 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: Most assessments prepared for annual ISP meetings now included the assessor's recommendation regarding transition to the community. In addition, individuals' ISPs generally included a recommendation from the Facility's team members' with regard to whether or not community placement was appropriate. This was positive. However, unfortunately, the assessments and/or ISP narratives often did not include sufficient justification for the teams' recommendations, including recommendations both for and against transition to the community. Although teams were identifying obstacles to community referral, the specific reasons for the obstacles were often missing. For example, when teams identified "medical issues" as the obstacle, little, if any, information was provided about the specific concerns that led the teams to believe the person could not be supported in the community due to their medical needs or a lack of medical supports. Similarly, when "LAR choice" was identified as the obstacle, little information was provided regarding the LAR's specific concerns. Without further detail, identifying potential solutions to the issues was difficult. Action plans to address obstacles were being developed, but they were poor in that they often did not address the underlying issue, and were not individualized. Similarly, the Facility continued to provide a number of educational opportunities to individuals and their families. However, an ongoing concern was the lack of individualization of action plans related to expanding individuals and their guardian's knowledge of supports in the community that could meet their needs. Teams had not yet begun to systematically identify obstacles to transition that individuals encountered after the referral was made. However, although still limited, the Facility had begun to analyze the aggregate data related to obstacles to referral. Although more work was needed with regard to completing a full analysis, the Facility's annual obstacles report had begun to include some information that could be helpful in addressing obstacles to referral as well as transition, including integration of information the Facility had in relation to the community provider network(s) in the local area, and some initial analysis of the most frequent obstacles (i.e., LAR Choice and Individual Choice). Admissions and Placement Department staff had continued 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), and reviews were completed thoroughly. In addition, Facility staff were following up to ensure that necessary corrections were made or supports were provided to ensure individuals received the protections, supports, and services they needed. The Facility was found to be in substantial compliance with Section T.2.a.

#	Provision	Assessment of Status	Compliance
T1	**Planning for Movement, Transition, and Discharge**		
T1a	Subject to the limitations of court-ordered confinements for individuals determined incompetent to stand trial in a criminal court proceeding or unfit to proceed in a juvenile court proceeding, the State shall take action to encourage and assist individuals to move to the most integrated settings consistent with the determinations of professionals that community placement is appropriate, that the transfer is not opposed by the individual or the individual's LAR, that the transfer is consistent with the individual's ISP, and the placement can be reasonably accommodated, taking into account the statutory authority of the State, the resources available to the State, and the needs of	As reported in previous reports, on 3/31/10, DADS issued a revised policy entitled "Most Integrated Setting Practices." This State policy accurately reflected the provisions contained in Section T of the Settlement Agreement. The policy's stated purpose was to "prescribe procedures for encouraging and assisting individuals to move to the most integrated setting in accordance with the Americans with Disabilities Act and the Untied States Supreme Court's decision in Olmstead v. L.C.; identification of needed supports and services to ensure successful transition in the new living environment; identification of obstacles for movement to a more integrated setting; and, post-move monitoring." The policy included components to ensure that any move of an individual to the most integrated setting was consistent with the determinations of professionals that community placement was appropriate, that the transfer was not opposed by the individual or the individual's LAR, and that the transfer was consistent with the individual's ISP. During future reviews, the Monitoring Team will continue to evaluate the State and the Facility's implementation of this policy. With regard to the availability for funding community transition of individuals from ABSSLC, funding availability was not cited as a barrier to individuals moving to the community. No one appeared to be on a waiting list. At ABSSLC, the Facility was making efforts to ensure transitions were occurring at a reasonable pace. The State's expectation was that once a referral was made, the transition to the community should occur within 180 days. Justification needed to be documented for any transitions that were anticipated to take longer than the 180-day timeframe. At the time of the previous	Noncompliance

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	others with developmental disabilities.	review in August 2012, six individuals had exceeded the 180-day timeframe. 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. At the time of the most recent review, although the Facility submitted some conflicting information (i.e., dates on the Community Placement report versus those submitted in Document Request TX-AB-1305.XVI.2), it appeared six individuals had exceeded the 180-day timeframe. These dates ranged from 10/6/11 through 10/18/12. Based on documentation submitted and interview with staff, there were reasons for each of these delays. Of concern was that one of the reasons that three individuals' transitions had been delayed was due to problems a provider had had with a homeowner's association reacting negatively to the use of a home as a group home. Although not all of the details were discussed, staff reported that State Office had been made aware of the issue. Given the implications of this, it was positive that the Facility had shared information about this obstacle with State Office, so that they could take appropriate action. In general, the Admissions Placement Department and Transition Specialists appeared to be continuously working with individuals' teams to move the transition process forward. The Admissions Placement Coordinator indicated that the goal was by July 2013, no one would have been on the referral list for more than 180 days. Although this was an important goal, 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, teams also needed to fully 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 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 five plans were reviewed including those for: Individual #255, Individual #447, Individual #418, Individual #218, and Individual #374. Based on this review,	

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		assessments prepared for annual ISP meetings increasingly included the assessor's recommendation regarding transition to the community. Of the five ISPs reviewed, all of the assessments for none of the individuals (0%) included the applicable statement/recommendation. However, for all five of individuals most of the assessments included such a statement. For these five individuals, four individuals' ISPs (80%) included an independent recommendation from the professionals on the team to the individual and LAR (i.e., as discussed below, Individual #218's team did not make a definitive recommendation). However, as is discussed in more detail with regard to Section T.1.b.3, for none of these individuals, the assessments and/or ISP narratives included sufficient justifications for the teams' recommendations, including recommendations both for and against transition to the community. 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 the Effective Date hereof and with full implementation within two years, each Facility shall review, revise, or develop, and implement policies, procedures, and practices related to transition and discharge processes. Such policies, procedures, and practices shall require that:	As noted in the Monitoring Team's last report, the Facility had a policy related to Section T of the Settlement Agreement, entitled: "Admissions, Alternate Placement, Transfers, and Discharges," dated 5/1/12. 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. 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.	Noncompliance
	1. The IDT will identify in each individual's ISP the	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	Noncompliance

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	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.	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, 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. 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 identified and provided in a timely and complete manner. <u>Identification of and Plans to Overcome Obstacles to Transition to Community</u>	

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		The revised ISP format included a section on obstacles the IDT identified. 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. In reviewing the sample of five ISPs, teams generally had identified some obstacles. Of the five ISPs reviewed, five should have had obstacles defined (i.e., none of these individuals had been referred to the community). Of the five remaining plans, none (0%) included an adequate list of obstacles. The problems associated with the lists of obstacles included the following: ▪ When guardians or individuals objected, adequate inquiry did not occur with regard to specifically what their concerns were (e.g., for Individual #418, the obstacles identified were LAR and Individual Choice, but the specific reasons for either of their reluctance were not identified; and for Individual #255, the reasons for the guardian's reluctance were not identified; for Individual #374, some of the reasons for the guardian's reluctance were included in the ISP Preparation meeting documentation, but this information was not carried forward or addressed in the ISP); ▪ At times, the team, independent of the individual and guardian, did not recommend transition to the community. However, no obstacle beyond individual or guardian choice was selected. If the team's independent recommendation was for the individual not to transition, then another obstacle should have been identified (e.g., Individual #218 - The obstacles identified were individual choice due to lack of understanding, and LAR choice - had been provided information, but was not interested. The narrative identified other obstacles that the team identified, including her history of eloping and the risk this would pose in a residence that was not as protected as ABSSLC. This was not documented formally as an obstacle); and ▪ Some were not adequately justified (e.g., for Individual #255, "medical issues" was one of the obstacles identified, but no justification was provided; for Individual #447, the obstacles the team identified included "Individual choice" and "medical issues." The specific medical issues and supports not available in the community to address her medical needs were not identified anywhere in the ISP. She had expressed a choice to move to the community, but then the team talked to her about their concerns, and she changed her mind). Similarly, the Facility provided some examples of ISPs in the Presentation Book for this subsection, and one showed some of the same concerns (the other individual was referred with apparently the whole team in agreement). For example, in addition to Individual #498's ISP not explaining how the Facility members of the team reached their	

