United States v. State of Texas

Monitoring Team Report

Abilene State Supported Living Center

Dates of Review: November 4th through 8th, 2013

Date of Report: January 15, 2014

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Table of Contents

I. Background

In 2009, the State of Texas and the United States Department of Justice (DOJ) entered into a Settlement Agreement regarding services provided to individuals with developmental disabilities in state-operated facilities (State Supported Living Centers), as well as the transition of such individuals to the most integrated setting appropriate to meet their needs and preferences. The Settlement Agreement covers 12 State Supported Living Centers (SSLCs), including Abilene, Austin, Brenham, Corpus Christi, Denton, El Paso, Lubbock, Lufkin, Mexia, Richmond, San Angelo and San Antonio, as well as the Intermediate Care Facility for Persons with Mental Retardation (ICF/MR) component of Rio Grande State Center.

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

In order to conduct reviews of each of the areas of the Settlement Agreement, each Monitor has engaged an expert team. These teams generally include consultants with expertise in psychiatry and medical care, nursing, psychology, habilitation, protection from harm, individual planning, physical and nutritional supports, occupational and physical therapy, communication, placement of individuals in the most integrated setting, consent, and recordkeeping.

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

The Monitor's role is to assess and report on the State and the facilities' progress regarding compliance with provisions of the Settlement Agreement. Part of the Monitor's role is to make recommendations that the Monitoring Team believes can help the facilities achieve compliance. It is important to understand that the Monitor's recommendations are suggestions, not requirements. The State and facilities are free to respond in any way they choose to the recommendations, and to use other methods to achieve compliance with the Settlement Agreement.

II. Methodology

In order to assess the Facility's status with regard to compliance with the Settlement Agreement and Health Care Guidelines, the Monitoring Team undertook a number of activities, including:

(a) **Onsite review** – During the week of the tour, the Monitoring Team visited the State Supported Living Center. As described in further detail below, this allowed the team to meet with individuals and staff, conduct observations, review documents, as well as request additional documents for off-site review.
(b) **Review of documents –** Prior to its onsite review, the Monitoring Team requested a number of documents. Many of these requests were for documents to be sent to the Monitoring Team prior to the review, while other requests were for documents to be available when the Monitors arrived. The Monitoring Team made additional requests for documents while on site. In selecting samples, a random sampling methodology was used at times, while in other instances a targeted sample was selected based on certain risk factors of individuals served by the Facility. In other instances, particularly when the Facility recently had implemented a new policy, the sampling was weighted toward reviewing the newer documents to allow the Monitoring Team the ability to better comment on the new procedures.
(c) **Observations** – While on site, the Monitoring Team conducted a number of observations of individuals served and staff. Such observations are described in further detail throughout the report. However, the following are examples of the types of activities that the Monitoring Team observed: individuals in their homes and day/vocational settings, mealtimes, medication passes, Personal Support Team (PST) meetings, discipline meetings, incident management meetings, and shift change.
(d) **Interviews** – The Monitoring Team also interviewed a number of people. Throughout this report, the names and/or titles of staff interviewed are identified. In addition, the Monitoring Team interviewed a number of individuals served by the Facility.

III. Organization of Report

The report is organized to provide an overall summary of the Supported Living Center's status with regard to compliance with the Settlement Agreement, as well as specific information on each of the paragraphs in Sections II.C through V of the Settlement Agreement. The report addresses each of the requirements regarding the Monitors' reports that the Settlement Agreement sets forth in Section III.I, and includes some additional components that the Monitoring Panel believes will facilitate understanding and assist the facilities to achieve compliance as quickly as possible. Specifically, for each of the substantive sections of the Settlement Agreement, the report includes the following sub-sections:

(a) **Steps Taken to Assess Compliance:** The steps (including documents reviewed, meetings attended, and persons interviewed) the Monitor took to assess compliance are described. This section provides detail with regard to the methodology used in conducting the reviews that is described above in general;
(b) **Facility Self-Assessment**: No later than 14 calendar days prior to each visit, the Facility is to provide the Monitor and DOJ with a Facility Report regarding the Facility's compliance with the Settlement Agreement.

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

(c) **Summary of Monitor's Assessment:** Although not required by the Settlement Agreement, a summary of the Facility's status is included to facilitate the reader's understanding of the major strengths as well as areas of need that the Facility has with regard to compliance with the particular section;

(d) **Assessment of Status:** A determination is provided as to whether the relevant policies and procedures are consistent with the requirements of the Agreement, and detailed descriptions of the Facility's status with regard to particular components of the Settlement Agreement, including, for example, evidence of compliance or noncompliance, steps that have been taken by the Facility to move toward compliance, obstacles that appear to be impeding the Facility from achieving compliance, and specific examples of both positive and negative practices, as well as examples of positive and negative outcomes for individuals served;

(e) **Compliance:** The level of compliance (i.e., "noncompliance" or "substantial compliance") is stated; and

(f) **Recommendations:** The Monitor's recommendations, if any, to facilitate or sustain compliance are provided. The Monitoring Team offers recommendations to the State for consideration as the State works to achieve compliance with the Settlement Agreement. It is in the State's discretion to adopt a recommendation or utilize other mechanisms to implement and achieve compliance with the terms of the Settlement Agreement.

(g) **Individual Numbering:** Throughout this report, reference is made to specific individuals by using a numbering methodology that identifies each individual according to randomly assigned numbers (for example, as Individual #45, Individual #101, and so on.) The Monitors are using this methodology in response to a request form the parties to protect the confidentiality of each individual.

IV. Substantial Compliance Ratings and Progress

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

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

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

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

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

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

V. Executive Summary

As this report indicates, at Abilene State Supported Living Center (ABSSLC), since the Monitoring Team's last visit, improvements had occurred in a number of areas. However, there remained a number of areas on which Facility staff were still working. It is particularly important that over the next six months, in addition to focusing on improving a number of the processes that are essential to providing effective supports to individuals, that the Facility also emphasize the implementation of individuals' plans, and the protocols designed to ensure that they are receiving the supports and treatment they need. This will require not only clinicians implementing protocols that are designed to

ensure proper care is provided, but also strongly supporting staff with direct support responsibilities to implement the portions of plans for which they are responsible. This is necessary to ensure that the outcomes for individuals are realized.

In June 2013, the parties agreed that some modifications to monitoring could be made under specific circumstances. These include the following: 1) sections or subsections for which smaller samples are drawn, or for which only status updates are obtained due to limited or no progress; 2) no monitoring of certain subsections due to little to no progress for provisions that do not directly impact the health and safety of individuals; and 3) no monitoring of certain subsections due to substantial compliance findings for more than three reviews. For each review for which modified monitoring is requested, the State submits a proposal to the Monitor and DOJ for review, comment, and approval. This report reflects the results of a modified review. Where appropriate, this is indicated in the text for the specific subsections for which modified monitoring was conducted.

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>

- Areas of progress included:
  - The Facility was managing the use of protective mechanical restraint to minimize its use.
  - A process for the use of medical/dental restraints had been developed.
  - The Restraint Reduction Committee had continued to meet to review systemic trends, and to review when restraint was used more than three times in a rolling 30-day period.
  - There had been progress in restraint monitors arriving at the site of the restraint within 15 minutes, though more work was needed.
- Some areas that needed improvement included:
  - The curriculum for Restraint Monitors had been adjusted to indicate that Restraint Monitors should not act as both the restraint monitor and the person applying the restraint at the same time. The change, however, did not make it clear that when a Restraint Monitor must assist with the restraint, that another Restraint Monitor should be summoned to take on that role. This should be clarified.

- Corrective Action Plans (CAP) needed to be developed, particularly where there were systemic or cross-disciplinary issues related to restraint use. While one CAP had been developed to address repeated restraints, there might be other issues that would also benefit from CAPs.
- Restraint documentation needed to capture good descriptions of the behavior that happened before the behavior that caused the restraint.
- Issues with extracting data from the system need to be resolved in order to assure that the good work on analysis and trending that was being done was not based on faulty data.
- The Medical/Dental Restraints policy needed to be implemented.

Abuse, Neglect and Incident Management

- Progress was noted in a number of areas. Highlights of progress included:
  - Training had been done to assure that staff reported suspected abuse to both Department of Family and Protective Services (DFPS) and to the Director, and it was resulting in progress in staff understanding about what was required.
  - A tracking log was added in September to document when a call alleging abuse or neglect was made to the Director as well as DFPS.
  - Considerable work had been done on auditing injuries to ascertain whether injuries had been consistently documented and reported, and a format for an audit log had been established.
  - A log of recommendations and concerns from investigation reports had been established. This was important so that concerns could be tracked to completion and verified by a follow-up visit by the Program Compliance Monitor (PCM), although further follow-up was needed to ensure expected changes had occurred.
- Some of the areas in which improvements were necessary for the Facility to progress toward full compliance with the Settlement Agreement included the need to:
  - The data on injuries should be reviewed to determine if there are any patterns or numbers of injuries that indicate a need to investigate the causes and processes to reduce injuries to individuals, particularly when injuries are caused by peer-to-peer altercations.
  - While there was some good narrative analysis in tracking and trending reports, work was needed to: conduct additional analyses; track abuse, neglect, and exploitation (A/N/E) by disposition, not just by allegation; and to track and trend over at least a year.
  - When it is clear in an investigation that staff did not report A/N/E, recommendations in the DFPS report and the UIR need to be made to address that failure to report.

Quality Assurance

- Since the Monitoring Team's last visit, the Facility had made some progress with regard to Section E. The Facility had:

- Revised the Quality Assurance (QA) Plan to add definitions, Quality Assurance/Quality Improvement (QA/QI) Council process, and a number of details to create a complete and useful plan.
- Produced drafts of a new data inventory and QA Plan Matrix that evidenced an understanding of the need to utilize quality indicators to develop a new style of QA Matrix, and turn the data inventory into one that included the data to track the quality indicators.
- The draft QA Matrix included some key indicators of performance for the various sections of the Settlement Agreement, and included results obtained through monitoring tools as one of those indicators in each section.
- Increased the number of CAPs from five to 21.
- Improved the tracking of CAPs by producing a system that captured the CAP with all of its steps, designated the person with primary responsibility, and included comments about revisions.
- Produced a good presentation of data on infectious diseases that provided an excellent example of how to display and use data to drive CAP development and create system change.
- Amassed considerable data in many areas, and provided trend analyses in an increasing number of areas such as peer-to-peer aggression, infection control, and medication variance.

- Some of the areas the Facility will need to continue to improve to progress towards substantial compliance with the Settlement Agreement included:
  - Using the former QA Matrix as the base to create an inventory of quality monitoring tools that can be updated each time a tool is modified, and can be used to assure that quality-monitoring tools are in place and being used.
  - Continuing to develop the draft QA Matrix so that it includes a column for data source for each entry in the inventory and make that source column one that is searchable, so that it will be possible to sort the inventory by data sources.
  - Refining the list of key indicators to include both outcome and process indicators, and limiting the number of key indicators addressed at any one time according to the priorities of the Facility.
  - Using the CAPs database to produce a tracking sheet that displays key information for each CAP on a grid to make the QA/QI Council and other committees' reviews easier.
  - Working 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.

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

- Since the last review, the Facility had made a significant change in the development of Individual Support Plans (ISPs). In September 2013, the Facility had shifted to using Facilitator Qualified Intellectual Disability Professionals (QIDPs) and Home QIDPs. The Facilitator QIDPs had primary responsibility for the preparation for and facilitation of the ISP meetings and drafting of the ISP documents, and the Home QIDPs participated in the ISP process and meetings, but also had other responsibilities related to the implementation of ISPs. At the

time of the Monitoring Team's onsite review, this process remained in the initial stages of implementation. However, members of the QIDP Department believed that it already had begun to assist with the timeliness of the completion of ISP documents, and hoped that, by better using various QIDPs' specific skill sets, it would result in improved ISP processes and documents, as well as provide better oversight of the implementation of ISPs.

- ISP meetings were being held annually, and individuals newly-admitted to the Facility were having ISP meetings within 30 days of their admission. In addition to continuing its efforts to complete ISP documents timely, the Facility needed to ensure implementation began in 30 days, and make changes to ISPs as dictated by individuals' needs. The Facility was working to develop and implement a system to train staff on the necessary components of the ISPs, and track this training.
- Timeliness of assessments prepared for the annual ISP meetings and quality of a number of these assessments continued to be problematic. On a positive note, the Facility recognized the need to work with the disciplines to improve the quality of assessments, as well as the incorporation of assessment results into ISPs and skill acquisition programs. As a result, some collaboration and cross-training had begun to occur. For example, a Speech Language Pathologist (SLP) had provided training on how to incorporate recommendations into skill acquisition programs and ISPs, and this had resulted in some discussion about the need to ensure recommendations in speech language (SL) assessments were written in a way that facilitated their integration into ISPs. The Facility is encouraged to continue these collaborative efforts and pursue its plan to expand such efforts to other disciplines.
- 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.
- The Facility was using the Integrated Health Care Plan (IHCP) format, which often expanded the array of protections, supports, and services teams were discussing. However, teams were still not identifying the full configuration of supports and services necessary to address individuals' needs and preferences.
- Action plans included more measurable action steps, which was positive, but this was an area in which work was still needed. Although some limited improvement was seen, ISPs generally continued to lack measurable objectives necessary 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 recognized this was an area needing improvement, but 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.

<u>Integrated Clinical Services</u>

- Based on the Monitoring Team's limited review of only Section G.2, primary care practitioners (PCPs) were generally reviewing and documenting their review of consultation reports. However, Integrated Progress Notes (IPNs) were not consistently found with documentation of the PCP's agreement or disagreement with the

recommendations. The Facility also needed a system to determine for which consultation reports the interdisciplinary team (IDT) needed to complete a follow-up Individual Support Plan Addenda (ISPA), and which reports the IDTs needed to review to ensure they had updated information.

Minimum Common Elements of Clinical Care

- Based on the Monitoring Team's limited review of Section H, the Facility remained in substantial compliance with Section H.2, which required diagnoses to clinically fit the assessments/evaluations, and be consistent with current diagnostic criteria. The Facility was found to be in substantial compliance for both medical and psychiatric diagnoses.