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		recommendation that he not be referred given that there were differences of opinion between them, one of the obstacles identified was "Medical Issues," and the only explanation provided was "the need for 24-hour nursing and multiple medical concerns." The specific services that a nurse would need to provide 24 hours a day were not spelled out, nor were the medical concerns that would have precluded the individual from living in a small group home or ICF/ID. Moreover, action plans to overcome the obstacles to referrals generally were not adequate. ▪ Of the five ISPs, four (80%) included an action plan to overcome obstacles identified (i.e., the one that did not was the ISP for Individual #418). ▪ Of these four, none (0%) were adequate. o The plans were not adequately individualized. Many of the plans included action steps such as "Attend provider fairs," "Community Tours," or "contact family about living options annually." These did not specifically address the individuals' needs by, for example, tailoring visits to show the individual options that might meet his/her needs, identifying tools that could be used to assist an individual to learn about options that would be meaningful to him/her, or for an individual who could not verbally express his/her opinion identifying how the team would determine the individual's choice; o At times, the plan did not address the stated obstacle and/or the underlying issues [e.g., for Individual #374, the plan did not address "LAR Choice;" for Individual #255, the plan did not address the "Medical Issues" obstacle; for Individual #418, the plan did not address LAR Choice, which was the stated obstacle; for Individual #447, the plan to overcome the obstacles included a skill acquisition program to increase her walking (this appeared to be to make it more likely she could move to one of the quieter homes on campus), and "Community Tour." None of these addressed the underlying issue of the team's concern about the ability of a community provider to meet her medical needs]. 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 or individual action. For the example in the Presentation Book for Individual #498, the team had developed	

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		an action plan. The team had included a component to assess his reaction to the community tour(s) that he attended, which was positive. However, the methodology for doing this was not stated other than saying documentation would be maintained in the Observation Notes. For example, options might be for a staff who knew him well to go on the tour with him to provide feedback to the team, or for certain ways in which he communicated to be identified and relied upon to help the team gauge his reaction. In addition, the community tours were not defined in any way. As noted above, the team was concerned about the ability for his medical issues to be addressed in a community setting. However, the tours were not to occur specifically to homes that could meet his needs, no member of the team was assigned responsibility for further researching options or specific providers that could potentially meet his needs, etc. The Monitoring Team has provided numerous examples in previous reports regarding the concerns related to the identification of obstacles, and the lack of plans to overcome them. The Facility is encouraged to review the previous reports. On 3/8/13, the Admissions Placement Coordinator provided training to the QDDPs on Obstacles to Placement and Transition and the CLDP Process. Based on review of the data for obstacles identified over the last one-year period, it appeared that from November 2012, a couple of obstacles to transition had been identified. However, the Facility was not yet consistently documenting obstacles to transition, because it was unclear what the obstacles had been for other individuals, who had transitioned, but for whom it had taken longer than 180 days, or for the others currently in the transition process. It also was unclear if there were obstacles for individuals who had not exceeded the 180 days. The Settlement Agreement clearly states that: "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" (emphasis added). Therefore, if an individual's needs or preferences are not accommodated for a vocational program, for example, it should be identified as an obstacle. 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. ABSSLC had essentially maintained its previous status with regard to identifying obstacles to community referral and transition, and 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 did not address the underlying obstacle/issue. 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.	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**: Since the last review, two provider fairs were held, including one on September 14, 2012, and another on Saturday, March 23, 2013. Based on data the Facility provided, family member/LAR attendance remained low, with two family members attending the fall fair, and two family members attending the spring fair. Of note, one of the families that attended the spring fair decided to pursue a referral. The Admissions Placement Department was continuing to try to develop ideas to increase family attendance. Individual attendance had fluctuated with 94 individuals attending the fair in March 2012, 52 individuals attending the September 2012, but then, in March 2013, 155 individuals attended. This increase in individual and staff attendance in the spring was very positive. A satisfaction survey was completed. A total of 28 individuals and 55 staff responded. However, based on the information provided, it did not appear that outcome measures had been established with regard to attendance and/or satisfaction. Review of such data from year to year would be important to allow the Facility what was working and not working, and to determine whether changes needed to be made to future provider fairs. ▪ **Education about community options:** Individuals and their guardians also were provided information through the following: o Based on review of ISPs, the Local Authority CLOIP process appeared to have 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 agreed to take new or additional actions regarding exploring community options, or the number of individuals and families/LARs who refused to participate in the CLOIP process. Collection and review of such outcome data would allow the State to evaluate the effects of the process and make changes made to future educational activities. o Transition Specialists were attending some ISP meetings to provide information on living options to individuals and their families. In addition, as noted above, the Transition Specialists had begun to work with specific individuals and families to provide more information about specific supports and/or to seek out providers that might be able to meet individuals' needs. This was an important part of the education process. In addition, they were working on resource directories to	Noncompliance

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		describe the services that all community providers in the area offered. ▪ **Tours of community providers**: Documentation indicated that educational community tours continued to be offered in collaboration with a Local Authority. These occurred on Fridays, and the residences on campus were invited to attend on a rotating basis, or individual tours could be arranged. Based on review of individuals' ISPs, at times, teams included this as an action step to provide individuals with greater exposure to options available in the community. However, as discussed in further detail below, such action plans often were not individualized. 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 individuals' specific preferences, needs, etc.; and 3) the individual's response to the tour is assessed. As noted in the past report, it was positive the Facility used the form entitled "Community Living Options Tour Attendance Sheet," and it 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, Facility staff recognized that this should be formalized in a plan, and expected to develop a plan once the revised State Office policy on the Most Integrated Setting was issued. It should be noted that the Facility planned to add a component to New Employee Orientation on the most integrated setting beginning in June 2013. On the forms used to track attendance at the provider fairs and Local Authority training, the Facility was identifying the staff that participated, and this data had been aggregated. However, generally, 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 November/December 2012, January/February 2013, and March/April 2013 editions of the Maple Street Messenger included articles highlighting stories about individuals that had successfully moved to the community. These were good articles that discussed some of the new opportunities the individuals had had since they moved.	

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		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. Staff reported that this was happening some with individuals that had moved and had reached out to invite some of their peers to their new homes for visits or to celebrate special occasions. However, staff indicated they planned to try to formalize ways to facilitate such opportunities; o As appropriate, pairing families/LARs who have experienced a successful transition with families/LARs who are reluctant. Again, staff indicated that some of this had occurred when a community provider had facilitated it, but they intended to play more of a role in the future, and had begun to talk to some families of individuals that had moved who expressed interest in participating; and o If aggregate data showed that families and guardians had similar 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:** Based on interview and documentation provided: o The Admissions Placement Department staff were offering education at Self-advocacy meetings. The Transition Specialist had presented at the Self-Advocates meeting on 11/13/12, and attended to answer questions on 2/12/13, and 3/12/13. o The Facility also had begun implementing a creative idea entitled "Provider in the Diner." On 2/22/13 and 4/19/13, two different providers had been invited to provide information and interact with individuals and staff as they came to the diner. Given that the diner was a popular place on campus, this was a potential forum for individuals and staff to learn more about community options in a casual atmosphere. o It did not appear that the Facility was currently engaging in educational activities during house meetings, and no specific information was provided about involvement with the Family Association. ▪ **Regular SSLC meeting with the Local Authority:** Based on documentation provided, the ABSSLC Admission and Placement Department staff and Transition Specialists were meeting quarterly with Local Authority staff. Based on the minutes from the meetings, it appeared that relevant topics were discussed, including current referrals, as well as questions that either the LAs or ABSSLC had regarding transitions. It was positive to see that ABSSLC staff had raised the question of whether LA staff could assist in further defining the reasons for	

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		guardian or individual reluctance to consider community transition. As the ABSSLC staff indicated in the minutes, this could assist teams in developing more meaningful individualized plans. ▪ **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 five recently completed ISPs, none of the individuals had been referred to the community. For these five individuals, four (80%) had a plan that addressed education about community options. However, none of these (0%) was 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. In cases where the individual or LAR's choice is identified as the obstacle, 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. Based on the sample of ISPs, teams had not developed individualized plans. Creative ideas and brainstorming within ABSSLC and with other SSLCs will be necessary to identify the best ways to provide effective educational opportunities. o The plans could be measured in terms of whether or not the limited activities described occurred. However, they did not provide for the team's follow-up to determine the individual or guardian's reaction to the activities offered. 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). The action plans generally provided for the team to provide ongoing monitoring, but no specific strategies were included to obtain the individual's reaction at the time or shortly after an educational opportunity. o The following individual had no plan for further education: Individual #418. ▪ The plan for Individual #218 was the only one of the five ISPs (20%) to identify	