At-Risk Individuals

- Since the last review, the Facility indicated that a new Section Lead had been designated for Section I. In addition, an Assessment Workgroup was established to focus on improving the timeliness and quality of the discipline assessments. The Facility's documentation indicated that the Workgroup conducted a time study in order to identify issues/barriers that the different disciplines might be experiencing that hampered assessments from being completed timely. At the time of the review, the Assessment Workgroup had completed the time study. However, the data had not yet been analyzed nor recommendations developed.
- In addition, since the last review, the Facility had spent considerable time assessing its compliance with the At Risk policy and had identified a number of areas that were in need of attention, such as misunderstandings of the At Risk policy, communication deficits between departments, and the lack of review by IDT members regarding the Integrated Risk Rating Forms (IRRFs) and IHCPs within 14 days after the ISP. As the Facility works through these issues, it is recommended that attention be paid to the implementation of the IHCPs to ensure individuals receive the needed care determined by the teams.
- Regarding the Facility's auditing for Section I, the Monitoring Team noted that the Facility had incorporated many of the indicators the Monitoring Team used for this area, and noted a number of the Facility's findings were in alignment with the findings of the Monitoring Team.
- The Facility clearly had invested a great deal of effort in reviewing the requirements and their overall systems regarding the At-Risk system at ABSSLC. However, the lack of clear documentation included in the ISPs, IRRFs, IHCPs, and the associated disciplines' assessments regarding what actions were taken in response to pertinent events or health issues, and the lack of dates and supporting documentation addressing actions and completion of action plans made it difficult to sequentially follow the assessment and action plan processes. Consequently at the time of the review, the Facility's efforts had not yet translated into any consistent measurable progress.
- 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 plans with 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.

Psychiatric Care and Services

- ABSSLC employed one full-time Psychiatrist, one full-time advanced Nurse Practitioner (with prescribing privileges), one full-time locum tenens advanced Nurse Practitioner, 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 providers that took into account the requirements of the Settlement Agreement, and it appeared that this number of Psychiatrists should be adequate.
- The data available indicated there had been continued progress in completing the Comprehensive Psychiatric Evaluations (CPEs). The Psychiatry Department also had developed a Psychiatric Treatment Plan (PTP), which was to serve as both a compilation of material for the individuals' annual ISP and the annual update to the CPE. These annual updates were completed to coincide with the annual ISP, which should make the process self-sustaining. The Facility's data indicated the completion rate for a CPE and/or a PTP within the last year was 100 percent, although the results of the Monitoring Team's current review revealed a few omissions.
- Observation of the Psychiatric Clinics indicated that the Psychiatric Assistant, the Nurse Case Manager, the QIDP, and the Behavioral Health Services Provider, who played an important 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 had 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. The data they had assembled indicated that the adjusted rate (i.e., for unjustified polypharmacy) was currently in the six percent range.
- The Facility had made incremental progress in implementing Pre-treatment Sedation Desensitization Plans for dental procedures, but there was still little progress in developing these procedures for medical procedures.
- The Monitoring Team's prior reviews stressed the importance of making sure the information required in Sections J.8, J.9, and J.10 were represented in the ISPs. The Facility had acted on these recommendations, but work was still needed to ensure that the teams discussed and documented their discussions of the use of psychotropic medications in combination with other therapy/treatment, as appropriate.

Psychological Care and Services

- Although not addressed during this modified review, it should be noted that the Facility had made marked gains in increasing the number of staff who were Board Certified Behavior Analysts (BCBAs). The Facility also had expanded its peer review system to include weekly meetings of a committee whose primary purpose was to review individuals who were displaying limited progress on their behavior support plans or who presented as

especially challenging cases. This was a very positive addition to the already existing Behavior Support Committee (BSC) and External Peer Review Committee (EPRC) functions.

- Behavioral Services Department staff had increased their review of staff members' understanding of positive behavior support plans (PBSPs) and their implementation of these plans to determine if it was with a high degree of integrity. As treatment integrity was largely assessed through videotaped recordings of behavioral events, staff are encouraged to schedule daily visits to the homes and day habilitation programs of the individuals they serve. The focus should be to train staff to competently implement individuals' behavior support plans. The provision of feedback, in the moment, will enhance staff members' skills when working with the individuals served.
- Behavior coaches continued to provided support and training to the direct support professionals working with individuals residing at the Facility. These department staff were available during the two daytime shifts, seven days a week. The plan was to expand the schedule of behavior coaches to the overnight shift ensuring around the clock support, which would be a positive addition.
- Functional Behavior Assessments (FBAs) continued to reflect greater emphasis on direct observation of identified problem behavior. Additionally, several assessments included reports in which identified preferences were tested to evaluate their effectiveness as reinforcers. Similarly, there were several PBSPs that reflected improved focus on dense schedules of reinforcement for appropriate behavior.
- Concerns remained regarding the accuracy of data collection. Problems reported in the past remained evident. Likewise, restricted ideas for addressing identified problem behaviors reduced the effectiveness of behavior support plans and the quality of life experienced by the individuals served. A focus for the future should be on improved preventative strategies, including but not limited to more comprehensive habilitation programming.

<u>Medical Care</u>

- The Medical Department had made considerable progress in many areas, including:
  - The morning medical meeting was well attended by several disciplines, and the QIDP representative took concerns back to the IDT for ISPA development, when needed. Hospitalizations, Emergency Room (ER) visits, and Infirmary admissions were reviewed. The PCPs provided some clinical and critical information when reviewing cases. Consultations were reviewed. Other departments provided periodic updates.
  - There had been considerable progress concerning obtaining quality family histories, which were then added to the annual medical assessments.
  - There was an internal QA system, which was expanding. Currently, there were three quality of care monitoring tools recently initiated, and there were seven additional tools being developed.
  - An extensive medical services manual was created to reflect the processes of the Medical Department.
- There were several areas needing guidance or improvement, including:

- Post-hospital ISPAs required review at the morning medical meeting. For the post-hospital ISPA to be of value, the pre-hospital review (i.e., open record review) and the hospital reviews needed to be completed prior to the IDT meeting for the ISPA.
- During the morning medical meetings, there remained the need for peers to challenge one another in critical clinical areas, such as whether the evaluation of Gastroesophageal Reflux Disease (GERD) was completed and in a timely manner in those with episodes of reactive airways disease.
- Tracking was needed of the annual medical assessments, because timeliness remained a concern.
- Review of the content of the quarterly medical reviews was needed to decrease the length of the document, with a focus on information a covering PCP would need. Most quarterly medical reviews were not done timely.
- Some of the databases had conflicting information.
- The external peer review process needed to expand to a 10 percent sample size (i.e., 20 percent per year), and it needed to cover additional topics.
- Some of the administrative death review recommendations were completed, but some remained incomplete and tracking to closure appeared to need further review.

<u>Nursing Care</u>

- 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 was aggregating and trending data generated from the Infection Control Real Time Audits, and including much of this information in the minutes of the Infection Control Committee meetings.
  - Although there continued to be significant problematic issues regarding the care plans addressing infectious illnesses, there was some noted improvement in the quality of some of the care plans that were reviewed.
  - 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 of the infection resulting in some systematic changes in the Facility's procedures.
  - The Facility had implemented some procedures to track the excesses and shortages of medications in an attempt to reconcile these numbers and identify the issues related to medications that were being returned to the Pharmacy without explanation.

- On a very positive note, some of the minutes of the Morning Medical Meetings indicated that data regarding unreconciled medication variances was beginning to be clinically reviewed in relation to individuals who were experiencing changes in status.

- Although the Facility had made some positive steps forward in the areas noted above, there continued to be an 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.

Pharmacy Services and Safe Medication Practices

- The following strengths were noted:
  - The Pharmacy Department initiated a number of QA monitoring tools for new orders and QDRR quality.
  - The new order process, with review of drug-drug interactions, lab, allergies, correct dosage, and side effects, was in place and the system appeared to be efficient and effective.
  - A system was in place to bring information to the morning medical meeting for missed anti-epileptics or constipation medications, and to correlate this information with any recent seizure, or problem with constipation, respectively.
  - Timely QDRR completion approached 100 percent.
  - The chemical restraint form had an entry area for the Psychiatrist to comment on effectiveness of the restraint.
- Some of the remaining concerns included:
  - Additionally, the problem of excess/unknown medication returns continued, and the Pharmacy is encouraged to continue to seek new ways to assist nursing in reducing this concern. Focus also should continue on the reduction of Pharmacy medication variances.
  - The number of medication variances originating from the Pharmacy Department continued to improve, but further improvement was indicated, and sustainability of that improvement will be needed.
  - The medication variance data provided needed to be in a user-friendly format demonstrating data consistency across documents. It should consist of a series of documents that is self-explanatory and easily understood by a wide audience.

Physical and Nutritional Supports

- The Facility's Physical and Nutritional Management Team (PNMT) had the required qualified core members as outlined in the Settlement Agreement, and was meeting regularly. However, some members [i.e., Occupational Therapy (OT), and Physical Therapy (PT)] were not in attendance at a significant number of meetings.
- The PNMT members were identifying systemic issues in meeting minutes, but documentation was missing for resolution of these issues. PNMT meeting minutes were missing important information. For example, the

minutes did not consistently identify individualized clinical indicators, individuals' progress or lack thereof, and results of PNMT recommendations.

- The PNMT and the PNMT Medical Liaison had developed a PNMT referral/consultation form. However, individuals were identified within the Monitoring Team's sample that met the PNMT referral criteria, but had not been referred to the PNMT. The PNMT assessment content had improved since the last review, but additional work was needed to ensure all elements were addressed in PNMT assessments. Additional work also was needed to integrate PNMT recommendations in IHCPs and, most importantly, implement them.
- Since the last review, progress had been made with individuals' Physical and Nutritional Management Plans (PNMPs) having more of the necessary components. The Monitoring Team observed PNMT members doing an exceptional job of auditing on individual's PNMP to ensure it was complete.
- A member of the Monitoring Team, in conjunction with Facility staff, completed multiple direct observations of staff's implementation of individuals' PNMPs and dining plans. On a positive note, the two PNMP Coordinators and one Habilitation Technician were able to successfully intervene and provide coaching and mentoring to staff to demonstrate correct implementation of individuals' PNMPs. The observations the Monitoring Team completed showed that some staff were not competent and/or compliant in implementing foundational PNMP and dining plan strategies.
- On a positive note, the Facility had begun to implement a Mealtime Management System. At the time of the review, 247 staff had been trained. A Unit Director had been reassigned to provide leadership in the implementation of the Mealtime Management System. This was viewed as a constructive appointment and significantly expanded the responsibility of mealtime management beyond the Habilitation Therapy (HT) Department. The development and implementation of a Mealtime Management System was a significant positive initiative in enhancing a safe environment for individuals during mealtimes and snacks.

<u>Physical and Occupational Therapy</u>

- Six of the seven individuals newly admitted to the Facility received an OT/PT assessment within 30 days. Since the last review, the Facility's OT/PT assessment content had improved. However, additional work was needed to ensure necessary assessments elements were completed.
- The Facility's Provision Action Information, Presentation Book, and staff interviews indicated that no initiatives had been started for Section P.3 and P.4 since the last review. However, the action plans for these subsections included valuable action steps. If implemented, they should move the Facility towards substantial compliance.

<u>Dental Services</u>

- The Dental Department continued to improve. Some of the areas of strength included:
  - Annual dental assessments were completed in a timely manner.
  - The Dental Department responded rapidly to emergencies.
  - The dental desensitization/compliance improvement program continued to make a positive impact on dental care of some individuals that would otherwise be resistant or uncooperative. The data collection

was occurring, but as discussed below, needed to be more sensitive to changes. A number of dental plans and strategies were in place, but a number of additional individuals had been identified as needing them.

- Concerns included:
  - At times, the annual dental summary was based on annual dental assessments that might be outdated. A more recent exam would assure the IDT had access to current information.
  - The annual dental summary appeared to not include some important areas of oral health.
  - With the challenge of sustaining good and fair oral hygiene rating scores, little information was available concerning teaching tooth brushing in the residences to both individuals and staff.
  - Guidance was needed in developing measurements for the dental desensitization program. The tools currently being used might not be sensitive enough to measure progress. Dental administration might need to assist in this process.
  - The Dental Department will need ongoing Behavioral Health Services Department/consultant assistance for some challenging individuals with sensory defensiveness.
  - Additional clinical indicators were needed to measure the quality of dental services.

<u>Communication</u>

- The Facility had five full-time SLPs and one full-time Speech Language Assistant (SLA). The five SLPs were licensed to practice in the state of Texas and were certified by the American Speech Language Association (ASHA). The SLPs had completed continuing education directly related to communication and transferrable to the population served.
- Five of seven newly admitted individuals since the last review received a SL/communication assessment within 30 days of admission or readmission.
- Review of the Facility-selected sample of three individuals' SLP/communication assessments revealed the Facility had made notable progress as evidenced by 17 of 23 assessment elements being present in each of the assessments reviewed. In addition to continuing to address the areas of the assessments still needing work, as additional individuals' SL assessments are completed, the Facility is encouraged to expand the improved practices seen with this small sample of individuals.
- The Facility's Provision Action Information, Presentation Book, and staff interviews indicated that since the last review, no initiatives had been started for Section R.3 and R.4. However, if implemented, a number of the action steps in the Facility's action plans, should assist in moving the Facility towards substantial compliance.

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

- 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 QIDP Department now included four Facilitator QIDPs who were responsible for guiding the ISP process and meetings. In the meeting observed on 11/7/13, the Facilitator QIDP kept the group focused,

drew participants into the discussion, and encouraged a lively exchange of ideas. Topics that required further discussion and follow-up were identified with meetings scheduled to ensure this occurred.
    - Direct support professionals reported a very positive response to the mealtime management initiative. The plan to use a similar model to address engagement was a very positive step.
    - Summaries of recently completed Functional Skills Assessment (FSA) reflected more comprehensive reviews of individual strengths and needs. Although not evident yet, this should allow for more thoughtful and greatly expanded identification of habilitation programs that consider the individual's preferences and foster greater independence and a more enriched life.
    - A staff member from the Behavioral Services Department continued to provide training and technical assistance to Active Treatment staff to address skill acquisition programs (SAP) and engagement.
- Areas in which continued work was necessary include the following:
    - Staff should use the Preferences and Strengths Inventory (PSI) to create a vision for the future that extends beyond what is currently available at the Facility.
    - Training objectives remained limited in scope with few identified opportunities for training. Community-based training was infrequent.
    - Engagement remained quite limited. The dignity of the individual was not always considered, as adults were observed seated or lying on the floor of their homes. Activities were often the same from one setting to another with little consideration of individual interests.
    - Direct support professionals also reported that skill acquisition plans sometimes were non-functional or addressed skills the person already demonstrated.

<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 included a recommendation from the Facility's team members with regard to whether or not community transition was appropriate. This was positive. However, a requirement of Section T is that: "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." Based on review of ISPs, a number of concerns were noted. For example, teams continued to make decisions not to refer individuals to the community, but often did not provide adequate justifications for their decisions, particularly when all assessments indicated the individual could be supported in a more integrated setting. ISPs reviewed did not include individualized plans to address guardians and/or individuals' need for further education about what was available in the community and/or the need for a well-planned transition process (i.e., time to explore options, slow transitions for individuals that need them, strong transition plans to ensure supports are made available, etc.), or even inform guardians and individuals that these were options. In some cases, teams appeared either to not have sufficient information to answer guardians' questions, or were found to discourage as opposed to encourage transition to the community. For example, for

one individual in the sample, the ISP documented discussion of the team encouraging the family to obtain guardianship because: "although the team tries very hard to honor a family's wishes, there is increasing pressure to refer to the community if there are no obstacles to referral. The QIDP informed [the father] that if they feel strongly about [the individual] remaining at the ABSSLC, then guardianship would provide them with more control over the decision about community placement."

- On a more positive note, since the Monitoring Team's last review, 20 individuals had transitioned to the community, and 22 individuals were on the referral list. Despite the continuing problems noted above with regard to some teams' discussions and decisions about referrals, the Facility clearly had some initiatives in place that were designed to encourage individuals and their guardians to consider community transition, and to assist them in finding community providers that could meet their preferences and needs. For example, based on interview, a very important component of education was the discussions that the Admissions Placement Coordinator was having with individuals and their families at the time of admission about the need to think from the beginning about future plans for transition back to the community. Similarly, as noted in the last report, 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. During this most recent review, anecdotally, Facility staff reported some notable success stories.
- Admissions and Placement Department staff and individuals' teams had continued to expand the scope and definition of pre-move and post-move required supports in individuals' Community Living Discharge Plans (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. However, the expanded supports in individuals' ISPs, particularly in the IHCP portion, were generally not incorporated into CLDPs. CLDPs continued to be missing a number of important pre-move and post-move required supports.
- The Special Review Documentation for an individual that returned to the Facility as a result of significant behavioral concerns showed the Special Review Team critically reviewed the behavioral aspects of his transition plan and its implementation. As a result of its review, the Special Review Team identified a list, albeit not a complete list, of action steps to take in developing and implementing CLDPs for other individuals with "more involved BSPs." The Facility and this Special Review Team should be commended for conducting this critical review, and for developing meaningful recommendations that should assist in the development and implementation of future transition plans for this individual as well as other individuals.
- Post-move monitoring had been completed in a timely and thorough manner for individuals who had transitioned to the community. When concerns were identified, action was taken to correct the issues.

<u>Consent</u>

- The parties agreed the Monitoring Team would not monitor this section of the Settlement Agreement, because the Facility had made limited to no progress due to the lack of a functional capacity assessment.

Recordkeeping and General Plan Implementation

- According to staff, all of the individuals at ABSSLC had Active Records, Master Records, and Individual Notebooks.
- Although recent data was showing some improvements, 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. In addition, a formal corrective action plan was in place that involved the Competency Training Department (CTD) re-training supervisory staff on recordkeeping requirements. On 10/14/13, this training had begun, and at the time of the review, it reportedly was in the final stages of completion. Supervisory staff would then be expected to play a role in overseeing recordkeeping practices, and intervening when they noted problems. The Unified Records Coordinators had sent a list of the first group of staff that had been identified through record audits as failing to comply with recordkeeping guidelines. The next phase of the training was for CTD to provide them with competency-based training.
- 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 updated, and a number of department heads had been retrained. A focus of the training was ensuring that when policies were revised, the revisions were clearly identified, as well as the staff that would require training. CTD was finalizing a system to track training on policies, including the production of reports that would allow easy identification of staff that still needed to complete specific training. This represented significant progress.
- 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, significant 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. For example, multiple observations showed staff completing data for the entire shift at the end of the shift, and in some cases, prior to the time periods for which documentation was entered.

VI. Status of Compliance with the Settlement Agreement

SECTION C: Protection from Harm-Restraints	
Each Facility shall provide individuals with a safe and humane environment and ensure that they are protected from harm, consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** ▪ **Review of Following Documents**: o State Policy #001.1: Use of Restraint, dated 4/10/12; o ABSSLC Policy: Use of Restraints, dated 6/3/13; o Process for Medical Restraint Plans (for Medical and Dental), undated; o Medical Restraint Plan form, dated 8/2013; o ABSSLC Self-Assessment, dated 10/21/13; o ABSSLC Action Plan, dated 10/21/13; o Presentation Book for Section C; o Presentation for Section C at the entrance meeting, on 11/4/13; o Psychologists Restraint Documentation Checklist, undated; o QA Plan for Restraint Section C, undated; o QA Report for Restraint Use, April 2013, May 2013, June 2013, July 2013, August 2013, and September 2013; o Medical Restraints 4/1/13 to 9/27/13; o ABSSLC Restraints Trend Analysis Reports for June 2013, July 2013, August 2013, and September 2013; o Restraint Reduction Committee Minutes, dated, 4/4/13, 8/29/13, 9/27/13, 10/25/13, and agenda and handouts from the 11/7/13 meeting; o Do Not Restrain/Modification of Restraint List, undated; o List of Restraint Monitors, undated; o Curriculum for Restraint Monitors, dated 5/31/12, but with more recent amendments noted; o ABSSLC Course Delinquency List for Prevention and Management of Aggressive Behavior (PMAB) 4, RES0115, RES0110, and RES0105, dated 10/14/13; o List of individuals with Crisis Intervention Plans (CIP), undated; o Behavior Support Plan for: Individual #178, Individual #250, Individual #440, Individual #305, Individual #95, Individual #4, Individual #242, Individual #373, Individual #99, Individual #303, Individual #81 (draft), Individual #347, Individual #455, Individual #441, Individual #337, Individual #425, Individual #462, Individual #486 (draft), Individual #354, Individual #444, Individual #94, Individual #439, Individual #139, Individual #165, Individual #9, Individual #510, and Individual #177; o List of individuals with dental desensitization plans; o Dental desensitization plans and progress notes for: Individual #427, Individual #390, Individual #505, and Individual #140; o Dental Monthly Reports (from 5/27/13 through 9/27/13) for: Individual #178, Individual #440, Individual #488, Individual #427, Individual #151, Individual #390, Individual #105, Individual #476, Individual #422, Individual #479, Individual #303, Individual

#505, Individual #104, Individual #127, Individual #168, Individual #140, Individual #507, Individual #82, Individual #198, Individual #273, Individual #67, Individual #169, Individual #469, Individual #148, Individual #205, Individual #312, Individual #144, Individual #324, Individual #384, Individual #69, Individual #182, Individual #51, Individual #177, and Individual #246;

- Dental Monthly Report (3/27/13 to 4/26/13) for Individual #242;
- **Sample #C.1**: Chosen from list individuals restrained as crisis intervention between 4/1/13 and 9/30/13 per II.7 of document request, "All Restraints – In Descending Order, 4/1/13 -9/30/13, dated 10/9/13. The list included 101 incidents of crisis restraint. (A total of 307 restraints less 108 dental/medical and 98 PMR-SIB). Of note, however, this number was not consistent with numbers the Facility provided in its Self-Assessment and/or the chart requested for Section C.1. A sample of 20 (20%) of the restraint episodes was drawn. A modified sample of seven (noted with asterisks) was identified for use in monitoring the provisions the parties agreed would have reduced monitoring, because little progress had occurred and the noncompliance finding from the previous review would stand. The restraint record included:
  - Restraint checklist form,
  - Face-to-face/debriefing form,
  - The individual's Crisis Intervention Plan, if applicable,
  - For each restraint, the documentation of any and all reviews of this use of restraint, and
  - Any addenda or changes to the ISP or Safety Plan that resulted.

Sample #	Name	Date and time
C1.1	Individual #17	4/15/13 at 3:25 p.m.
C1.2	Individual #318	4/19/13 at 1:18 p.m.
C1.3	Individual #318	5/8/13 at 12:30pm
C1.4	Individual #318	7/10/13 at 3:40 p.m.
C1.5*	Individual #318	9/12/13 at 3:35 p.m.
C1.6	Individual #199	7/7/13 at 2:25 p.m.
C1.7	Individual #199	7/17/13 at 2:20 p.m.
C1.8	Individual #256	5/27/13 at 6:10 p.m.
C1.9*	Individual #256	8/15/13 at 8:44 p.m.
C1.10	Individual #95	4/10/13 at 8:20 p.m.
C1.11	Individual #95	7/27/13 at 3:25 p.m.
C1.12*	Individual #323	9/11/13 at 6:00 p.m.
C1.13	Individual #423	6/12/13 at 3:07 p.m.
C1.14*	Individual #231	8/20/13 at 10:00 a.m.
C1.15*	Individual #37	9/4/13 at 11:33 a.m.
C1.16	Individual #9	7/24/13 at 9:12 a.m.
C1.17*	Individual #379	9/16/13 at 10:59 p.m.

C1.18*	Individual #354	9/20/13 at 8:00 p.m.
C1.19	Individual #397	5/1/13 at 1:00 p.m.
C1.20	Individual #323	4/28/13 at 4:05 p.m.

- **Subsample of three records from #C.1** for use in section C.4.e and f was drawn. A shortened sample was selected for use in the abbreviated review and that record is identified with an asterisk in the chart below. The records included:
- Annual Medical Summary Active Problems list,
- The form used by the Facility to document restraint considerations/restrictions,
- ISPs/ISPAs indicating that restraint considerations that have been identified by any member of the IDT have been addressed and documented.

Sample #	Name	Date and time
C1.5*	Individual #318	9/12/13 at 3:35 p.m.
C1.10	Individual #95	4/10/13 at 8:20 p.m.
C1.16	Individual #9	7/24/13 at 9:12 a.m.

- **Sample #C.2:** The following documentation for a selected sample of 24 staff:
- Their start dates,
- The dates they were assigned to work with individuals,
- Their training transcripts showing date of most recent:
  - PMAB training,
  - Training on use of restraints, and
  - Training on abuse/neglect/exploitation, and
  - The signed forms to show that each identified staff member had acknowledged his/her responsibility to report abuse/neglect.
- **Sample #C.3:** Chosen from the list provided in response to document request II.7b of 108 medical/dental restraint reports involving 60 individuals. The sample of 27% of the individuals (15% of the restraint episodes) was drawn and resulted in a total of 16 records. The shortened sample is identified with asterisks in the chart below. Documentation in each record included:
- The physicians' orders for the restraint including the monitoring schedule,
- The medical restraint plan,
- The restraint checklist,
- The documentation of the monitoring that occurred,
- Any reviews of this use of restraint, and
- Any applicable desensitization plan.

Sample #	Name	Date
C3.1	Individual #69	6/11/13 at 5:45 a.m.
C3.2*	Individual #363	8/14/13 at 7:00 a.m.

C3.3*	Individual #122	8/19/13 at 10:45 a.m.
C3.4	Individual #233	4/17/13 at 1:00 p.m.
C3.5	Individual #486	5/9/13 at 7:00 a.m.
C3.6	Individual #304	7/22/13 at 8:00 a.m.
C3.7	Individual #17	6/4/13 at 7:30 a.m.
C3.8*	Individual #196	9/9/13 at 3:05 p.m.
C3.9	Individual #84	5/7/13 at 5:15 p.m.
C3.10*	Individual #233	9/15/13 at 10:00 a.m.
C3.11	Individual #383	6/21/13 at 8:35 a.m.
C3.12	Individual #140	5/15/13 at 7:30 a.m.
C3.13	Individual #530	4/29/13 at 3:40 a.m.
C3.14*	Individual #77	9/5/13 at 8:45 a.m.
C3.15	Individual #70	7/3/13 at 6:00 p.m.
C3.16*	Individual #97	9/18/13 at 8:05 a.m.

- **Sample #C.4: Chemical Restraints for Crisis Intervention**: Chosen from the list provided in response to the document request II.7a. The total number of chemical restraints for crisis intervention was eight. The sample size was two, or 25%. Both records were used for provisions with reduced monitoring.

  The two restraints in the sample are the same as in sample #C.1 above, and documentation was requested of evidence of contact between the psychologist and physician prior to the use of the restraint.

Sample #	Name	Date and Time
C1.19*	Individual #397	5/1/13 at 1:00 p.m.
C1.20*	Individual #323	4/28/13 at 4:05 p.m.

- **Sample #C.5: Off Grounds Restraints:** There were four off-grounds restraints during this review period. The sample included all four records.

Sample #	Name	Date and Time
C5.1	Individual #534	5/24/13 at 8:10 p.m.
C5.2	Individual #74	7/19/13 at 6:40 p.m.
C5.3	Individual #379	9/4/13 at 1:07 p.m.
C5.4	Individual #81	9/13/13 at 2:36 p.m.

- **Sample #C.6:** Crisis Intervention Restraint Checklist, Crisis Intervention Face-to-Face Assessment and Debriefing Form, and Psychologist's Restraint Documentation Checklist for the following restraints:

Individual	Date of Restraint	Time of Restraint
Individual #95	4/10/13	8:20 p.m.
	4/22/13	4:45 a.m.
	4/22/13	5:28 p.m.
	4/23/13	12:58 p.m.
	4/24/13	2:36 p.m.
	4/30/13	9:18 p.m.
Individual #318	4/19/13	1:18 p.m.
	4/21/13	3:45 p.m.
	4/25/13	1:03 p.m., 1:09p.m., and 1:46 p.m.
	4/29/13	12:01 p.m.
	4/30/13	1:00 p.m.
	5/8/13	12:30 p.m.
	5/17/13	12:40 p.m.
	5/19/13	12:12 p.m.
	5/19/13	12:14 p.m.
	5/23/13	7:08 a.m., 7:11 a.m.
	5/26/13	2:08 p.m.
	7/10/13	3:40 p.m.
	7/22/13	8:48 a.m.
	7/22/13	10:45 a.m.
	7/28/13	2:07 p.m.
	8/6/13	9:05 a.m.
Individual #256	7/28/13	3:30 p.m.
	7/29/13	2:50 p.m.
	7/30/13	1:10 p.m.
	8/5/13	8:08 p.m.
	8/15/13	8:44 p.m., 8:54 p.m.
	9/13/13	7:15 a.m.
	9/16/13	6:52 p.m. (total of five restraints)

- **Sample #C.7: Protective Mechanical Restraints to Prevent Self-Injurious Behavior:** This sample was chosen from the list of Protective Restraints, dated 10/9/13, and submitted in response to Document Request II.7. The reduced sample of one is designated with an asterisk in the chart below.