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		what happened with the previous year's plan. The individual had not gone on the community home visit the team had included in the previous plan, and this year's plan included an identical action step. For Individual #447, based on the ISP document, some discussion occurred about the activities over the last year, but this was not linked specifically to a plan. 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 most individuals had a plan in their ISP, the plans were not individualized. 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 Facility was implementing the State Office's process 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. The newer format of the ISP included a section that more specifically addressed teams' recommendations regarding transition to the community. Five plans were reviewed including those for: Individual #255, Individual #447, Individual #418, Individual #218, and Individual #374. The following highlights some of the findings: ▪ In order for the State Office requirement to be met, each discipline's assessment needed to include an opinion/recommendation about the individual's appropriateness for a more integrated/less restrictive setting. In addition, at the ISP meeting, the team needed to make a recommendation to the individual/guardian. Based on the review of records: o Of the five ISPs reviewed, for none (0%), all of the assessments included the applicable statement/recommendation. This had definitely improved over time, but the ones that sometimes did not include a statement were dental and psychiatry (although some of these did), and recreation. o Of the five ISPs reviewed, none of the individuals had been referred for transition to the community. Four individuals' ISPs (80%) included a recommendation from the professionals on the team to the individual and LAR (i.e., as discussed below, Individual #218's team did not make a definitive recommendation). However, for none of these individuals (0%) was adequate justification provided for the team's recommendation. The following provide examples of the problems identified:	Noncompliance

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		▪ The ISP for Individual #447 summarized the team's recommendations that had been included in assessments. All of these indicated that the individual could be supported in a more integrated setting. The individual also had previously requested community placement. She did not have a guardian, although the team had determined that she could not make decisions in most areas. It appeared that the team was concerned about the ability of a community provider to meet her medical needs, but this was not reflected in their assessment recommendations. In the body of the ISP, the team stated: "It was discussed that the services could be offered in the community that doesn't mean (sic) that she will actually get them 1) in a timely manner 2) changing PCP's (sic) and nursing staff is disruptive to her well-being and continuity of care 3) no amount of "tech" support can replace actual nurses or doctors when it comes to dealing with someone who has serious health concerns. It would be negligent on our part to allow her to pursue community living as an option to getting a quieter environment when what her true desire is just a quieter environment. The QDDP asked [individual] what she wanted to do and she stated that she would like to move to a quieter home on campus versus a community referral at this time." The team then indicated: "The **facility discipline members** (independent of the resident and LAR) determined that [Individual] would benefit from moving to a less restrictive environment at this time. This is based on: [Individual's] supports and services could be met in a less restrictive environment. The IDT will not be making a referral due to: Individual Choice - Individual has been provided information and exposure to community living options, but is not interested in alternative placement... Medical Issues." This was not an accurate summary, and was very concerning. It appeared that the team had concerns about supports available to meet Individual #447's needs in the community, but instead of stating that, and providing a justification, the team recommended community transition and then convinced the individual, whom they indicated in other parts of the ISP could not make informed decisions related to programming, medical, etc., to retract her request to move to the community. ▪ Based on the ISP for Individual #218, the team's conclusion was: "... the team has mixed feelings about whether or not the	

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		community setting would be able to provide for all of [Individual's] safety and security needs as effectively as the SSLC does." This was not a clear recommendation one way or the other, and although some discussion was documented about the reasons for this, it was not clear which team members modified their recommendations from their assessments (i.e., all but psychiatry had said she could be supported in a less restrictive setting). ▪ For Individual #418, although many assessments included statements regarding appropriateness for community transition and all of these indicated that the individual could be served in a more integrated setting, the team concluded the following without justification: "[Individual] would not benefit from moving to a less restrictive environment at this time. This determination is based on the level of services required at this time to ensure his health and safety." ▪ For Individual #255, the assessments that included a statement/recommendation indicated he could be supported in a less restrictive environment. However, the team concluded in the ISP that he could not, due to his medical needs, but no specific justification was provided. ▪ All of the assessments that did include recommendations indicated that Individual #374 could be supported in a less restrictive/more integrated setting. However, without justification, the team concluded: "The IDT considered all information and preferences identified. The facility discipline members (independent of the resident and LAR/family) determined that [Individual] wouldn't benefit from moving to a less restrictive environment at this time. This determination is based on: [Individual] and his family/LAR's desires to continue to live at ABSSLC." This appeared to be the conclusion of the whole team, not one that was separate from the LAR and/or individual. It is important to note that during the onsite interview, the Admissions Placement Coordinator reported that teams were still having difficulty separating their recommendations regarding transition from the individuals and LAR's opinions, and/or properly justifying their recommendations. It was positive that the Facility was aware of this problem, so that the next step could be fixing it. In past reports, the Monitoring Team had recommended that for some individuals for	

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		whom their teams believed transition would be appropriate "if appropriate supports were available" 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. Based on interview, some teams had begun to implement some of the pieces of such a process. Specifically, the Transition Specialists had begun to work with some individuals and guardians to identify some specific supports and/or visit providers who had been identified as being able to support individuals with specific needs (e.g., supports for individuals with hearing impairments, or with Prader Willi Syndrome). This was a positive development, and the Facility is encouraged to formalize the process further through the development of action plans that are incorporated into individuals' ISPs. 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. Although some problems persisted, the newer 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 documenting a well-supported justification for their decisions when most or all team members stated the individual could be served in a more integrated setting, but the Facility team members recommended to the LAR and/or individual 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 continued to be made with regard to teams' development of CLDPs. The CLDPs included a wider scope of 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 five of the 15 individuals who had had CLDPs developed during the previous six months, representing 33% of this group of individuals. The CLDPs reviewed were for Individual #179, Individual #194, Individual #197, Individual #274, and Individual #50. With regard to the timeliness of the Community Living Discharge Plans, five (100%) included documentation to show that they were developed sufficiently prior to the	Noncompliance

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		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. For some of the more recent CLDPs, the header at the top of the document that listed the dates the team had met to revise the plan had been removed. This had been a helpful addition, and it was unclear why it was removed. 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.	
	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 five 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. Although measurability had improved, some supports remained difficult to measure. Some examples of the general strengths and weaknesses 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. In addition, there was improvement in defining 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.) (e.g., the plans for Individual #274 and Individual #197). ▪ Similarly, the CLDPs had begun to identify what level of mastery of the information was required (e.g., didactic training, shadowing staff, demonstration of competence, etc.). However, for individuals for whom this had been identified as necessary, it was unclear how "verbal mastery" or "performance mastery" would be measured, and this was particularly challenging when a list of items was associated with a training support. The specific competency check-off forms should have been identified. ▪ Although present in some (e.g., Individual #197 and Individual #50), a 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.) was missing in a number of plans (e.g., Individual #194, Individual #197, and Individual #179). ▪ Similarly, no coordination was specified as needing to occur between current and future residential or day/vocational staff.	Noncompliance

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		▪ One of the plans (i.e., Individual #179) 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. Although progress was being made, 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 five 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.	Substantial Compliance
	3. Be reviewed with the individual and, as appropriate, the LAR, to facilitate their decision-making regarding the supports and services to be provided at the new setting.	Based on review of five CLDPs, four (80%) included documentation that the plans had been reviewed with the individual and/or the LAR, as appropriate. For Individual #197, she and her mother were present, but her guardian was not in attendance at the CLDP meeting without explanation, although it appeared the guardian had been involved in the process. Given that this appeared to be an isolated event, 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	Substantial Compliance

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		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.	
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 continued to be 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 five of the individuals' CLDPs reviewed (100%), it appeared that assessments had been updated within the 45-day timeframe. However, at times, assessments were missing from the packages of assessments. In addition, the quality of these assessments was lacking. None of the five 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 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. ▪ 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	Noncompliance

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		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 #274 or Individual #194). ▪ 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, 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 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. 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 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,	Noncompliance

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	the supports identified in the comprehensive assessment that are determined by professional judgment to be essential to the individual's health and safety shall be in place at the transitioning individual's new home before the individual's departure from the Facility. The absence of those supports identified as non-essential to health and safety shall not be a barrier to transition, but a plan setting forth the implementation date of such supports shall be obtained by the Facility before the individual's departure from the Facility.	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 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. In none of the five 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, etc.) that were sometimes now referenced in the CLDPs. However, this seemed to vary across disciplines. Psychology, psychiatry, dietary, and medical clinicians often were identified as necessary, and some brief requirements (e.g., qualifications and frequency or review of the individual), but for other clinical supports (e.g., Habilitation Therapy and nursing), no reference was made to the need to individuals to interact with such clinical staff, their roles, or their qualifications. This definition is necessary for all of the clinicians involved with the individual, and needs to	

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		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 in community settings where nurses were not stationed in each home, and habilitation therapists generally were external vendors. Just to say that the PCP would determine the need for clinical intervention was not sufficient. ▪ 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 (e.g., Individual #197, and Individual #179). 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. ▪ 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.).	

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		However, this was an area that required continued attention. For some individuals (e.g., Individual #50, Individual #197, Individual #179, and Individual #274), 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 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. ▪ None of the CLDPs identified a crisis intervention plan and/or descriptions of how the current methods for dealing with crises at the Facility needed to be modified in a community setting. This would have been appropriate, for example, for Individual #50 and Individual #197). ▪ 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.). Individuals for whom this was clearly necessary, but not present included Individual #50, Individual #197, and Individual #179. ▪ 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 improve. 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. 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 four individuals' pre-move site visit documentation (i.e., Individual #48, Individual #163, Individual #194, and Individual #274). These reviews appeared thorough, and included each pre-move required support listed in the individual's CLDP. In a couple of instances, the Post-Move Monitor found supports that were not in place, notified the provider of the corrections needed, and returned to confirm that the necessary changes had been made. Overall, a finding of noncompliance was made for this component of the Settlement Agreement. Progress had been maintained with regard to confirmation of pre-move required supports. 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.	Areas in which progress had been sustained included: ▪ The Facility was conducting monitoring using the tools that had been modified based on the Monitoring Teams' audit tools. Both the QA Department and the Admissions Placement Department were responsible for conducting reviews. ▪ Based on the documentation provided, inter-rater reliability scores had increased, and were estimated at 100% for all of the portions of Section T for which the Admissions Placement Department and the Program Compliance Monitor were responsible for monitoring. However, work was ongoing to establish inter-rater reliability between the PCM and the QDDP Department for the portions of Section T related to the individual planning process. ▪ The Facility had used some of the data related to obstacles to conduct an initial analysis, including some action steps to address the two highest obstacles (i.e., LAR Choice and Individual Choice). Although not directly connected to the monitoring data the Facility was collecting, quarterly section reviews were completed and presented to the QA/QI Council. ▪ The Facility had continued to incorporate the data into its self-assessment. Areas in which continued efforts needed to be made included: ▪ As noted above, inter-rater reliability needed to be established between all	Noncompliance

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		auditors. ▪ The accuracy of the monitoring data was questionable, particularly with regard to the components of the individual planning process components of Section T. ▪ The Monitoring Team continues to have concerns about the adequacy of the guidelines provided to reviewers. Efforts to improve these are necessary to ensure accuracy in monitoring. Based on information contained in the Monthly Meeting Notes for Section T, State Office was developing a revised tool for Section T.1 to correspond more with the new ISP process. As this is developed, efforts should be made to provide necessary guidelines to reviewers. ▪ An important part of quality assurance for Section T will be review of the outcome data for individuals that transition to the community. Analysis should include review of supports that might have prevented potentially negative outcomes, and a determination of whether or not such supports were included in CLDPs, as well as whether or not community providers provided the necessary supports. The Facility provided data on 24 individuals that had transitioned to the community between 4/21/12 and 4/3/13. Of these 24 individuals, a total of six individuals experienced potentially negative outcomes. The following summary is provided. However, it is important to note that further analysis would need to be completed to draw conclusions from the data. Such an analysis should be part of the Facility's QA system: o One individual had two police contacts, and subsequently moved to a different home "due to conflicts between her and the staff at her first home." o Another individual had five police contacts, two observations at a psychiatric hospital, and three ER visits. This individual also moved to a different home than the one to which he transitioned with more staffing. o One individual had an ER visit related to a medical issue, with further follow-up with his PCP. o A fourth individual was seen three times in the ER, including twice for injuries and once for a gastrointestinal issue. The injuries were caused by a problem with the shower chair she was using, and a fall from bed after not asking for assistance. In addition, two individuals that had moved to the community since the Monitoring Teams began conducting reviews had recently died. One individual's causes of death were listed as myocardial infarction and hypertension. The other individual's causes of death were listed as respiratory failure, septic shock, and aspiration pneumonia. The physician member of the Monitoring Team reviewed the records, and many questions could not be answered based on the information provided. However, it did not appear that	

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		the Facility and/or State had done its own analysis of these events. The Facility is strongly encouraged to conduct such reviews in the spirit of identifying ways in which improvements can be made to reduce preventable negative outcomes in the future. Good transition planning requires the commitment of the entire IDT, as well as those tasked with primary responsibility for developing the CLDPs. The entire team should be involved in critical, but constructive reviews of issues that individuals have experienced once they transition to the community. ▪ Analysis of the data, and development of appropriate corrective action plans had not yet occurred. For example, neither the Admissions Placement Coordinator nor the Program Compliance Monitor referenced monitoring data in their respective reports. Although the Facility submitted action plans as part of the QA information, it was unclear if these were developed in response to the Facility's internal monitoring, or if the action plans were in response to the Monitoring Team's findings. Although progress continued to be made in this area, the Facility recognized the need to fully develop and implement quality assurance processes necessary to assess its implementation of Section T. The Facility should continue to expand its monitoring activities in this area, including modifying, as appropriate, the monitoring tools, particularly to improve the guidance provided to auditors; training staff who will conduct the monitoring on the review tools and their implementation; ensuring the reviews accurately evaluate quality as well as the presence or absence of items; and establishing inter-rater reliability between all auditors with responsibility for monitoring. In addition, the Facility should analyze information resulting from monitoring activities, and, as appropriate, develop, implement, and monitor action plans to address concerns identified. Such plans should include action steps, person(s) responsible, timeframes for completion, and anticipated outcomes.	
T1g	Each Facility shall gather and analyze information related to identified obstacles to individuals' movement to more integrated settings, consistent with their needs and preferences. On an annual basis, the Facility shall use such information to produce a comprehensive assessment of obstacles and provide this information to DADS and other	DADS issued an Annual Report: Obstacles to Transition Statewide Summary. It included data as of 8/31/12 from all 13 Facilities. Although the report was undated, the State provided it to the Monitors and DOJ on February 26, 2013, six months after the data collection period ended. A number of problems with the report are discussed below. However, the following summarizes some positive aspects of the report: ▪ The statewide report listed the 13 obstacle areas used in FY12. DADS indicated it would continue working with the Facilities in relation to the annual reporting of obstacles to transition. Such technical assistance is needed given the continuing problems with data collection discussed below. ▪ DADS included a list of 12 initiatives it was continuing to support. Five were related to the IDT/ISP process and ongoing changes to this process; three were	Noncompliance

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	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.	related to working with local authorities and local agencies, including a pilot project with the Austin SSLC; one was related to the Community Living Specialist positions that DADS created using Money Follows the Person funds; one was related to ongoing implementation of existing Home and Community-Based Medicaid Waivers; and two were related to reviewing negative outcomes for individuals that transitioned to the community (i.e., conducting mortality reviews, and reviewing other negative outcomes such as arrests, psychiatric hospitalizations, etc.). In general, these efforts were in the early stages of implementation and/or were ongoing activities related to Section T as well as other sections of the Settlement Agreement (e.g., revisions to the ISP process). ▪ The report included attachments with each of the Facilities' annual reports. The following concerns were noted with regard to the report: ▪ Section T.1.b.1 of the Settlement Agreement requires that within two years each individual's team "identify the major obstacles to individuals' movement to the most integrated setting consistent with the individual's needs and preferences at least annually." It is important to note that the State's definition of obstacles was not consistent with this definition from the Settlement Agreement (i.e., on page 2, the report read: "Obstacles are defined as issues, barriers, or impediments that delay an individual from moving to a service delivery setting of his/her choice. These include any supports not currently available to meet the needs and preferences of the individual in the alternate setting.") At the time the data for this report was available, the Settlement Agreement had been in the implementation phase for three years, but significant problems continued to be noted with the data available. For example: o As the report indicated on page 3, if a team did not refer an individual for transition, then an obstacle to a referral should be identified. However, generally, the numbers of obstacles to referrals were much lower than they should have been given the limited numbers of referrals at each of the Facilities. For example, ABSSLC's numbers were better than some of the other Facilities, but the total number of obstacles to transition identified was 309, and based on reviews of ISPs, often more than one category was checked for an individual. Given that at the end of the fiscal year, according to the Facility-specific report, the census was 412, and in FY 2012, approximately 18 individuals were referred for transition to the community, many data were missing. o This might have been complicated by the fact that Table 4 in each of the Facility-specific reports was labeled: "Residents not recommended for movement that prefer to reside in the community from the [Facility Name] State Supported Living Center, 2012." Based on some of the narratives and data provided, it appeared Facilities had interpreted this	