Sample #	Name	Date
C7.1	Individual #233	7/17/13
C7.2	Individual #9	7/31/13
C7.3*	Individual #74	9/22/13

- Functional Assessments for: Individual #95 (5/22/12), Individual #318 (8/3/12), and Individual #256 (5/23/13);
- Behavior Support Plans for: Individual #95 (6/14/13), Individual #318 (revised 3/15/13), and Individual #256 (8/1/13);
- Crisis Intervention Plans for: Individual #95 (6/14/13), Individual #318 (1/15/13), and Individual #256 (9/26/13);
- Individual Support Plans for: Individual #95 (5/1/13), Individual #318 (7/24/13), and Individual #256 (4/1/13);
- Individual Support Plan Addenda for: Individual #95 (4/10/13), Individual #318 (4/19/13, 5/8/13, 7/10/13, and 9/12/13), Individual #256 (7/30/13);
- Interdisciplinary Team Review of Repeated Restraints for: Individual #95 (4/30/13), Individual #318 (5/6/13, and 8/14/13), and Individual #256 (8/16/13 and 9/27/13);
- Psychology Monthly Progress Notes for: Individual #95 (4/13), Individual #318 (4/13 and 9/13), and Individual #256 (8/13 and 9/13);
- Nursing Restraint documentation from the Restraint Checklists for the following individuals:
- Individual #17 on 4/15/13 at 3:25 p.m.;
- Individual #318 on 4/19/13 at 1:18 p.m., 5/8/13 at 12:30 p.m., 7/10/13 at 3:40 p.m., and 9/12/13 at 3:35 p.m.;
- Individual #199 on 7/7/13 at 2:35 p.m., and 7/17/13 at 2:20 p.m.;
- Individual #256 on 5/27/13 at 6:10 p.m. and 8/15/13 at 8:44 p.m.;
- Individual #95 on 4/10/13 at 8:20 p.m., and 7/27/13 at 3:25p.m.;
- Individual #323 on 9/11/13 at 6:00 p.m.;
- Individual #423 on 6/12/13 at 3:07 p.m.;
- Individual #231 on 8/20/13 at 10:00 a.m.;
- Individual #37 on 9/4/13 at 11:33 a.m.;
- Individual #9 on 7/24/13 at 9:12 a.m.;
- Individual #379 on 9/4/13 at 1:07 p.m., and 9/16/13 at 10:59 p.m.;
- Individual #354 on 9/20/13 at 8:00 p.m.;
- Individual #534 on 5/24/13 at 8:10 p.m.;
- Individual #74 on 7/19/13 at 6:40 p.m.; and
- Individual #81 on 9/13/13 at 2:36 p.m.

- **Interviews with**:
  - Linda Hinshaw, Facility Director;
  - Jolene Willis, Assistant Director of Programs;
  - Pat Smith, Director for Quality Assurance;
  - Ron Manns, Chief Psychologist;
  - Rene Kellum Program Compliance Monitor;

	○ Mary Willingham, RN, Program Compliance Nurse; ○ Mary White, RN, MSN, Chief Nurse Executive (CNE); ○ Amy Jo Bramlett, LVN, Risk Coordinator, ○ Ron Manns, BCBA, Director of Behavioral Health Services, and Kathy Theiss; and ○ Various staff in residential units, including ten direct support professionals. ▪ **Observations of**: ○ Quality Assurance/Quality Improvement (QA/QI) Council Meeting, on 11/4/13; ○ Unit IV Team Meeting, on 11/5/13; ○ IMRT meeting, on 11/5/13; ○ Residence 5961, Residence 5962, Residence 5971, Residence 5972, Residence 6330, Residence 6350, 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, Activity Center 6390, and Activity Center 6700; ○ Workshop 1, Workshop 2, and Workshop 3; ○ Clara Campbell Center; ○ 5th Street Diner; ○ Behavior Support Committee, on 11/6/13; ○ Internal Peer Review Committee, on 11/7/13; and ○ Restraint Reduction Committee, on 11/7/13.
	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 one of the eight provisions in Section C: Section C.3. This was not consistent with the Monitoring Team's findings, because the Monitoring Team did not find substantial compliance for Section C.3. To conduct its self-assessment, the Facility used a combination of data resulting from audits of a sample of restraint documentation using a Crisis Intervention Restraint Checklist, and review of tracking information for such indicators as length of restraint. The records sampled totaled 53 out of 206 (26%) instances of restraint over the period from 4/1/13 to 8/30/13. (There was no explanation as to the source of this number, which differed from the one noted in the documents reviewed list above.) Overall ratings from checklists were not included, which was good. Instead the Facility chose specific elements related to the section to illustrate whether or not there was substantial compliance. For example, in Section C.1, the Facility relied on four measures: whether there was evidence of immediate and serious danger, whether there was a description of the antecedents to the behavior that necessitated the restraints, whether there was any evidence of prone restraint, and whether less restrictive alternatives were tried. The Facility concluded that documentation was not consistent enough to support substantial compliance For 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 Facility examined the length of time individuals were restrained and determined

	that while the time in restraint was increasing, it was still less than 10 minutes, but that their findings for Section C.1 meant that some individuals might have been restrained unnecessarily and concluded noncompliance. The Monitoring Teams' approach was to first identify individuals in the sample who had Crisis Intervention Plans and compare the instructions for release in the plan to the documentation on the Restraint Checklist to determine if the CIP instructions had been followed. The Monitoring Team found that CIPs often required the individual to be in restraint for three to five minutes while calm in order to be safely released. The Restraint Checklists documented the release when calm or no longer a danger, but did not document the time the person became calm and the required minutes in that condition before release was attempted. Then, the Monitoring Team reviewed the individuals who did not have CIPs to determine if the documentation showed release when no longer a danger. While both the Facility and the Monitoring Team found noncompliance, the basis was quite different. To be a useful process, the Facility needs to monitor measures that will determine substantial compliance, such as those used in this report. Other observations included: ▪ The data included in the self-assessment was graphed and displayed in helpful ways. ▪ The tool being used for monitoring should have some guidelines added to be useful in the self-assessment process. Action Plans were provided for Section C, but they did not appear to be used as a working tool to improve compliance. There were four action plans in place with a total of 14 action steps. Seven steps were recorded as completed, five as in process, and two as not started. There were no indications of progress on the remaining steps or possible need for revision. It was not clear how the remaining seven steps in these plans would bring the Facility into compliance with this section.
	Summary of Monitor's Assessment: The Monitoring Team did not find ABSSLC to be in substantial compliance with any of the subsections of Section C. During the last monitoring review, the Facility was found to be in substantial compliance with Section C.2 (timely release from restraint). However, since then, a change appeared to have occurred with the requirements in Crisis Intervention Plans (CIPs) to specify that some individuals needed to be calm for three to five minutes in order to be safely released. These periods of delay were not documented on the Restraint Checklists. While this meant that individuals were released as soon as no longer a danger, they were not released in accordance with their CIP, which was designed to avoid episodes of rapid release and re-restraint. Areas of progress included: ▪ The Facility was managing the use of protective mechanical restraint to minimize its use. ▪ A process for the use of medical/dental restraints had been developed. ▪ The Restraint Reduction Committee had continued to meet to review systemic trends, and to review when restraint was used more than three times in a rolling 30-day period. ▪ There had been progress in restraint monitors arriving at the site of the restraint within 15 minutes, though more work was needed. Some areas that needed improvement included:

	▪ The curriculum for Restraint Monitors had been adjusted to indicate that Restraint Monitors should not act as both the restraint monitor and the person applying the restraint at the same time. The change, however, did not make it clear that when a Restraint Monitor must assist with the restraint, that another Restraint Monitor should be summoned to take on that role. This should be clarified. ▪ Corrective Action Plans (CAP) needed to be developed, particularly where there were systemic or cross-disciplinary issues related to restraint use. While one CAP had been developed to address repeated restraints, there might be other issues that would also benefit from CAPs. ▪ Restraint documentation needed to capture good descriptions of the behavior that happened before the behavior that caused the restraint. ▪ Issues with extracting data from the system need to be resolved in order to assure that the good work on analysis and trending that was being done was not based on faulty data. ▪ The Medical/Dental Restraints policy needed to be implemented. ▪ Clarification was needed of the respective roles of the Program Compliance Monitor and the Behavioral Health Services Department, and the use of monitoring tools, since it was not apparent that the Quality Assurance Monitoring Tool was a resource for the Facility Self-Assessment.

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td>C1</td><td>Effective immediately, no Facility shall place any individual in prone restraint. Commencing immediately and with full implementation within one year, each Facility shall ensure that restraints may only be used: if the individual poses an immediate and serious risk of harm to him/herself or others; after a graduated range of less restrictive measures has been exhausted or considered in a clinically justifiable manner; for reasons other than as punishment, for convenience of staff, or in the absence of or as an alternative to treatment; and in accordance with applicable, written policies, procedures, and plans governing restraint use. Only restraint techniques approved in the Facilities' policies shall be used.</td><td>The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., a smaller sample) for this subsection, because the Facility had made limited progress. The noncompliance finding from the last review stands.

Data the Facility supplied for the past two six-month periods showed:

<table>
<tr><th>Type of Restraint</th><th>10/1/12 to 3/31/13</th><th>4/1/13 to 9/30/13</th></tr>
<tr><td>Personal restraints (physical holds) during a behavioral crisis</td><td>67</td><td>116*</td></tr>
<tr><td>Chemical restraints during a behavioral crisis</td><td>20</td><td>10</td></tr>
<tr><td>Mechanical restraints during a behavioral crisis</td><td>6</td><td>94</td></tr>
<tr><td>TOTAL restraints used in behavioral crisis</td><td>93</td><td>220</td></tr>
<tr><td>TOTAL individuals restrained in behavioral crisis</td><td>32</td><td>53</td></tr>
<tr><td>Of the above individuals, those restrained pursuant to a Crisis Intervention Plan</td><td>15</td><td>21</td></tr>
<tr><td>Medical/dental restraints</td><td>102</td><td>113</td></tr>
<tr><td>TOTAL individuals restrained for medical/dental reasons</td><td>89</td><td>72</td></tr>
</table>
*This number was calculated by the Facility and may have been drawn from a different</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		list than was supplied to the Monitoring Team in response to request #II.7. <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 and reduced for this review as indicated by asterisks in the list provided in the Documents Reviewed Section above. c. Based on a review of the restraint records for individuals in Sample #C.1 involving seven individuals, none (0%) showed use of prone restraint. d. Based on questions posed to 10 direct support professionals, all 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 with the following results: ▪ f. In seven of the seven records (100%), there was documentation showing that the individual posed an immediate and serious threat to self or others. However, as noted below with regard to Section C.7, for the restraint episodes selected for the sample of individuals for whom restraint had occurred more than three times in any rolling 30-day period, two examples were found where the documentation did not support that a crisis existed. ▪ g. For the seven restraint records, a review of the descriptions of the events leading to behavior that resulted in restraint found that six (86%) contained appropriate documentation that indicated that there was no evidence that restraints were being used for the convenience of staff or as punishment. Sample # C1.14 did not. ▪ h. In five of the records (71%), there was evidence that restraint was used only after a graduated range of less restrictive measures had been exhausted or	

#	Provision	Assessment of Status	Compliance
		considered in a clinically justifiable manner. In sample #C1.14, it was not clear that staff had tried putting a pillow between the individual's hands and his stomach to deter picking of a scab as indicated in his Crisis Intervention Plan. In sample #C1.17, it was not clear that staff had followed the Crisis Intervention Plan that indicated staff should say "no" to the behavior and back away. ▪ i. Facility policies did not identify a complete list of approved restraints. ABSSLC policy: Restraint Policy, dated April 2013, which had been updated to coincide with the State Policy, had language to indicate the mechanical restraints that could be used included helmets, mittens with ties, and other mechanical restraints as approved by the Crisis Intervention Plan or by the Behavioral Health Services Provider, the administrator on duty, and the Center Director of Behavioral Health Services. As noted in the Monitoring Team's last report, the Facility policy needs to include a full list of mechanical restraints that may be used. The Facility was using wristlets, Kevlar vests, abdominal binders, and a shoulder harness, none of which were specified in its most recent policy. ▪ j. Based on the review of seven restraints, involving seven individuals, all (100%) were approved restraints. k. In five of these records (71%), 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: ▪ In Sample #C1.5, an individual was searching through envelopes in the mailroom attempting to find money. When staff redirected him he attacked and pulled the staff member's hair. Documentation indicated that he had not been engaged in an activity and no activity was planned, despite his need for assistance from staff to engage in meaningful activity. ▪ In Sample #C1.14, an individual was sitting in the living room and began picking at a sore on her stomach until it bled. It was not clear whether Facility staff had offered the individual an activity at the time that would have provided an alternative to engaging in self-injurious behavior. l. Of the eight restraints the Facility considered to be Protective Mechanical Restraint – Self Injurious Behavior (PMR-SIB), the Monitoring Team reviewed one (Sample C7.3). Of these, none (0%) followed DADS policy regarding the use, management, and review of PMR. For sample #C7.3, PMR-SIB was started on 9/20/13, when the individual's psychotropic medications were withdrawn in an effort to determine the cause of pain he had been experiencing. He had begun to seriously self-injure, and, after an interdisciplinary team (IDT) meeting, use of a Kevlar vest was ordered. The process appeared to follow the policy on use of restraints except for the following:	

#	Provision	Assessment of Status	Compliance
		▪ There was no Positive Behavior Support Plan (PBSP) in the record, and no instructions on the use of the Kevlar vest were found; ▪ One-to-one staffing appeared to be in place, given the ISPA that established the use of the vest, but the staffing level was not recorded on the Restraint Checklist; ▪ Since there was no specific plan for the use of the vest, it was not possible to determine if releases were in accordance with the plan. Based on this limited review, the finding of noncompliance stands. While there had been improvement in documentation of restraints, not all restraint records contained necessary documentation, and the individual with PMR-SIB restraint did not have a related PBSP. In addition, the Facility policy on restraint use did not include a full list of approved mechanical restraints.	
C2	Effective immediately, restraints shall be terminated as soon as the individual is no longer a danger to him/herself or others.	Although the Facility was found to be in substantial compliance for the last review, the Facility agreed onsite that the Monitoring Team would conduct reduced monitoring (i.e., a smaller sample) for this subsection. In the abbreviated review, the Monitoring Team found noncompliance. If the abbreviated review had indicated substantial compliance, a full sample review would have been conducted. The restraint records involving the seven individuals in Sample #C.1 were reviewed. Of these, six of the individuals had Crisis Intervention Plans that defined the use of restraint. Of the seven restraint records, two (sample #C1.12 and #C1.17) were eliminated from the following review. This was because the restraints were released when staff could not maintain the restraint or when the individual was released prematurely due to his arm hurting. a. For four individuals who had Crisis Intervention Plans, one (25%) included sufficient documentation to show that the individual was released from restraint according to the criteria set forth in the Crisis Intervention Plan. In three of these records (sample #C1.14, #C1.15 and #C1.18), the CIP required that the restraint be held for three minutes after the individual became quiet, but the record indicated the release was done when the individual was quiet. In one (sample #C1.5) the restraint was released according to the CIP. b. For one individual who did not have Crisis Intervention Plan (sample #C1.9), one (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 limited review, the Facility was not in substantial compliance with this provision. Although the Facility was determined to be in substantial compliance during	Noncompliance

#	Provision	Assessment of Status	Compliance
		the Monitoring Team's last review, it appeared that CIPs now included requirements for a specified period of calm before release of the restraint to ensure safety, and the documentation on the Restraint Checklists did not provide evidence that the required waiting period had been observed. In the three records with such requirements, all were released when calm or not a danger, observing the usual standard for when release would be required if a CIP were not in place. However, based on interview, it was clear that the requirement to wait was intended to avoid multiple releases and re-restraints, which can add to the dangers inherent in the use of restraint. It did not appear that staff applying the restraints or restraint monitors were versed in the requirements of the CIPs.	
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.	Based on the Facility's Self-Assessment in which the Facility found substantial compliance, while the Monitoring Team was on site, the Facility requested a full review of this subsection, and the Monitor agreed. As a result, the full samples of individuals and staff members were included in the review for this subsection. The Facility's policies related to restraint are discussed above with regard to Section C.1 of the Settlement Agreement. 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; ▪ 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. A sample of 24 current employees was selected from a current list of staff. 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: ▪ All of the 24 (100%) had current training in RES0105 Restraint Prevention and Rules. ▪ All of the 14 (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. ▪ All of the 24 (100%) had completed PMAB training within the past 12 months. ▪ All of the 14 (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	Noncompliance