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		differently. In some instances, it appeared Facilities had provided data for the list of obstacles for all individuals for whom they had data, regardless of whether the individual's preference was to transition to the community (e.g., Abilene SSLC). However, in other instances, it appeared this data was for the subgroup of individuals who had expressed an interest in transition, but their guardians were reluctant to consider it (e.g., Lubbock SSLC). Both sets of information were important, and the reports certainly should have included the data on obstacles for all individuals the Facilities supported. o As the State noted in the report: "Data collected from each respective facility varied, from very detailed obstacle identification/collection to little to no obstacles identified. Within each facility report, a plan for future obstacle identification and collection is provided." Although it was positive that the State recognized the need for improvements with data, at this juncture of the implementation of the Settlement Agreement, it is concerning that valid and complete data were not available. In addition, the plans included in the Facility reports often did not describe specific actions that would be taken to make improvements with the data. For example, although ABSSLC identified a number of steps to improve data collection, including ongoing retraining QDDPs and IDTs, as well as review of obstacles and coordination with the data analyst, it was unclear if these actions were based on an analysis to determine the underlying causes for teams not properly identifying obstacles to referral and/or transition. o As the Monitors discussed with the parties, at this juncture, adequate methodologies were not in place to collect data on obstacles to transition. As a result, the validity of the data provided in the report was questionable. For example, ABSSLC indicated no obstacles to transition existed, despite the fact that, as discussed above, during FY12, a number of individuals had exceeded the 180-day time period in which the State expected transitions to occur, and other individuals did not identify supports that addressed their preferences, such as for employment services. It appeared ABSSLC provided narrative information about individuals in the category of past the 180-day timeline, but this was only for individuals in this category at the time the report was written, not throughout the fiscal year period that the report covered. ▪ The Facility-specific reports generally did not provide the "comprehensive assessment" the Settlement Agreement requires. They merely stated the data with little to no analysis of the data. Beyond some minimal descriptions of often vague actions the Facilities would take, the reports offered no recommendations	

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		to DADS with regard to issues that went beyond the capacity of the Facilities to address, and for which DADS' intervention was needed. It is important to note that ABSSLC's Facility-specific report included some additional analysis, which was positive. For example, the "Profile" section of the report included some additional information about the provider community in the Abilene area, and some analysis, although limited, was conducted of the top two obstacles to referral (i.e., LAR choice and individual choice). More work was needed to identify more specific causes for these obstacles and to tailor action plans to address the underlying issues. However, it was positive that the Facility had looked a little deeper at the obstacles identified. Even though the Facility identified some issues beyond its control (e.g., limited provider capacity with regard to day and vocational supports, and limited Home and Community-Based Waiver funded homes), the Facility offered no recommendations to DADS. ▪ The lack of complete data as well as lack of "comprehensive assessment" of the data from the Facilities limited the State's ability to comply with the requirement that: "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." Moreover, it was unclear how the State intended to comply with this requirement without conducting and including in the report an analysis on a systemic level of the data the Facilities provided. As noted above, DADS included a list of initiatives it was continuing to support. However, even with the clear problems with full data collection, these initiatives did not address many of the obstacles that the Facilities had identified. For example, according to the 2012 Annual Obstacle Report Data spreadsheet, 112 individuals were not referred for transition due to "Behavioral health/psychiatric needs requiring continuous monitoring/intervention," and 100 individuals had encountered the following obstacle to transition: "Lack of supports for people with significant challenging behaviors." Similarly, 54 individuals were not referred to the community due to "medical issues requiring 24-hour nursing interventions/services," and 92 individuals had encountered the following obstacle to transition: "Lack of availability of specialized medical supports." Even without full data, it was clear that these two areas required attention. However, beyond general statement about maximizing use of available funding and "Engaging local authorities and private providers in joint discussions on how to enhance provider capacity to meet the characteristics of	

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		those individuals transitioning from the SSLCs to community placement settings," the report provided no indication of the specific steps, if any, the State was taking "to overcome or reduce identified obstacles to serving individuals in the most integrated setting appropriate to their needs…" ▪ In addition, DADS did not, but should, include a description as to whether it determined it to be necessary, appropriate, and feasible to seek assistance from other state agencies (e.g., DARS).	
T1h	Commencing six months from the Effective Date and at six-month intervals thereafter for the life of this Agreement, each Facility shall issue to the Monitor and DOJ a Community Placement Report listing: those individuals whose IDTs have determined, through the ISP process, that they can be appropriately placed in the community and receive community services; and those individuals who have been placed in the community during the previous six months. For the purposes of these Community Placement Reports, community services refers to the full range of services and supports an individual needs to live independently in the community including, but not limited to, medical, housing, employment, and transportation. Community services do not include services provided in a private nursing facility. The Facility need not generate a separate Community Placement Report if it complies with the requirements of this paragraph by means of a Facility Report submitted pursuant to	In response to a document request, the Facility submitted to the Monitoring Team a Community Placement Report, dated 4/16/13. It should be noted that this report provided information back until the time the last Community Placement report was produced. This was done in response to the request in the Monitoring Team's last report, and is appreciated. This was helpful, because although it was a longer period of time than six months, this provided continuity from one report to the next, resulting in more complete information about individuals transitioning to the community. The report listed: ▪ Current Referrals: 15 individuals were included on this list. At the time of the review, based on other information the Facility provided, two of these individuals had transitioned to the community, and an additional four individuals had been referred. ▪ Community Placements: since 7/16/12 (i.e., since the last community placement report was submitted), 22 individuals were included on this list. As noted above, between the time of the document production and the Monitoring Team's onsite review, an additional two individuals had moved to the community. ▪ Rescinded Referrals: two individuals were included on this list. The reasons for the referrals being rescinded were "Medical," and "Other Reason." 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 7/13/12 and 4/16/13, 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 one individual. The reason was "Behavior/Psychiatric. The Monitoring Panel asked that a final category be added that includes a list of names of individuals who would be referred by the team except for the objection of the LAR whether or not the individual himself or herself has expressed, or is capable of	Substantial Compliance

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	Section III.I.	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. Based on the report the Facility provided, 25 individuals were on this list.	
T2	**Serving Persons Who Have Moved From the Facility to More Integrated Settings Appropriate to Their Needs**		
T2a	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility, or its designee, shall conduct post-move monitoring visits, within each of three intervals of seven, 45, and 90 days, respectively, following the individual's move to the community, to assess whether supports called for in the individual's community living discharge plan are in place, using a standard assessment tool, consistent with the sample tool attached at Appendix C. Should the Facility monitoring indicate a deficiency in the provision of any support, the Facility shall use its best efforts to ensure such support is implemented, including, if indicated, notifying the appropriate MRA or regulatory agency.	<u>Timeliness of the Checklists</u> Post-move monitoring documentation was reviewed for five of the 14 individuals (36%) that had transitioned to the community in the previous six months (i.e., Individual #107, Individual #48, Individual #163, Individual #194, and Individual #274). For these individuals during the time period reviewed, the ABSSLC Post-Move Monitor should have conducted 11 reviews. Of the 11 required visits, 11 (100%) had been documented as having been completed on time. In addition, it should be noted that the Post-Move Monitor sometimes conducted additional follow-up visits to ensure issues were rectified. <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> 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 seemed to facilitate the IDTs review of the often lengthy reports. The narrative sections also described the findings of the review. The checklists reviewed generally were completed thoroughly. In other words, all pre-move and post-move supports were reviewed, and the evidence that was used to support the findings was documented. Generally, it appeared that thorough reviews had been completed, and the narrative helped significantly in justifying the Facility's findings.	Substantial Compliance

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		At times, issues were noted that required follow-up. Some of these involved supports that had not been fully provided and/or issues that had arisen since the transition. Generally, based on the evidence provided, it appeared that the Post-Move Monitor had correctly rated the pre-move and post-move supports as being present or not. <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 the protections, supports or services that the individual requires are in place, and, if any issues are identified, to take action to correct them. The following summarizes the findings of the review of post-move monitoring documentation: ▪ Of the five individuals reviewed, five of them had needs identified for which follow-up was necessary to ensure supports were implemented. ▪ Of the seven individuals for whom follow-up was indicated, documentation was present to show that for five individuals (100%), sufficient follow-up had occurred to address the issues identified. In some instances, it appeared that the Post-Move Monitor had taken a number of steps to follow-up. In addition, the Post-Move Monitor had referred some items to individuals' teams. ISPA documentation was available to show that the teams had reviewed the information, and made recommendations, including, at times, that they provide additional training to provider staff. In addition to thorough post-move monitoring reviews being completed, Facility staff were following up to ensure that necessary corrections were made or supports were provided to ensure individuals received the protections, supports, and services they needed. The Facility was found to be in substantial 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	During the week of the onsite review, a member of the Monitoring Team accompanied the Post-Move Monitor on a post-move monitoring visit for Individual #107, including to his day program and home. The Monitoring Team appreciates the Post-Move Monitor finalizing the report from the visit, because this provided the opportunity to compare the observations of the visit with the written report. The Post-Move Monitor systematically reviewed the supports included in Individual #107's CLDP. She asked many good questions, conducted observations, and reviewed relevant documentation. In many instances, she confirmed supports were in place through multiple methodologies (e.g., interview with staff and review of documentation). The report was thorough, and included a complete description of the evidence that the Post-Move Monitor had reviewed to draw her conclusions. Her conclusions appeared to be sound, and she documented the follow-up that would occur to address the outstanding issues identified.	Substantial Compliance

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	date.	Due to the thorough and accurate post-move monitoring observed, the Facility has been found in substantial compliance with this provision. As has been discussed, maintaining substantial compliance will require the Post-Move Monitor to keep pace with the expanded responsibilities for monitoring that will occur as CLDPs continue to improve.	
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	The parties had agreed that in addition to the categories listed in the Settlement Agreement, other circumstances resulting in 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. One of these reasons was an individual transferring to another SSLC. In the previous six months, two individuals had transferred another SSLCs. One of these individuals was selected for review (i.e., Individual #81). Based on a review of the discharge summary completed for Individual #81, 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	Noncompliance

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	during the required 20-day timeframe; (d) individuals receiving respite services at the Facility for a maximum period of 60 days; (e) individuals discharged based on a determination subsequent to admission that the individual is not to be eligible for admission; (f) individuals discharged pursuant to a court order vacating the commitment order.	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 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., the decision for ABSSLC to no longer serve minors). ▪ The Facility provided a reasonable time to prepare the individual and her parents or guardian for the transfer or discharge (except in emergencies): The discharge summary indicated that the QDDP first informed the parents of the need for a transfer in November 2012, and he moved in March 2013. This was a reasonable time period. Based on the narrative in the discharge summary, his parents were involved in making the decision about where he would go and 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 one individual (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. However, the psychological/behavior summary included some summary information about various programs or services that had been tried, but were unsuccessful. o Incomplete historical and current status information was provided (e.g., he had a speech program, but the status of his progress with the program was not provided; no information was provided from nursing; and the psychiatric information was minimal). 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. As a few examples, Individual #81 had significant behavioral issues for which he had a BSP and Crisis Intervention Plan. Although a summary was provided of the BSP, including target and replacement behaviors, no data or summary was provided of his progress with the current plan. Similarly, a counseling plan was referenced, but no information was provided about his progress with it.	

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		The OT/PT summary addressed the mealtime supports in a way that offered the new Facility staff a sense of what was working, but indicated that with the exception of these supports, "All previous formal OT/PT recommendations are to be discontinued." No justification was provided, and it was unclear what supports these recommendations included. The Functional Skills Assessment section provided an overview of the skill acquisition programs on which he was working. This was positive, but could have been improved with the inclusion of data. The psychiatric section provided little information, and although the medical section indicated that psychotropic medications had had to be changed due to their impact on other health issues and his psychotropic medications were continuing to impact his weight, this was not expanded upon in the psychiatric section. ▪ 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 one of the one individual (100%), ABSSLC provided copies of the sign-in sheet for the meeting at which the discharge summary and related assessments were reviewed. Participants included staff from each Facility. Of note, it was unclear why the individual and/or parents/legal guardians were not in attendance at this meeting. ▪ 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 individual would need in his new setting. 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). Some supports were missing from the listing. For example, although the QDDP summary indicated that Individual #81 was attending the public school, no information was included in this section on enrolling him in school and/or assisting in transitioning the educational supports to a new setting. In addition, based on the medical information, he had some needs for nursing supports, but no information was provided from nursing, including, for example, information about nursing care plans. For psychiatry, no specific information was provided about the services needed in the new setting, except to say: "continue current treatment plan." Due to the inadequacies of the discharge/transfer summaries, ABSSLC was not in	

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		compliance with this provision.	

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

1. As has been recommended in previous reports, 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)
2. 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)
3. 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)
4. 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)
5. 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)
6. With regard to educational opportunities:
    a. For the CLOIP process, outcomes/measures should be 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, and the number of individuals and families/LARs who refuse to participate in the CLOIP process. Collection and review of such data should be completed to allow the State to evaluate the effects of the process and make changes to future CLOIP activities.
    b. With regard to community tours, data should be 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.
    c. The Facility should develop a formal plan to address education on community living options to management staff, clinical staff, and direct support professionals.
    d. The Facility should facilitate opportunities for individuals to visit friends who live in community, and guardians/families who have gone through the transition process to share their experiences with other guardians/families;
    e. If the analysis of aggregate data showed that families and guardians had similar concerns, then using mechanisms to provide information on specific topics should be used. For example, offering specific educational seminars might be useful.
    f. The Facility should provide education at house meetings for the individuals.
    g. The Facility should add creative and individualized educational activities to meet the needs of various individuals and

families/guardians, including action plans in individuals' ISPs designed to meet their specific needs. (Section T.1.b.2)

7. The Facility should analyze the reasons teams, independent of the LAR and individual, are not making recommendations regarding individuals' transition to the community that are justified by the recommendations in team members' assessments and/or the discussion documented in the ISPs. Based on the results of this analysis, the Facility should develop and implement a plan to correct these issues. (Section T.1.a and T.1.b.3)
8. 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)
9. 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)
10. For some individuals, particularly those individuals for whom teams are not sure whether or not appropriate supports exist in the community to meet their needs, teams should consider an exploratory phase prior to making a decision about a referral or no referral. During this time, the team could ensure that it had an exhaustive list of protections, supports, and services the individual required, and use this list to determine which community providers might be able to support the individual. The team could support the individual and his/her guardian to explore these different options to determine if they meet the needs as well as the preferences of the individual. To ensure that this process occurs expeditiously, an action plan should be developed with specific action steps and associated timeframes, and persons responsible. (Section T.1.b.3)
11. 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 write 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.), teams 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)

12. 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 been 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)
13. 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)
14. 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 with all auditors; 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)
15. 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), whose community transitions are in jeopardy, or who otherwise experience negative outcomes. (Section T.1.f)
16. With regard to the obstacles report:
    a. The format the State provides Facilities for their Facility-specific obstacle reports should include data for the list of obstacles to referral for all individuals at the Facility, as well as the subgroup of individuals who have expressed an interest in transition, but their guardians are reluctant to consider it.
    b. The State should define the process Facilities use to collect data on obstacles to transition.
    c. The Facility should expand the analysis of the data included in its Facility-specific report, include specific action plans to address the findings from the analysis, and whenever issues identified are outside of the scope of the Facility to correct, the Facility should include recommendations for DADS' intervention.
    d. The State should conduct and include in the report an analysis on a systemic level of the data the Facilities provide, and provide a description of the specific steps, if any, the State had or planned to take "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…"
    e. In the obstacles report, the State should include a description as to whether it determined it to be necessary, appropriate, and

feasible to seek assistance from other state agencies (e.g., DARS). (Section T.1.g)

17. 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, with updates dated 12/7/12; o ABSSLC Rights Assessment with prompts for QDDPs; o Guardianship Priority Discussion template, revised 12/12; o Consent/Authorization for Rights Restriction, dated 9/21/06; o Prioritization Tool with instructions; o Rights Information and Incident Management training materials and roster, dated 11/2/12, and follow-up emails; o Guardianship Priority 1 list, updated 4/1/13; o Guardianship Priority 2 list, updated 9/4/12; o List of individuals referred to Guardianship Committee for Prioritization, undated; o List of individuals who obtained a guardian since last review, updated as of 5/6/13; o List of individual in guardianship process, updated as of 5/6/13; o Guardianship Committee meeting minutes, dated 10/17/12; o ABSSLC Guardianship brochure; o Family Association Agenda, dated 10/6/12; o List of persons interested in serving as advocates, undated; o Emails to and from local nonprofit guardianship agency, various dates; o Guardianship Tracking Sheet/Information; o Narrative description of Monitoring/Audit for Section U 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, committee meeting minutes, and some review of the Rights Assessments teams were completing. The Facility submitted a document entitled "Monitoring/Audit for Section U." This document indicated that once the Facility's new process for completing the portion of the Rights Assessment related to consent was incorporated into 50% of those needing a guardian for one consecutive month, monitoring would begin. It also will be important that once State Office finalizes procedures for formally assessing individuals and pursing guardianship or other decision-making resources, that the self-assessment process be designed and implemented to assess teams' use of the tools and/or processes developed. 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.
	Summary of Monitor's Assessment: As previously reported, the State Office Guardianship Policy had been disseminated, but the policy on consent remained in the development phase. ABSSLC had adopted the State Office Guardianship policy and had begun to implement portions of the policy. The Facility also had individualized the policy some to reflect its internal processes. Teams continued to use the process for estimating an individual's priority need for guardianship discussed in the previous report, with some modifications to the prompts provided. It was anticipated that the Guardianship Committee would begin reviewing the teams' recommendations, but this process had not yet begun. 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 tools the Facility created in the absence of a State Office policy. Based on this list, a total of 74 out of the 393 individuals residing at ABSSLC (19%) were in need of guardians. However, Facility staff recognized that this likely underestimated the numbers of individuals requiring guardians or some other form of decision-making assistance. Since the last review, nine individuals identified as requiring a guardian had been appointed a guardian or successor guardian. According to information the Human Rights Officer had from individuals' families or