#	Provision	Assessment of Status	Compliance
		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 16 of 20 records (80%), 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. Those that did not have at least some explanation in addition to checking boxes, so it could be determined whether or not the prescribed least restrictive measures had been used, were: sample #C1.2 and #C1.10. Those that clearly did not follow the PBSP were: sample #C1.14, where staff did not indicate they had tried placing a pillow as indicated in the plan, and #C1.17 where it was not clear that staff had tried saying "no" and backing away. Based on this review the Facility was not in substantial compliance, because 20% of the records in the sample did not include sufficient information to determine if necessary steps were taken or did not document that staff followed some required steps in the process of attempting to avoid the use of restraint. In addition, as described with regard to Section C.1 above, the Facility policy did not include a list of approved mechanical restraints.	
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.	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., a smaller sample) for this subsection, because the Facility had made limited progress. The noncompliance finding from the last review stands. a. Based on a review of seven restraint records in the limited sample used for this review (Sample #C.1), in seven (100%) there was evidence that documented that restraint was used as a crisis intervention. However, as noted below with regard to Section C.7, for the restraint episodes selected for the sample of individuals for whom restraint had occurred more than three times in any rolling 30-day period, two examples were found where the documentation did not support that a crisis existed. b. A total of 27 Behavior Support Plans were reviewed for Section K.9 of this report. In none of these plans was there evidence of the use of programmatic restraint. c. In addition, Facility policy did not allow for the use of <u>non-medical</u> restraint for reasons other than crisis intervention. d. In all seven 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	Noncompliance

#	Provision	Assessment of Status	Compliance
		Restrain" list the Facility maintained. Based on a limited subsample of one record for this review (as described in the Documents Reviewed list: subsample #C.1.5): e. In one of one restraint record reviewed (100%), there was evidence that the restraint used was not in contradiction to the individual's medical orders according to a comparison of the Annual Medical Summary Active Problems list and the form the Facility used to document restraint considerations/restrictions. f. In one of one restraint record reviewed (100%), there was evidence that the restraint used was not in contradiction to the individual's ISP, PBSP, or crisis intervention plan. According to the Master List of Restraints applied between 4/1/13 and 9/30/13, a total of 50 individuals required restraint for medical procedures and 18 required restraint for dental procedures. Although the Facility had developed a template for medical restraint plans, no completed plans were provided to the Monitoring Team for review. Conversely, the Facility provided the following documentation regarding dental desensitization programming: a) list of individuals with dental desensitization plans; b) plans and progress notes for four individuals whose desensitization plans had been implemented in the previous six months; and c) Dental Monthly Reports for 35 individuals. A summary of the Monitoring Team's review is provided below: ▪ Documentation the Facility provided indicated that desensitization plans or strategies had been developed for 42 individuals. ▪ Eighteen individuals had experienced restraint for dental procedures during the six-month period of 4/1/13 through 9/30/13. Four of these individuals had written desensitization strategies. ▪ The Dental Monthly Reports completed between 5/26/13 and 9/27/13 were reviewed for 34 individuals. (It should be noted that reports completed prior to 5/26/13 were not included in this analysis.) The number of reports for each individual ranged from one month to four months. o Each of the reports followed a similar format. Identifying information was listed followed by information regarding the number of sessions scheduled, attended, and excused. This was followed by information regarding the current step of the program, the number of sessions within which criteria were met, and the last mastered step. Next was a narrative regarding the individual's performance during desensitization and regular dental office visits, if any were scheduled. Lastly, there was a summary of data from the previous month. o These reports provided an excellent review of the individual's progress. They also reflected creative and thoughtful strategies the Registered	

#	Provision	Assessment of Status	Compliance
		Dental Hygienist applied. Examples included the following: ▪ As she participated in the ISP for Individual #422, the Registered Dental Hygienist learned that he had a preference for cheese. She discussed with the team a plan to use canned cheese as a reinforcer during dental visits. When this was implemented at a regularly scheduled dental visit in September, the individual participated successfully. ▪ During a regularly scheduled dental visit, the Registered Dental Hygienist advised the dentist to stand while examining Individual #505, because he did not like anyone sitting next to him. The individual was cooperative until the dentist sat. At that time, the individual stood and would not return to the dental chair. The exam was completed while he stood. ▪ For other individuals, the Registered Dental Hygienist had provided different flavored toothpastes, she had worked with the individual inside the van when she refused to exit, she had played preferred DVDs, she had provided frequent breaks, and she had worked to identify individual specific reinforcers. She was attentive to environmental variables that might be upsetting to the individual and responded accordingly. Her work reflected a consistent use of shaping techniques to improve participation in dental procedures. o In the 4/13 monthly report for Individual #242, the Registered Dental Hygienist did conclude that oral sedation was the most appropriate and safest way to provide him with quality dental care. During future reviews, the following will be measured: 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); ▪ 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 Although the Facility had made improvements in addressing dental restraint through the implementation of dental desensitization plans, it remained out of compliance with this provision of the Settlement Agreement. The majority of individuals who experienced restraint for dental procedures did not have plans. Plans to address those who required	

#	Provision	Assessment of Status	Compliance
		restraint for medical procedures had not yet been developed.	
C5	Commencing immediately and with full implementation within six months, staff trained in the application and assessment of restraint shall conduct and document a face- to-face assessment of the individual as soon as possible but no later than 15 minutes from the start of the restraint to review the application and consequences of the restraint. For all restraints applied at a Facility, a licensed health care professional shall monitor and document vital signs and mental status of an individual in restraints at least every 30 minutes from the start of the restraint, except for a medical restraint pursuant to a physician's order. In extraordinary circumstances, with clinical justification, the physician may order an alternative monitoring schedule. For all individuals subject to restraints away from a Facility, a licensed health care professional shall check and document vital signs and mental status of the individual within thirty minutes of the individual's return to the Facility. In each instance of a medical restraint, the physician shall specify the schedule and type of monitoring required.	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., a smaller sample) for this subsection, because the Facility had made limited progress. The noncompliance finding from the last review stands. 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. Two versions of the Curriculum for Restraint Monitors were provided. Both were dated May 21, 2012. One had the addition of a sentence indicating: "the restraint monitor should not participate in the restraint unless safety of individual or others is at risk." The Monitoring Team's concern was that the training be clear that the restraint monitor should not participate in the restraint. If it becomes necessary for a restraint monitor to assist with a restraint, that staff member ceases to be the monitor and another restraint monitor needs to be summoned to ensure the safety of the individual. The modification to the curriculum needs to clarify this concept, and the new version of the curriculum needs to include the effective date of the modified version. b. This training was competency-based. c. Based on review of training records, six staff at the Facility who performed the duties of a restraint monitor in the limited sample (100%) successfully completed the training to allow them to conduct face-to-face assessment of individuals in crisis intervention restraint. However, they may not have been trained on the need to avoid participating in a restraint and acting as the monitor for that restraint. Based on a review of seven restraint records (limited Sample #C.1), a face-to-face assessment was conducted: ▪ d. In six out of seven incidents of restraint (86%) by an adequately trained staff member. Records that did not contain documentation of this included: sample #C1.9, because no copy of the face-to-face assessment was provided. ▪ e. In four out of seven instances (57%), 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 #C1.9, where there was no documentation of face-to-face assessment; #C1.12, where the monitor arrived one hour and 45 minutes after the start of the restraint; and #C1.17 where the monitor arrived 39 minutes after the start of the restraint. ▪ f. In four instances (57%), the documentation showed that an assessment was completed of the application of the restraint. Records that did not contain documentation of this included: o Sample #C1.9 where there was no face-to-face assessment;	Noncompliance

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		o Sample #C1.14 where the restraint checklist did not contain documentation of what happened before the behavior that caused the restraint, and did not give information about whether the PBSP was followed with regard to using a pillow to block the self-injurious behavior, and the monitor did not explain or supplement the restraint checklist information; o Sample C1.18 where the restraint monitor did not explain or supplement the restraint checklist concerning the nature of the aggression that caused the restraint. ▪ g. In six instances (86%), the documentation showed that an assessment was completed of the consequences of the restraint. Records that did not contain documentation of this included: Sample #C1.9, which did not include a face-to-face assessment. There were no records of restraint for which physicians had ordered alternative monitoring schedules. If there had been, the following metrics would have been completed. ▪ 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 18 restraint records for 12 individuals for restraints that occurred at the Facility (i.e., Individual #17, Individual #318, Individual #199, Individual #256, Individual #95, Individual #323, Individual #423, Individual #231, Individual #37, Individual #9, Individual #379, and Individual #354) (i.e., chemical restraints were excluded and only the first restraint in a series of restraints that occurred one after the other were used in this review), there was documentation that a licensed health care professional: ▪ j. Conducted monitoring at least every 30 minutes from the initiation of the restraint in 12 (67%) of the instances of restraint. Records that did not contain documentation of this included: Individual #318 on 7/10/13 at 3:40 p.m. and 9/12/13 at 3:35 p.m.; Individual #95 at 8:20 p.m.; Individual #323 on 9/11/13 at 6:00 p.m.; Individual #423 on 6/12/13 at 3:07 p.m.; and Individual #231 on 8/20/13 at 10:00 a.m. ▪ k. Monitored and documented vital signs in 16 (89%) episodes. Records that did not contain appropriate documentation of this included: Individual #423 on 6/12/13 at 3:07 p.m.; and Individual #231 on 8/20/13 at 10:00 a.m. Problematic issues that resulted in noncompliance included vital signs not recorded or 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 13 (72%) episodes. Records that	

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		did not contain appropriate documentation of this included: Individual #17 on 4/15/13 at 3:25 p.m.; Individual #318 on 7/10/13 at 3:40 p.m.; Individual #95 on 4/10/13 at 8:20 p.m.; Individual #423 on 6/12/13 at 3:07 p.m.; and Individual #231 on 8/20/13 at 10:00 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. In addition, four restraint episodes that had occurred off the grounds of the Facility in the last six months were reviewed (i.e., Individual #379 on 9/4/13 at 1:07 p.m.; Individual #534 on 5/24/13 at 8:10 p.m.; Individual #74 on 7/19/13 at 6:40 p.m.; and Individual #81 on 9/13/13 at 2:36 p.m.). A licensed health care professional: ▪ m. For the following metric, the Monitoring Team was unable to make a finding, because the Facility provided no documentation to indicate the specific time the individuals returned to the facility: Conducted monitoring within 30 minutes of the individual's return to the Facility in __ out of ___ (__%). ▪ n. Monitored and documented vital signs in all four (100%). ▪ o. Monitored and documented mental status in all four (100%). From discussions with the Chief Nurse Executive, the Facility's Nursing Department had still 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. Sample #C.3 was selected from the list of individuals who had medical restraint in the last six months. (Sample C.3 is defined above in the Documents Reviewed section.) A smaller sample of six records, denoted by asterisks, was selected for this limited review. For these individuals, the physicians' orders were reviewed, as well as documentation of monitoring. One restraint (Sample #C.3.3) involved use of a physical hand-hold that lasted 11 minutes. This was less than the time when monitoring of the restraint would be needed, and it was eliminated from the following metrics. ▪ p. In one out of the five remaining (20%), the physician specified the schedule of monitoring required, or the specified Facility policy regarding this was followed. That one was sample #C3.2, where the schedule of monitoring was specified in the medical restraint plan. For the remaining five, no schedule was indicated (Sample #C3.10, #C.14 and #C.16), the instruction was to follow the protocol, but it was not clear what protocol (#C3.8). ▪ q. In none out of five (0%), did the physician specify the type of monitoring required as the Facility standard or a different schedule.	

#	Provision	Assessment of Status	Compliance
		▪ r. In four out of five of the medical restraints (80%), appropriate monitoring was completed either as required by the Settlement Agreement, Facility policy, or as the physician prescribed. In those four, the restraint was monitored at least every 30 minutes. In one (Sample #C3.16) the monitoring intervals were sometimes over 30 minutes. Based on this review, the Facility was not in substantial compliance. It was noted, however, that a new Process for Medical Restraint Plans (for Medical and Dental) was available, though the documentation did not include a "date effective." The Medical Restraint Plan form, dated 8/2013, specified that the physician would order the restraint, but did not provide guidance to assure the physician would specify the type and schedule of monitoring. To move forward towards substantial compliance, guidance to the physician/dentist needs to specify that the order contain the type and schedule of monitoring.	
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.	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., a smaller sample) for this subsection, because the Facility had made limited progress. The noncompliance finding from the last review stands. A limited sample (Sample #C.1 with asterisks) of seven 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 seven (100%), continuous one-to-one supervision was provided; ▪ b. In seven (100%), the date and time restraint was begun; ▪ c. In seven (100%), the location of the restraint; ▪ d. In five (71%), information about what happened before, including what was happening prior to the change in the behavior that led to the use of restraint. The two that did not included sample #C1.9, where the individual was jumping on the couch, calling staff names, and pulling hair. There was no information about what was happening prior to these actions that might have precipitated the behavior, and there was no face-to-face or debriefing to supplement the information on the Restraint Checklist. The second was sample #C1.14, where staff and the individual were reported to have been sitting on the couch, and the individual was picking at a sore on her stomach. There was no other information about what was going on in the home or what behavior the individual was engaging in before she began to pick at her stomach. ▪ e. In two (29%), the actions taken by staff prior to the use of restraint to prevent the use of restraint were adequate to permit review per Section C.8. Those two were: o Sample #C1.5, where the individual was in the mailroom, going through and opening mail. The Restraint Checklist indicated he was prompted to	Noncompliance

#	Provision	Assessment of Status	Compliance
		leave, but grabbed the nurse and pulled her hair with both hands leading to a "finger weave" to extricate the nurse. This information supplemented the checked boxes. o Sample #C1.12, where the individual started yelling and hitting the wall when he overheard staff interacting with a peer. When staff attempted communication, he became physically aggressive. The Restraint Checklist indicated the behavior was unanticipated and imminently dangerous, requiring immediate action. In the remaining five records, while boxes were checked to indicate attempts to avoid restraint, it was not clear in what order the attempts were made or with what result, and sometimes the checked boxes provided conflicting information. For example, for sample #C1.9, boxes were checked to indicate prompting replacement behavior, following steps in the PBSP, and PMAB communication skills were all tried, but the box for unanticipated imminent danger was also checked, making it difficult to determine exactly what happened, in what order, or with what results. In addition, the PBSP for the individual indicated there should be no reaction to aggression with any kind of communication. Such information did not support a meaningful review of the restraint documentation to ensure its accuracy. ▪ f. In seven (100%), the specific reasons for the use of the restraint; ▪ g. In seven (100%), the method and type (e.g., medical, dental, crisis intervention) of restraint; ▪ h. In seven (100%), the names of staff involved in the restraint episode; ▪ Observations of the individual and actions taken by staff while the individual was in restraint, including: o i. In seven (100%), the observations documented every 15 minutes (if 15 minutes or longer) and at release; o j. In two (100%) of those restraints that lasted more than 15 minutes, the specific behaviors of the individual that required continuing restraint; and o k. In one (100%), 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 six (86%), the level of supervision provided during the restraint episode. The one that did not was sample #C1.14, where the Level of Supervision box was not checked; and ▪ m. In all (100%), the date and time the individual was released from restraint. Based on a review of 18 restraint records for 12 individuals for restraints that occurred at the Facility (i.e., Individual #17, Individual #318, Individual #199, Individual #256,	

#	Provision	Assessment of Status	Compliance
		Individual #95, Individual #323, Individual #423, Individual #231, Individual #37, Individual #9, Individual #379, and Individual #354) (i.e., chemical restraints were excluded and only the first restraint in a series of restraints that occurred one after the other were used in this review): ▪ n. In 16 (89%), 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 appropriate documentation of this included: Individual #231 on 8/20/13 at 10:00 a.m. in which the Restraint Checklist section addressing injuries was left blank, and Individual #95 on 4/10/13 at 8:20 p.m. in which the Restraint Checklist indicated an injury had occurred. However, the integrated progress notes and CIRs requested by the Monitoring Team were not included in the documentation the Facility provided, and as a result, a determination could not be made as to whether or not an assessment of the injury had occurred or what the results were. Four restraint episodes that had occurred off the grounds of the Facility in the last six months were reviewed (i.e., Individual #379 on 9/4/13 at 1:07 p.m.; Individual #534 on 5/24/13 at 8:10 p.m.; Individual #74 on 7/19/13 at 6:40 p.m.; and Individual #81 on 9/13/13 at 2:36 p.m.). ▪ In three (75%), the results of assessment by a licensed health care professional as to whether there were any restraint-related injuries or other negative health effects were appropriately documented. Records that did not contain appropriate documentation of this included: Individual #379 on 9/4/13 at 1:07 p.m. in which the section addressing injuries on the Restraint Checklist was left blank. o. In a sample of seven records (limited Sample #C.1), restraint-debriefing forms had been completed for five (71%). The two this did not were Sample #C1.9 and #C1.12. p. A sample of six individuals subject to medical restraint was reviewed (Sample #C.3), and in one (17%), there was evidence that the monitoring had been completed as required by the physician's order. That one was sample #C3.2 which included a medical restraint plan. In two (sample #C3.3 and #C3.10), there was no completed restraint checklist or the restraint checklist did not contain the name of the person monitoring. In the remaining three, monitoring was conducted, but since the physician did not specify the monitoring, it was not possible to conclude that it was adequate. 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 two individuals who were the subject of a chemical restraint was reviewed.	

#	Provision	Assessment of Status	Compliance
		q. In one (50%), 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 sample #C1.19, the form was completed, but it was 15 minutes after the start of the restraint. Based on this review, the Facility was not in substantial compliance with this subsection.	
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 documentation, between 4/1/13 and 9/30/13, crisis intervention restraint was utilized one or more times for a total of 30 individuals. (It should be noted that this list might be inaccurate, because minutes from two IDT Review of Repeated Restraints held within this six-month period were provided for Individual #99 whose name was not found on the master list.) This excludes those who were placed in restraint for the purpose of medical or dental procedures. The form of crisis intervention restraint was physical, chemical, or mechanical. Of these 30 individuals, a total of nine were placed in restraint more than three times in any rolling 30-day period. Three of these individuals were selected for review. For these three individuals, four or more consecutive restraints were identified and reviewed. Documents reviewed for these specific incidents included: Crisis Intervention Restraint Checklists, Crisis Intervention Face-to-Face Assessment and Debriefing Forms, Psychologist's Restraint Documentation Checklist, Functional Assessment, Behavior Support Plan, Crisis Intervention Plan, Individual Support Plan, ISP Addenda including IDT Review of Repeated Restraint, and Psychology Monthly Progress Note. It should be noted that although the documents that were in place at the time of the restraints were requested, these were not always provided. A review of Crisis Intervention Restraint Checklists raised concerns, because conditions leading to restraint were not always clearly described. Examples included the following: ▪ The restraint applied on 5/26/13 at 2:08 p.m. to Individual #318 noted that he was taking food that did not belong to him out of the refrigerator. ▪ The restraint applied on 7/29/13 at 2:50 p.m. to Individual #256 indicated that she had displayed "inappropriate conversation… and redirection caused	Noncompliance

#	Provision	Assessment of Status	Compliance
		behavior." Behavioral Services staff should carefully review all checklists to ensure that a crisis situation existed. Crisis Intervention Face-to-Face Assessment and Debriefing Forms should allow for this review, but these were not always completed in full. For five of the six instances of more than three restraints in 30 days (83%), there was evidence that the team met within 10 business days following each occurrence of more than three restraints in a rolling 30-day period. The following are examples where teams met and utilized the IDT Review of Repeated Restraints template to guide the discussion: ▪ The team for Individual #95 met on 4/30/13 to discuss the repeated restraints that had occurred between 3/29/13 and 4/24/13. ▪ The team for Individual #318 met on 5/6/13 and 8/14/13 to discuss repeated restraints that had occurred between 4/19/13 and 4/30/13, and 7/10/13 and 8/6/13, respectively. ▪ The team for Individual #256 met on 8/16/13 and 9/27/13 to review the restraints that occurred between 7/28/13 and 8/5/13, and 9/13/13 and 9/16/13, respectively. The following is an example of where the team failed to meet within 10 business days following an occurrence of more than three restraints in a rolling 30-day period. ▪ The team for Individual #318 did not meet to review the repeated restraints that had occurred between 5/8/13 and 5/26/13. When the individuals' teams met to discuss repeated restraint, it was evident that a discussion had taken place regarding the individual's adaptive skills, as well as biological, medical, and psychosocial factors. For each of the three individuals (100%) there was evidence that the team hypothesized that one or more factors that affected the behavior that resulted in restraint. Recommended action plans were identified in each case. Examples included the following: ▪ The team for Individual #318 had identified several factors that contributed to the use of restraint. Each of these was addressed and is described below. o The team identified contact with his family as very important to the individual. When the operator told him that he needed to wait to place a second call to his family, he became upset. The team worked with appropriate Facility staff to create two speed dial numbers, which the individual could activate independently from his home. o The team worked with the Dietician to make small, healthy snacks for the individual when it was evident that frequent requests for food often led to aggression, which led to restraint. o The team also recommended the discontinuation of one medication that often increased hunger. This was completed in July. ▪ Several health issues had been identified for Individual #256. Appropriate action	

#	Provision	Assessment of Status	Compliance
		was taken to address her discomfort. The team was also going to consult with the dietician to determine whether her gluten free diet could be discontinued, allowing her access to a broader variety of food. The Facility remained out of compliance with this provision of the Settlement Agreement. Although the Facility had shown improvement with the discussion and planning related to potentially contributing factors related to adaptive behavior and/or medical, psychiatric, or psychosocial variables, there will need to be evidence of consistent review of instances of more than three restraints in 30-day periods.	
	(b) review possibly contributing environmental conditions;	For five of the six instances of more than three restraints in 30 days (83%), there was evidence that the team met within 10 business days following each occurrence of more than three restraints in a rolling 30-day period. The team for Individual #318 met on 5/6/13 and 8/14/13 to review repeated restraints, and held ISP addenda meetings on 4/19/13, 5/8/13, and 7/10/13, but should have met later in May to review repeated restraints applied between 5/8/13 and 5/26/13. ▪ Of the three individuals reviewed, meeting minutes suggested that the individuals' teams discussed potential contributing environmental conditions (100%). ▪ One or more environmental conditions were hypothesized to affect behavior that resulted in restraint in one of these cases (33%). Regrettably, although the team for Individual #318 identified his very limited schedule of activities as a contributing factor in the use of restraint, specific recommendations to enhance his active treatment were not provided. The Facility remained out of compliance with this provision of the Settlement Agreement. Although improvement was seen with regard to teams review of potentially contributing factors related to environment variables, there will need to be evidence of consistent review of repeated restraints, and action plans should be developed to address these environmental variables.	Noncompliance
	(c) review or perform structural assessments of the behavior provoking restraints;	For five of the six instances of more than three restraints in 30 days (83%), there was evidence that the team met within 10 business days following each occurrence of more than three restraints in a rolling 30-day period. The team for Individual #318 met on 5/6/13 and 8/14/13 to review repeated restraints, and held ISP addenda meetings on 4/19/13, 5/8/13, and 7/10/13, but should have met later in May to review repeated restraints applied between 5/8/13 and 5/26/13. For three of the individuals (100%), there was evidence of discussion of potential environmental and psychosocial antecedents to problem behaviors that led to restraint. Each of these individuals had a functional assessment that had been completed prior to	Noncompliance

#	Provision	Assessment of Status	Compliance
		the repeated restraint episodes. The assessments for Individual #95 and Individual #318 were completed in 2012. It is suggested that these should be updated annually or when repeated restraint occurs. The assessment for Individual #318 was identified as a draft on all pages other than the cover page. Of these individuals, one or more antecedent factors were hypothesized to affect the behaviors that led to restraint. There was evidence that action plans had been recommended to address at least one identified antecedent for each individual (100%). The Facility remained out of compliance with this provision of the Settlement Agreement. In addition to the need to timely review instances of more than three restraints in 30 days, Functional Assessments should be updated annually or more often in response to worsening behavior.	
	(d) review or perform functional assessments of the behavior provoking restraints;	For five of the six instances of more than three restraints in 30 days (83%), there was evidence that the team met within 10 business days following each occurrence of more than three restraints in a rolling 30-day period. The team for Individual #318 met on 5/6/13 and 8/14/13 to review repeated restraints, and held ISP addenda meetings on 4/19/13, 5/8/13, and 7/10/13, but should have met later in May to review repeated restraints applied between 5/8/13 and 5/26/13. For three of the individuals (100%), there was evidence of discussion of the variables that were potentially maintaining the problem behaviors that led to restraint. Each of these individuals had a functional assessment that had been completed prior to the repeated restraint episodes. The assessments for Individual #95 and Individual #318 were completed in 2012. It is suggested that these should be updated annually or when repeated restraint occurs. The assessment for Individual #318 was identified as a draft on all pages other than the cover page. Of these individuals, one or more factors were hypothesized to affect the behaviors that led to restraint. There was evidence that action plans had been recommended to address potentially maintaining variables for each individual (100%) to limit the future likelihood of restraint. The Facility remained out of compliance with this provision of the Settlement Agreement. In addition to the need to timely review instances of more than three restraints in 30 days, Functional Assessments should be updated annually or more often in response to worsening behavior.	Noncompliance
	(e) develop (if one does not exist) and implement a PBSP based	Three individuals reviewed (100%) had a BSP or a behavior protocol in place at the time of repeated restraints. (As policy indicated that a behavior protocol will be replaced with	Noncompliance

#	Provision	Assessment of Status	Compliance
	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;	a BSP 45 days following admission, Individual #256 should have had a BSP developed months earlier than 8/13). Although BSPs and protocols were provided for all three individuals, only the plans for Individual #318 and Individual #256 were in place at the time of repeated restraints. ▪ In the BSPs provided for three individuals (100%), there was evidence of operationally defined problem behaviors. ▪ In the BSPs provided for two individuals (67%), there was evidence of functionally equivalent replacement behaviors. o Individual #318 was to improve his communication skills, specifically asking for preferred items. He was also going to learn to wait for items or activities. It was unclear why his communication skill acquisition program had been discontinued. o Similarly, Individual #256 was going to learn to ask for a delay in beginning an activity or to request a break from an activity. She also was going to learn to wait. ▪ In the BSPs provided for three individuals (100%), there was evidence of other programs designed to reduce or eliminate the problem behaviors that led to restraint. o Individual #95 and Individual #256 were both involved in counseling services with the Facility provider. o The plans for Individual #318 and Individual #256 included several simple prevention strategies. o Concerns were noted for Individual #318. He was to learn problem-solving skills, however, he had limited communication skills. o For Individual #95 and Individual #256, escape from demands was noted as one potential function of identified problem behavior. Providing the individual with a choice of activities whenever possible, is one simple strategy that should have been considered. ▪ Token reinforcement programs were referenced in two BSPs. ▪ In the BSPs provided for three individuals (100%), there were clearly specified interventions designed to reduce or eliminate the behaviors that led to restraint. One individual (33%) had a Crisis Intervention Plan in place at the time of his repeated restraints. A note included on the Psychologist's Restraint Documentation Checklist for the 7/30/13 restraint applied to Individual #256 suggested that a plan existed, but it could not be found. The CIPs provided to the Monitoring Team for Individual #95 and Individual #256 were dated after the period of repeated restraints. ▪ The CIP for Individual #318 specified the types of restraint that could be used in a crisis situation. Although developed after the period of repeated restraint for the individual, the CIPs for Individual #95 and Individual #256 also specified the approved restraints. The plan for Individual #256 was particularly thorough in	

#	Provision	Assessment of Status	Compliance
		its description of approved restraints. ▪ The CIP for Individual #318 specified the maximum duration of restraint (i.e., 15 minutes) before a release was attempted. Once developed, this was also included in the CIPs for Individual #95 and Individual #256. ▪ The CIP for Individual #318 specified the crisis situation that could lead to restraint. Once developed, this was also included in the CIPs for Individual #95 and Individual #256. ▪ The CIP for Individual #318 specified the criteria for terminating restraint. Once developed, this was also included in the CIPs for Individual #95 and Individual #256. The Facility remained out of compliance with this provision of the Settlement Agreement. Behavior Support Plans and Crisis Intervention Plans will need to be developed and implemented in a timely manner and will need to include comprehensive prevention strategies, functionally equivalent replacement behaviors with adequate training guidelines, and enriched schedules of reinforcement for appropriate behavior.	
	(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	For three of the individuals reviewed (100%), measures of treatment integrity, as determined by staff interview and review of behavioral events recorded on videotapes, were included in the Psychology Monthly Progress Notes the Facility provided. However, for two out of three (67%) individuals' treatment plans were implemented with at least 80% treatment integrity, and it was not clear these scores were consistently valid: ▪ Interview scores were 90% for Individual #95, 80% for Individual #318, and 60% for Individual #256. ▪ Treatment integrity as determined by review of videotaped recordings of behavioral events were 100% for Individual #95 and Individual #318. However, integrity scores for Individual #256 were 0% and 100%. It should be noted that in the IDT Review of Repeated Restraints, held for Individual #95 on 4/30/13, there was a statement that consistent implementation of the BSP had been problematic. This was not reflected in the monitoring scores reviewed in his monthly progress note. The Facility remained out of compliance with this provision of the Settlement Agreement. Improved staff training and supervision will be necessary to ensure a high level of treatment integrity for all plans.	Noncompliance
	(g) as necessary, assess and revise the PBSP.	As noted, each of the three individuals had a BSP or Behavior Protocol in place at the time of repeated restraint. The BSP for Individual #256 had been developed after the first repeated restraint episodes and prior to the second repeated restraint episodes. The BSP for Individual #318 had been revised prior to the repeated restraint episodes reviewed for this report. The BSP for Individual #95 had been implemented after the repeated	Noncompliance