	attorneys, an additional nine individuals were in some stage of having a petition for guardianship filed. 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. The Facility also was continuing to make referrals as appropriate to a local nonprofit agency that offered guardianship services. Facility staff had developed a user-friendly brochure on guardianship. 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.	As noted in the last report, DADS State Office had issued Policy Number 019: Guardianship, dated 3/7/12, and ABSSLC had adopted the State Office policy. Since the last review, some information had been added. It reflected the Facility's process for using the section of the Rights Assessment on consent to discuss the team's determination of whether the individual could make decisions in certain areas. The Facility also had developed a form and process for identifying an individual's priority level for guardianship and notifying the Human Rights Officer. The policy also now described the process for the Human Rights Officer working with the Guardianship Committee to discuss an individual's need for and priority level for obtaining a guardian. At the State Office level, 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 indicated in the Monitoring Team's previous report, an important first step was missing. Specifically, the Facility continued to use the Rights Assessment to determine individuals' ability to make informed decisions. Although efforts clearly were continuing to be made to provide teams with prompts to discuss individuals' decision-making ability, this tool with its related instructions was inadequate to determine an individual's functional capacity to make decisions. For example, the Rights Assessment with Prompts for QDDPs, revised June 2007, included prompts for teams to determine if an individual could "consent to" a list of topics "if information is presented to the person in basic, everyday terms," "with just a little help understanding what it means," or "if they cannot understand the information." 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 moving forward with regard to the implementation of the Section U Settlement Agreement	Noncompliance

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		requirements. 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, and some efforts had been made in this regard. For example, one of the prompts on the Rights Assessment encouraged teams to think about whether or not the individual needed an advocate to assist with decision-making. This was an important alternative or support for teams to consider. Efforts should continue to be made to identify supports that might assist individuals to make decisions. These include, but are not limited to developing information in formats that are more easily understood, including utilizing simpler language, or formats with pictures; expanding individuals' knowledge about options available (e.g., making informed decisions about jobs or places to live might require individuals to see and experience the different options, or making a decision about inclusion of personal information in an article in the newsletter might require someone to see the newsletter and/or some of the places to which it is distributed); and identifying specific staffing supports to assist an individual to interpret information (e.g., sign interpreters, someone to read and explain information in a user-friendly manner, etc.). As noted in the last report, 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 Human Rights Officer provided additional training to the QDDPs on 11/2/12, and had subsequently sent reminder emails about the use of the use of the Guardianship Priority Discussion form. The form included the factors for prioritization from the DADS State Office policy, which were consistent with those in the Settlement Agreement. Based on the interview with the Human Rights Officer, although teams were using the form more, this remained inconsistent. It was anticipated that the Guardianship Committee would review the documentation for individuals after teams completed the Guardianship Priority Discussion form, and make	

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		final decisions about their priority on the guardianship list. However, this process had not yet started. At the time of the review, the Facility continued to maintain a Guardianship Priority List. However, as noted in previous reports, this list was based on incomplete information. At this point, a functional capacity assessment process was still missing, and the process for the Guardianship Committee to review teams' recommendations related to the need for and priority level for guardianship was in the initial stages of development. That being said, the following information was included on the Facility's Guardianship Priority List: ▪ Approximately 29 individuals had been identified as Priority I; and ▪ Approximately 45 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 processes. However, based on these initial projections, approximately 74 out of the 393 individuals residing at ABSSLC (19%) were in need of guardians. The Facility continued to make some progress in beginning to implement the new DADS State Office policy on Guardianship. 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	Since the last review, nine individuals identified as requiring a guardian had been appointed a guardian or successor guardian. According to information the Human Rights Officer had from individuals' families or attorneys, an additional nine 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 previous reports), if the individual qualified, or Guardianship Assistance	Noncompliance

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	LARs of other individuals, advocacy organizations, and other entities seeking to advance the rights of persons with disabilities.	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 Facility had developed a user-friendly brochure on guardianship. This was a nice addition to the lengthier document that was available, because it provided information about guardianship and the process for obtaining it in an unintimidating way. ▪ The Facility continued to try to recruit advocates as a possible alternative to guardianship. At the time of the review, two more people had expressed an interest in pursuing becoming an advocate for individuals the Facility supported. ▪ The Human Rights Officer continued to attend the meetings of the Family Association to discuss guardianship. ▪ The Facility had continued to maintain a relationship with a nonprofit agency that provided guardianship services. The funding came through the applied 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. As previously 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	

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		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 continuing to identify 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. 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)
7. 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)
8. 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 In response to request for State or Facility policies and procedures related to record keeping, purging, thinning, and archiving, if new or revised, the response: "No changes since last visit;" o List of persons responsible for management of records and for auditing records, including names and titles, revised 3/28/13; o ABSSLC Active Record Order and Maintenance Guidelines, revised 12/14/12; o Individual Notebook and Guidelines for Filing and Purging, revised 3/28/13; o Section V Recordkeeping – Minimum Documents Included in Master Record, undated; o In response to request for a description of quality assurance procedures, including description of the process for selecting records, the response: "No changes since last visit;" o Completed review tools for last 10 records reviewed, various dates; o Settlement Agreement Compliance Report: Section V – Recordkeeping and General Plan Implementation, Provisions 1, 3, and 4, from 9/1/12 to 3/31/13; o Settlement Agreement Compliance Report: Overall Compliance by Month for Section V – Recordkeeping and General Plan Implementation, Provisions 1, 3, and 4, from 9/1/12 to 3/31/13; o Inter-Rater Reliability per Indicator: V - Recordkeeping and General Plan Implementation, Provisions 1, 3, and 4, from 9/1/12 to 3/31/13; o Inter-Rater Reliability per Month: V - Recordkeeping and General Plan Implementation, Provisions 1, 3, and 4, from 9/1/12 to 3/31/13 o Section V Action Plans, updated 4/2/13; 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 4/3/13; o Dissemination, Training, and Implementation of New/Revised Policies and Procedures, dated 8/23/12; o List of staff trained on Dissemination, Training, and Implementation of New/Revised Policies and Procedures, dated 4/2/13; o Description of Electronic Record Personal Folder, undated; o Section F – Annual ISP Meeting Preparation Checklist, revised 3/8/13; o Policies and Course Participation Reports for the following: 1) Protection from Harm – Abuse, Neglect, and Exploitation, dated 12/4/12; and 2) ABSSLC Policy: Physical and

	Nutritional Management Team, revised 1/12/12; o Draft Monthly Meeting Minutes Section V: Recordkeeping, dated 4/25/13; o Records Committee Notes, dated 8/23/12, 10/24/12, 11/9/12, and 3/26/13; and o Presentation Book for Section V. ▪ **Interviews with**: o Kalana Allen, Records Coordinator; o Vickie Allmand, Unified Records Coordinator; and o Gloria Sprecher, Unified Records Coordinator.
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section V, dated 4/22/13. 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: o 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, the Section V.4 monitoring tool, and recently, added elements on the Section F monitoring tool. o The Facility was working to improve the tools to ensure they included adequate indicators to allow the Facility to determine compliance with the Settlement Agreement. For example, they had added a component to the Section F tool to assist in assessing Section V.4. The Records Department staff are encouraged to continue to work with the Quality Assurance Department and the Settlement Agreement Coordinator to make necessary changes to the monitoring tools. o 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 additional meetings and review of data collected in relation to skill acquisition programs, PBSPs, etc. needed to be added. o The Self-Assessment identified the sample(s) sizes. It also had added 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 sample sizes were adequate to consider them representative samples. o The Facility was continuing to work to improve the instructions/guidelines to ensure consistency in monitoring and the validity of the results. As discussed in previous reports, 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. ▪ The Facility 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. On a positive note, the Facility had begun to discuss monthly meetings with the QA Department with regard to compliance with Section V.3, as well as 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 The Facility generally presented the findings based on specific, measurable indicators. This was an improvement from last time when some overall scores had been included. o Although the quality of some items was measured, other important quality indicators were not included, such as the quality of the data included in records. 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.
	Summary of Monitor's Assessment: According to staff, all of the individuals at ABSSLC had Active Records, Master Records, and Individual Notebooks. 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. The Facility was in the process of implementing some formal corrective action plans, as well as identifying less formal solutions to address some of the systemic issued identified. However, the Monitoring Team continued to find a number of missing documents in the records. It was unclear if these were related to filing issues or that the documents were not completed and/or submitted

	for filing. 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 had been finalized and implementation had begun. It identified 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 begun to track training, but the system to track training required modification to allow easy identification of staff who still needed to complete specific 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. A remaining challenge was establishing inter-rater reliability between the auditors. 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 behavior support plans and 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.

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V1	Commencing within six months of the Effective Date hereof and with full implementation within four years, each Facility shall establish and maintain a unified record for each individual consistent with the guidelines in Appendix D.	Progress had been made and/or sustained with regard to the establishment and maintenance of a unified record consistent with the guidelines in Appendix D of the Settlement Agreement. Positive developments included: ▪ According to staff, all of the individuals at ABSSLC now had Active Records, Individual Notebooks, and Master Records. ▪ The Facility continued making changes, as appropriate to the content of the records. As indicated in some of the Monitoring Team's previous reports, 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 four meetings between August 2012 and March 2013 showed discussion of relevant issues, and the development of practical solutions. ▪ The Facility was in the process of implementing a corrective action plan related to concerns found through the monitoring process in relation to legibility; records being accurate, current, and complete; entries timed; signatures with first name, last name and title; and initials identified on the legends. Although as discussed below, these issues were not resolved, it was positive that the Facility	Noncompliance

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		had been working with staff for whom these particular issues were identified, as well as identifying areas in which in-services were necessary to correct problems. Areas in which improvements should be made in order to achieve compliance, included: ▪ As noted above, work was being completed to identify and correct problems with the quality of the records. However, based on the Monitoring Team's review of records while on site, concerns continued to exist with regard to issues such as legibility, as well as the completeness, accuracy, and/or timeliness of the documents filed in the records. Some examples of this included: o While touring the Facility, the Monitoring Team reviewed a total of 36 I-Books across 11 residences. One section of the I-Book was the ISP Action Plans. None of the 36 books contained this information, and 10 of the I-Books did not include a tab for this section. o As noted with regard to Section M.1, a significant number of nursing progress notes and signatures were illegible. o It was noted that a number of documents were missing from the active records. For example, a number of the most current Integrated Risk Rating Forms were not found in the Active Records. In addition, several Integrated Health Care Plans and Comprehensive Nursing Assessments were also missing from the records. However, it was unclear if these documents were missing or if the documents had not been completed. 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 the availability of 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 begun to implement the policy on Dissemination, Training, and Implementation of New/Revised Policies and Procedures. As described in the Monitoring Team's previous report, this policy set forth a reasonable process for review and approval of policies, including identification of which staff needed	Noncompliance

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		training, and what the training should entail. 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 included a mechanism to communicate the issuance of new policies and training requirements to relevant staff. ▪ The State Office recently had provided a list of the policies it had developed in relationship to the Settlement Agreement, and the Facility had completed a crosswalk to identify policies that needed to be officially adopted and/or individualized to include Facility-specific expectations or processes. ▪ A list was provided of 10 policies related to the Settlement Agreement that had been developed/revised and approved since the last review. Areas in which efforts are needed in order to achieve compliance, included: ▪ As noted in this report, in a number of instances, further work was needed to individualize or expand upon the State Office policies, or develop other Facility-specific 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. Based on discussions with Records Department staff, the Competency Training/Development Department was able to produce lists of staff that had completed training, but not an exception report to identify staff who still required training. 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 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	Progress had been made and/or sustained with this provision of the Settlement Agreement. Positive developments included:	Noncompliance

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	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.	▪ 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. 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. ▪ 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 indicated in previous reports, 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. ▪ As noted with regard to Section V.1, utilizing data reports, the Records Department had identified specific indicators for which data showed problematic trends. In addition to requiring staff demonstrating problems with recordkeeping requirements to attend training, the Records Department was also trying to identify tools that would assist staff. For example, staff could purchase a name stamp if they were having difficulty writing their name legibly. At times, specific actions were being taken, such as the provision of in-service training to staff on Observation Notes, or work to obtain birth certificates for individuals for whom these were not contained in the Master Records. When one particular home was identified as having particular problems with recordkeeping, one of the Unified Records Coordinators provided training to some of the staff at the home. From the documentation provided, it was unclear if all staff had participated in the training. On 12/5/12, the Clerks participated in additional training, including information on issues repeatedly found in the records. Staff had developed catchy reminders about some of the persistent issues related to the records, as well as the consequences for not following the rules related to records (i.e., extra training with the Unified Records Coordinators). As noted in the last report, this was a creative way to try to	

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		obtain staff's compliance with records management. ▪ The Facility had begun to review the effectiveness of the actions taken, and modify plans as appropriate. Areas in which improvements should be made in order to achieve compliance, included: ▪ Although the Facility had implemented the State Office's interview tool for monitoring Section V.4 of the Settlement Agreement, and had also added a component to the Section F monitoring tool to assess teams' use of records during ISP meetings, as has previously been discussed, monitoring of Section V.4 will require a number of different methodologies, including, for example, reviewing data staff are required to collect to ensure it is complete and accurate (e.g., behavioral support plan data, SAP data, trigger sheets, 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. ▪ Facility staff had been taking some steps to establish inter-rater reliability. A corrective action plan was being implemented to address this issue. The issues with establishing inter-rater reliability were discussed while the Monitoring Team was on site. Some of the ideas discussed were narrowing the focus of the records reviewed to a certain time period (e.g., the last month) to allow a more concentrated review, and to better determine where any discrepancies might lie, as well as conducting the reviews simultaneously to avoid any changes in the records being the cause for discrepancies. 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. The Facility remained out of compliance with this provision.	
V4	Commencing within six months of the Effective Date hereof and with full implementation within four years, each Facility shall routinely utilize such records in making care, medical treatment and training decisions.	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. Although an email from State Office included a list of these activities and indicated the monitoring tool had been revised in December 2012 to include them, the Facility's Self-Assessment did not yet reflect evaluation of all of these 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	Noncompliance

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		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. The Records Committee had continued to review requests for documents to be added to the set maintained electronically, and a number of documents were now available in this format in a user-friendly and organized format. 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. As discussed with regard to Section V.1, the Monitoring Team's experience with the records during the review indicated that some issues continued to exist with necessary documents being available in the records, but it was unclear if these were filing issues, or that the documents had not been completed and/or submitted for filing. 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 discussed with regard to Section K.4, observations during the onsite review indicated that staff were not recording behaviors that occurred. ▪ **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:** Since the last review, the Facility had developed a process for incorporating information regarding the use of records during ISP meetings into the database for Section V.4. As discussed with	

#	Provision	Assessment of Status	Compliance
		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, Human Rights Committee 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 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 behavior support plans or 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. 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, 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)
4. Inter-rater reliability should be established between the various staff monitoring the records. (Section V.3 and Facility Self-Assessment)
5. 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
CTD	Competency Training/Development
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
HPV	Human Papillomavirus
HRC	Human Rights Committee
HRO	Human Rights Officer

HT	Habilitation Therapies
I-Book	Individual Notebook
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
PCN	Program Compliance Nurse
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
PMI	Psychotropic Medication Initiation
PMR-SIB	Protective Mechanical Restraints to Prevent Self-Injurious Behavior
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)
PSA	Prostate-specific antigen
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
Tdap	Tetanus-Diphtheria-Pertussis
TIVA	Total Intravenous Anesthesia
TOC	Table of Contents
TSH	Thyroid Stimulating Hormone
TST	Tuberculin Skin Test
TWR	Temporary Work Reassignment
UTI	Urinary Tract Infection
VFW	Veterans of Foreign Wars
VNS	Vagus Nerve Stimulator
VPA	Valproic Acid
VTE	Venous Thromboembolism