#	Provision	Assessment of Status	Compliance
		restraint episodes reviewed for this report. Although he was scheduled to develop enhanced social skills, training was limited to three times per week and did not immediately address his attention seeking or escape motivated behavior. While it appears that vomiting had been added to the plan in response to observations, this plan did not include throwing feces, which had also been reported. The Facility remained out of compliance with this provision of the Settlement Agreement. Behavior Protocols should be replaced with Behavior Support Plans within 45 days of admission, and Behavior Support Plans should be revised as new behaviors emerge.	
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.	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., a smaller sample) for this subsection, because the Facility had made limited progress. The noncompliance finding from the last review stands. A sample of documentation related to three incidents of crisis intervention restraint was reviewed (Sample #C1.5, #C1.14, and #C1.18), including the Unit Team meeting minutes, IMRT meeting minutes, Restraint Reduction Committee minutes, and any related ISP addenda. This documentation showed that: ▪ a. In three (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 two (67%), the review by the IMRT occurred within three business days of the restraint episode, and this review was documented by signature on the Restraint Checklist. This did not occur for sample #C1.14. ▪ c. In two (67%), the circumstances under which the restraint was used were determined, and were documented on the Face-to-Face Assessment Debriefing form, including the signature of the staff responsible for the review. This did not occur in sample #C1.14. ▪ 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. No minutes of team meetings were provided. ▪ e. In none (0%), referrals were made to the team, as appropriate; and ▪ f. Although none were referred to the team, one (33%) was reviewed by the IDT and appropriate changes were made to the individual's ISP. Sample #C1.5 included an ISPA, dated 9/12/13, which addressed the restraint. It indicated that	Noncompliance

#	Provision	Assessment of Status	Compliance
		a review of his psychotropic medication should be undertaken since it did not appear to be having a beneficial effect on his behavior. The team added that it would investigate whether a level of supervision of one-to-one might be needed, if this behavior recurred. Sample #C1.14 did not include IDT minutes, although the bear hug restraint lasted over one hour, and it was unclear why the possibility of chemical restraint was not considered. Based on this review, the Facility was not in substantial compliance with this provision. A copy of a Corrective Action Plan related to Section C.8 was provided. It was developed on 8/10/13 to address Unit and IMRT reviews of restraint incidents, which were not consistently thorough or documented. It was not clear whether the CAP had been implemented or whether it had produced some results.	

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, revised 3/26/13; o ABSSLC Policy/Procedure: Spurious Allegations of Abuse/Neglect/Exploitation, dated April 18, 2012; o Self-Assessment, updated 10/21/13; o ABSSLC Action Plans, updated 10/21/13; o Presentation Book for Section D; o Abuse/Neglect/Exploitation Investigations as provided in document response TX-AB-1311-11.20; o Investigations Conducted Solely by Facility as provided in document response TX-AB-1311-11.20; o ABSSLC Unusual Incidents – Trending, 3rd Quarter (Q) FY13, dated 7/1/13, and 4th Quarter FY 13, dated 9/16/13; o Injury Trend Analysis Report for Q3 FY13 and Q4 FY 13; o List of incidents of peer-to-peer aggression, from 9/1/12 to 8/31/13; o List of individuals for whom the DFPS conducts streamlined investigations, undated; o ABSSLC Staff Status Tracking – by Date, undated; o ABSSLC Annual Employee Registry Check and Fingerprint Criminal History Submission, dated 9/6/13; o List of ABSSLC Volunteers with corresponding date on which background check was completed, dated 9/1/12 to 9/31/13; o Centers for Medicare and Medicaid (CMS) Intermediate Care Facility for Persons with Developmental Disabilities (ICF/DD) reports of 4/5/13 and 8/22/13; o ABSSLC Procedure: Injury Audits; o Semi-Annual Audit Reports: 8/1/12 to 2/28/13, and 3/1/13 to 8/1/13; o Monthly Meeting Notes: Section D, dated 7/31/13, 8/21/13, and 9/18/13; o **Sample #D.1:** A complete investigation record was requested for the following sample, including: ▪ The Unusual Incident Report, ▪ The record of the call, ▪ The final DFPS investigation report, ▪ Any extension approval, ▪ The documentation of any disciplinary action, ▪ Documentation that any recommendations were implemented, ▪ Any correspondence/notification from Office of Inspector General (OIG) or law

enforcement agencies,
- Documentation of supervisory review of the investigative report, and
- Any checklist maintained by the Facility or DFPS.

Note: A modified sample of 10 (noted with asterisks) was identified for use in monitoring the subsections the parties agreed would have reduced monitoring:

Sample ID#	Facility #	DFPS #
D1.1	774	42704279
D1.2*	784	42711484
D1.3	793	42719322
D1.4*	801	42722127
D1.5	809	42727748
D1.6*	816	42730449
D1.7	827	42735992
D1.8*	836	42747264
D1.9	845	42762312
D1.10*	853	42769940
D1.11	864	42779187
D1.12*	875	42788341
D1.13*	883	42796477
D1.14	890	42803999
D1.15*	907	42817576
D1.16	917	42822690
D1.17*	1013	42828415
D1.18	1061	42837882
D1.19*	1068	42846010
D1.20	1101	42869740

- **Sample #D.2**: A complete investigation report was requested for the following sample including:
  - The Unusual Incident Report,
  - The record of the call,
  - Any extension approval,
  - The documentation of any disciplinary action,
  - Documentation that any recommendations were implemented,
  - Any correspondence/notification from OIG or law enforcement agencies,
  - Documentation of supervisory review of the investigative report, and
  - Any checklist maintained by the Facility.

  Note: A modified sample of four (noted with asterisks) was identified for use in monitoring the subsections the parties agreed would have reduced monitoring:

Sample #	Facility #
D2.1*	818
D2.2	844
D2.3*	860
D2.4	894
D2.5*	919
D2.6	1058
D2.7*	1078

- **Sample #D.3**: No additional reports.
- **Sample #D.4:** the sample of Individual Support Plans (ISPs) reviewed included ISPs for the following individuals: Individual #9, Individual #17, Individual #37, Individual #74, Individual #95, Individual #199, Individual #318, Individual #323, Individual #354, and Individual #379
- **Sample #D.5:** a subsample of seven of the investigations included in Samples #D.1 and #D.2, including:

Sample ID#	Facility #	DFPS #
D1.12	875	42788341
D1.14	890	42803999
D1.15	907	42817576
D1.17	1013	42828415
D2.2	844	None
D2.4	894	None
D2.5	919	None

- **Sample #D.6:** a sample of 10 completed Injury Audit Record Reviews, including:

Individual Identification #	Audit Date
Individual #92	9/20/13
Individual #164	8/21/13
Individual #4	9/20/13
Individual #27	8/21/13
Individual #521	9/20/13
Individual #269	8/21/13
Individual #453	8/21/13
Individual #395	9/19/13
Individual #206	9/20/13
Individual #120	8/22/13

- **Sample #D.7**: None.

- **Interviews with**:
  - Linda Hinshaw, Facility Director;
  - Jolene Willis, Assistant Director of Programs (ADOP);
  - Pat Smith, Director for Quality Assurance;

- Luee McCreary, Incident Management Coordinator (IMC);
- Renay 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 11/4/13;
  - Unit IV Team Meeting, on 11/5/13;
  - IMT meeting, on 11/5/13;
  - Residences #6710, #6720, #6730, #6740, #6500, and #6400; and
  - Activity Centers #6390 and #6700.

Facility Self-Assessment: The Facility submitted a Self-Assessment for Section D, dated 10/21/13. 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.

The ABSSLC Self-Assessment indicated the Facility was in substantial compliance with 19 of the 22 provisions in Section D of the Settlement Agreement. The Monitoring Team found the Facility to be in compliance with 18 of the 22. However, the Facility's findings were not consistent with the findings of the Monitoring Team as described in the following chart:

Provision	Facility Self-Assessment	Monitoring Team's Finding
D.2.a	Noncompliance	Substantial Compliance
D.2.i	Substantial Compliance	Noncompliance
D.3.g	Noncompliance	Substantial Compliance
D.3.e	Substantial Compliance	Noncompliance
D.4	Substantial Compliance	Noncompliance

For Section D, in conducting its self-assessment:

- The Facility used monitoring/auditing tools. Based on a review of the Facility Self-Assessment, the monitoring/audit templates and instructions/guidelines, a sample of completed monitoring/auditing tools, inter-rater reliability data, as well as interviews with staff:
  - The monitoring/audit tools the Facility used to conduct its self-assessment consisted of a template entitled: "The Settlement Agreement Cross-Referenced with ICF-MR Standards: Section D – Protection from Harm – Abuse, Neglect and Incident Management." In conducting its self-assessment, the Facility selected a sample of investigations from the database of all cases from the previous two months, and applied this tool.
  - These monitoring/audit tools included adequate indicators to allow the Facility to determine compliance with the Settlement Agreement. The language in the monitoring tool was consistent with the provisions of the Settlement Agreement.
  - The monitoring tools included some adequate methodologies. For example, the investigation case files, training documentation, and rights posters were reviewed.

	Interviews and observation were to be conducted as appropriate. However, "appropriate" was not clearly defined, and there was no detailed evidence provided of observation in living units or interviews with individuals or staff. The monitoring appeared to consist of documentation review alone. o The Self-Assessment identified the sample sizes, including the number of records reviewed in comparison with the number of investigations for the same period. The sample sizes were adequate to consider them representative samples. o The monitoring tools had guidelines to ensure consistency in monitoring. However, there was not consistency (inter-rater agreement) 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. o The following positions were responsible for completing the audit tools: The Program Compliance Monitor from the Quality Assurance Department, the Incident Management Coordinator, and her staff of investigators and campus administrators worked collaboratively to conduct the audits. o The Incident Management staff conducting the monitoring were trained investigators. The Quality Assurance Program Compliance Monitor was trained on the monitoring tools through work with the investigators to establish inter-rater agreement. However, inter-rater agreement had not been established for all questions on the monitoring tool. This remained a priority issue for the Facility. ▪ The Facility used some other relevant data sources. In addition to data from the audits of investigation files, the Facility cited some other data in its Self-Assessment. For example, it used data from the Competency and Training Department database on A/N/E training. In addition, the Facility recognized that some data was not yet available, including data from a tracking system for alleged perpetrators. The Facility did not present data on key indicators and outcome measures in its Self-Assessment, although work had been done to establish a set of key indicators for this section. ▪ The Facility consistently presented some data in a useful way, but more work was needed. Specifically, the Facility's Self Assessment: o Presented its findings as specific, measurable indicators. o Did not measure consistently the quality as well as presence of items. ▪ The Facility rated itself as being in compliance with all provisions of section D except for D.2.a, D.3.g, and D.3.i. The Monitoring Team found D.2.a and D.3.g to be in substantial compliance and found D.2.i, D.3.e, and D.4 to be noncompliant, as well as D.3.i. The differences between the Facility and the Monitoring Team appeared to be the result of different measurement methods for compliance. ▪ The Facility Self-Assessment did not identify in sufficient detail the areas in need of improvement. There was scant analysis of the information, such as potential causes for the issues identified, or connections between the findings to 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: During this review, the Monitoring Team found the Facility to be in

	substantial compliance with 18 out of 22 provisions of Section D, as opposed to 17 provisions that were in substantial compliance during the last review. There were six provisions that required focused attention going forward, including: Section D.3.i where both the Monitoring Team and the Facility found noncompliance; Sections D.2.i, D.3.e and D.4 where the Monitoring Team found noncompliance, and Sections D.2a and D.3g where the Facility found noncompliance. For the subsections for which the Facility's findings differed from the Monitoring Team's findings, the Facility should review the standards set forth in the metrics for these sections for possible changes or additions to their monitoring tools or guidelines. Progress was noted in a number of areas. Highlights of progress included: ▪ Training had been done to assure that staff reported suspected abuse to both DFPS and to the Director, and it was resulting in progress in staff understanding about what was required. ▪ A tracking log was added in September to document when a call alleging abuse or neglect was made to the Director as well as DFPS. ▪ Considerable work had been done on auditing injuries to ascertain whether injuries had been consistently documented and reported, and a format for an audit log had been established. ▪ A log of recommendations and concerns from investigation reports had been established. This was important so that concerns could be tracked to completion and verified by a follow-up visit by the PCM, although further follow-up was needed to ensure expected changes had occurred. Some of the areas in which improvements were necessary for the Facility to progress toward full compliance with the Settlement Agreement included the need to: ▪ The data on injuries should be reviewed to determine if there are any patterns or numbers of injuries that indicate a need to investigate the causes and processes to reduce injuries to individuals, particularly when injuries are caused by peer-to-peer altercations. ▪ While there was some good narrative analysis in tracking and trending reports, work was needed to: conduct additional analyses; track A/N/E by disposition, not just by allegation; and to track and trend over at least a year. ▪ When it is clear in an investigation that staff did not report A/N/E, recommendations in the DFPS report and the UIR need to be made to address that failure to report.

#	Provision	Assessment of Status	Compliance
D1	Effective immediately, each Facility shall implement policies, procedures and practices that require a commitment that the Facility shall not tolerate abuse or neglect of individuals and that staff are required to report abuse or neglect of individuals.	The parties agreed the Monitoring Team would not monitor this provision, because the Facility was in substantial compliance for two consecutive reviews for this policy-related provision. The substantial compliance finding stands.	Substantial Compliance

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td>D2</td><td>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:</td><td></td><td></td></tr>
<tr><td></td><td>(a) Staff to immediately report serious incidents, including but not limited to death, abuse, neglect, exploitation, and serious injury, as follows: 1) for deaths, abuse, neglect, and exploitation to the Facility Superintendent (or that official's designee) and such other officials and agencies as warranted, consistent with Texas law; and 2) for serious injuries and other serious incidents, to the Facility Superintendent (or that official's designee). Staff shall report these and all other unusual incidents, using standardized reporting.</td><td>Although in the paragraphs that follow, the Monitoring Team has provided some figures with regard to allegations and incidents, it is essential to note that reviewing pure numbers provides very little meaningful information. For each of these categories, the Facility would need to conduct analyses to determine causes, and to review carefully whether for incidents that were preventable, 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*:

<table><tr><th></th><th>11/1/12 to 4/30/13 (Six months)</th><th>5/1/13 to 10/31/13 (Six months)</th></tr><tr><td>Total abuse allegations</td><td>138</td><td>141</td></tr><tr><td>Abuse substantiated</td><td>11</td><td>5</td></tr><tr><td>Total neglect allegations</td><td>87</td><td>82</td></tr><tr><td>Neglect substantiated</td><td>16</td><td>13</td></tr><tr><td>Total exploitation allegations</td><td>5</td><td>2</td></tr><tr><td>Exploitation substantiated</td><td>0</td><td>0</td></tr></table>*Note: There was some difficulty extracting this data from AVATAR. The reasons for that difficulty need to be explored and resolved.

According to Facility data provided:

<table><tr><th></th><th>11/1/12 to 4/30/13</th><th>4/1/13 to 9/30/13</th></tr></table></td><td>Substantial Compliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance

	(Six months)	(Six months)*
Deaths	7	4
Serious Injuries	20	26
Sexual Incidents	4	1
Suicide Threat (credible)	1	2
Unauthorized Departure	3	1
Choking	2	4
Other	0	0

*Note that data for April appeared in both six-month periods.

Metric 2.a.1: Based on the Monitoring Teams' review of DADS revised policies, including Policy #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, the policies were consistent with the Settlement Agreement requirements.

Metric 2.a.2: According to ABSSLC Policy #021.2, staff were required to report abuse, neglect, and exploitation immediately to DFPS**.** This was consistent with the Settlement Agreement requirements.

Metric 2.a.3: 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.

Metric 2.a.4: Although this was not a measure used to determine compliance, 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.

Metric 2.a.5: Although this was not a measure used to determine compliance, 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 20 investigation reports included in Sample #D.1:

- Metric 2.a.6: 18 (90%) included evidence that allegations of abuse, neglect, and/or exploitation were reported within the timeframes required by DADS/Facility policy. Those that did not included:
  - Sample #D1.2 involved an allegation of abuse that was confirmed. It

#	Provision	Assessment of Status	Compliance
		was reported two hours after the event. However, there were several witnesses who could have reported it sooner. o Sample #D1.17 involved an allegation of neglect when two staff used a two-person lift when a mechanical lift was required. The allegation was not reported for twenty-four hours, although it was witnessed by two staff members and was confirmed upon investigation. ▪ Metric 2.a.7: 20 (100%) included evidence that allegations of abuse, neglect, and/or exploitation were reported to the appropriate party as required by DADS/Facility policy. ▪ Metric 2.a.8: For the two allegations for which staff did not follow the Incident Management Policy and Reporting Matrix procedures, no UIRs/investigation folders (0%) included recommendations for corrective actions to deal with the failures to report timely. In Sample #D1.2, the DFPS investigator identified a concern that a report of suspected abuse was not registered in a related matter, but did not recommend corrective action for those who failed to report the abuse in #D1.2. Based on a review of seven investigation reports included in Sample #D.2: ▪ Metric 2.a.9: all (100%) showed evidence that unusual/serious incidents were reported within the timeframes required by DADS/Facility policy. ▪ Metric 2.a.10: seven (100%) included evidence that unusual/serious incidents were reported to the appropriate party as required by DADS/Facility policy. Metric 2.a.11: There were no unusual/serious incidents for which staff did not follow the IM Policy and Reporting Matrix reporting procedures, so no recommendations for corrective actions were needed. Metric 2.a.12: The Facility had a standardized reporting format. Metric 2.a.13: Based on a review of 27 investigation reports included in Samples #D.1 and #D.2, 27 (100%) contained a copy of the report utilizing the required standardized format and were completed fully. Based on this review the Facility had made progress in that it had begun using a tracking log to assure calls reporting allegations were made to the Director or Designee as well as to DFPS, and staff who were interviewed about reporting evidenced an understanding of the need to make reports to both. However two investigation reports did not contain recommendations to address failures to report timely. Since the metrics for this provision were modified on 6/10/13, after the last monitoring visit, and the Facility was in substantial compliance with this provision on the last review, substantial compliance will remain in place with a mandatory recommendation. The **mandatory recommendation** is: to maintain a substantial compliance rating for the next review,	

#	Provision	Assessment of Status	Compliance
		when investigations reveal issues related to staff reporting allegations of abuse, neglect, and exploitation, DFPS and the Facility should ensure that recommendations for corrective actions to deal with the failures to report timely are made and implemented.	
	(b) Mechanisms to ensure that, when serious incidents such as allegations of abuse, neglect, exploitation or serious injury occur, Facility staff take immediate and appropriate action to protect the individuals involved, including removing alleged perpetrators, if any, from direct contact with individuals pending either the investigation's outcome or at least a well- supported, preliminary assessment that the employee poses no risk to individuals or the integrity of the investigation.	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., a smaller sample) for this subsection, because previous reviews showed substantial compliance. The smaller sample has been used to confirm whether or not substantial compliance continues. 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 a limited sample of 14 investigation reports included in Sample D.1 and Sample D.2, in seven of the seven cases (100%) where the alleged perpetrator should have been removed, the alleged perpetrators were removed from direct contact with individuals immediately following the Facility being informed of the allegation. In the remaining seven, for one (sample #D1.8), the alleged perpetrator was unknown; two (sample #D1.10 and #D1.19) were handled as streamlined, and four (sample #D2.1, D2.3, D2.5, and D2.7) were Facility-only investigations where the incidents did not warrant removal of staff. Based on a review of seven investigation files, where the perpetrator was removed, in two the perpetrator was terminated (sample #D1.2 and #D1.6). Of the remaining five, five (100%) showed that staff that had been removed from direct contact were reinstated only after the conclusion of the investigation allowed their return to direct contact duties. Based on a review of 14 of the above documents, it was documented that adequate additional action was taken to protect individuals in 14 cases (100%). Based on this review, the Facility remained in substantial compliance with this provision.	Substantial Compliance
	(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	The parties agreed the Monitoring Team would not monitor this provision because the Facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding stands.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	documentation indicating completion of such training.		
	(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.	The parties agreed the Monitoring Team would not monitor this provision because the Facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding stands.	Substantial Compliance
	(e) Mechanisms to educate and support individuals, primary correspondent (i.e., a person, identified by the IDT, who has significant and ongoing involvement with an individual who lacks the ability to provide legally adequate consent and who does not have an LAR), and LAR to identify and report unusual incidents, including allegations of abuse, neglect and exploitation.	As noted in previous reports, according to Facility Policy #021, the Facility maintained a resource guide on recognizing and reporting abuse, and provided it to individuals, Legally Authorized Representatives (LARs), and primary correspondents upon admission and annually thereafter. Discussions with staff revealed that this guide was to be provided at the annual 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 ten individuals' ISPs (Sample #D.4), nine individuals or their LAR and/or other significantly involved individual (90%) had been informed of the process of identifying and reporting unusual incidents, including abuse, neglect, and exploitation. In interviewing a sample of 10 individuals, five were able to describe what they would do if someone hurt them, or they had a problem with which they needed help. The remaining five did not have sufficient communication skills to do this. The Facility did not report any incidents that were known to have been reported by individuals, or their LARS. However, it was reasonable to believe that many of the allegations handled as streamlined investigations and concluded to be "unfounded" were	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		reported by individuals. It appeared that some individuals were not afraid to report complaints and were provided with support to report. Based on this review, the Facility remained in substantial compliance with this provision.	
	(f) Posting in each living unit and day program site a brief and easily understood statement of individuals' rights, including information about how to exercise such rights and how to report violations of such rights.	The parties agreed the Monitoring Team would not monitor this provision because the Facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding stands.	Substantial Compliance
	(g) Procedures for referring, as appropriate, allegations of abuse and/or neglect to law enforcement.	The parties agreed the Monitoring Team would not monitor this provision because the Facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding stands.	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.	The parties agreed the Monitoring Team would not monitor this provision because the Facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding stands.	Substantial Compliance
	(i) Audits, at least semi-annually, to determine whether significant resident injuries are reported for investigation.	Metric 2.i.1: The Facility policy and/or procedures did not define sufficient procedures to audit whether significant injuries are reported for investigation. It was not clear that the Facility had adopted the State procedure, or that the Facility had developed its own procedures for the conduct of the audit. The Presentation Book for Section D contained a list of steps to be taken as part of the audit. But the list was not signed, dated or otherwise authenticated as the adopted Facility procedure. However, based on what was available, it appeared the sample size was adequate, the staff who conducted the audits were trained investigators, and the form used appeared to collect relevant information, though a guideline would have been useful to assure consistency.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Metric 2.i.2: The Facility had conducted audits at least semi-annually, during the preceding 13 months. Metric 2.i.3: The audits conducted were sufficient to determine whether significant resident injuries had been reported for investigation. To make this determination, the Monitoring Team drew a sample of 10 recently completed Injury Audit Record Reviews (as defined as Sample #D.6 in the Document Review section above). The audits followed a standard format, and documented review of injuries that had been reported, integrated progress notes related to those injuries, direct support staff observation notes and shift logs, client injury reports, unit meeting minutes, and the campus coordinator log. The auditor looked for inconsistencies between the various documents, trends in the review of history, and non-serious injuries involving areas of the body not normally associated with daily minor abrasions. Any needed actions such as initiating a Client Injury Report for an unreported injury, or notifying the Director and DFPS of an unreported possible abuse were documented. The audit samples were 12 per month for a total of 72 for each half-year or, 19% of the census of 379. The samples were random from the roster of individuals living at the Facility. The IMC (two) and the two investigators (four each) conducted the audits. Metric 2.i.4: There were no significant injuries identified by the audit that had not previously been investigated. The Facility was not in substantial compliance because it did not appear that a procedure was formally in place for conducting the audits. To move towards substantial compliance the Facility should formalize the procedure for audits in consultation with the State Office, and incorporate the comments offered by the Monitors on the last draft of the State procedure.	
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:		

#	Provision	Assessment of Status	Compliance
	(a) Provide for the conduct of all such investigations. The investigations shall be conducted by qualified investigators who have training in working with people with developmental disabilities, including persons with mental retardation, and who are not within the direct line of supervision of the alleged perpetrator.	The parties agreed the Monitoring Team would not monitor this provision because the Facility was in substantial compliance for three consecutive reviews. The substantial compliance finding stands.	Substantial Compliance
	(b) Provide for the cooperation of Facility staff with outside entities that are conducting investigations of abuse, neglect, and exploitation.	The parties agreed the Monitoring Team would not monitor this provision because the Facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding stands.	Substantial Compliance
	(c) Ensure that investigations are coordinated with any investigations completed by law enforcement agencies so as not to interfere with such investigations.	The parties agreed the Monitoring Team would not monitor this provision because the Facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding stands.	Substantial Compliance
	(d) Provide for the safeguarding of evidence.	The parties agreed the Monitoring Team would not monitor this provision because the Facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding stands.	Substantial Compliance
	(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,	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.	Noncompliance

#	Provision	Assessment of Status	Compliance
	findings and, as appropriate, recommendations for corrective action.	<u>DFPS Investigations</u> The following summarizes the results of the review of DFPS investigations: ▪ Nineteen out of 20 (95%) commenced within 24 hours or sooner, if necessary. This was determined by reviewing information included in the investigation that described the steps taken to determine the priority of investigation tasks, as well as documentation regarding the tasks that were undertaken within 24 hours of DFPS being notified of the allegation. For Sample #D1.18, no copy was provided of the Information and Referral that was made by DFPS to the Facility. There was information in the Facility's records documenting the referral, but there should have been a properly completed Information and Referral Form on file. ▪ Eighteen out of 20 (90%) were completed within 10 calendar days of the incident, including sign-off by the supervisor. The two that were not were Information and Referrals that were delayed in returning to the Facility (i.e., samples #D1.9 and #D1.18). ▪ For the two that were not completed within 10 days, one (50%) 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 (i.e., sample #D1.18). The other (i.e., sample #D1.9) did not have a formal extension request, but did have email exchanges with the IMC that documented the system issue causing the delay. ▪ Eighteen (90%) 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. Sample #D1.9 did not have a written report on file to indicate why it was being returned. However there were a series of emails in the file indicating it was an Information and Referral, and that the Facility could begin its investigation. Sample #D1.18 did not contain a copy of the Information and Referral. ▪ In 10 of the investigations reviewed, recommendations for corrective action were needed. Of those 10, recommendations sufficient recommendations were included for seven (70%). The three that needed recommendations, but did not include them were: o Sample # D1.13, which did not include recommendations to address the finding of systemic neglect; and o Sample #D1.17, which did not include a recommendation to address the failure to report abuse timely. o One that was not adequate was Sample #D1.2, which did not include a recommendation about failure to report abuse timely. However, the	

#	Provision	Assessment of Status	Compliance
		report did include a recommendation about reporting abuse in a related case, uncovered during investigation. The Facility's review of these investigations did not result in the addition of the necessary recommendations. <u>Facility Investigations</u> The following summarizes the results of the review of Facility investigations: ▪ Seven out of seven (100%) commenced within 24 hours or sooner, if necessary. This was determined by reviewing information included in the investigation that described the steps taken to determine the priority of investigation tasks, as well as documentation regarding the tasks that were undertaken within 24 hours of the Facility being notified of the serious incident. ▪ Six out of seven (86%) were completed within 10 calendar days of the incident, including sign-off by the supervisor. The one that did not was sample #D2.1. ▪ 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. ▪ Seven (100%) resulted in a written report that included a summary of the investigation findings. The quality of the summary and the adequacy of the basis for the investigation findings are discussed below with regard to Section D.3.f of the Settlement Agreement. ▪ In seven of the investigations reviewed, recommendations for corrective action were included. In all of the investigations (100%), the recommendations were adequate to address the findings of the investigation. The Facility was not in substantial compliance with this provision. Recommendations for corrective action were not made when needed in two investigations in the sample, and an additional investigation did not include recommendations about failure to report timely.	
	(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	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., a smaller sample) for this subsection, because previous reviews showed substantial compliance. The smaller sample has been used to confirm whether or not substantial compliance continues. <u>Metric 3.f.1</u>: 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. <u>Metric 3.f.2</u>: The Facility policy and procedures were consistent with the DADS policy	Substantial Compliance

#	Provision	Assessment of Status	Compliance

	witnesses; the name(s) of all alleged victims and perpetrators; the names of all persons interviewed during the investigation; for each person interviewed, an accurate summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material statements made; all documents reviewed during the investigation; all sources of evidence considered, including previous investigations of serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency; the investigator's findings; and the investigator's reasons for his/her conclusions.	with regard to the content of the investigation reports.
		
		The number of files reviewed for the reduced monitoring was ten DFPS records and four Facility-Only records, or approximately half of the full monitoring samples.
		
		DFPS Investigations
		The following summarizes the results of the review of DFPS investigations:
		▪ Metric 3.f.3: In 10 out of 10 investigations reviewed (100%), the contents of the investigation report were sufficient to provide a clear basis for its conclusion.
		▪ The report utilized a standardized format that set forth explicitly and separately:
		o Metric 3.f.4: In 10 (100%), each unusual/serious incident or allegations of wrongdoing;
		o Metric 3.f.5: In 10 (100%), the name(s) of all witnesses;
		o Metric 3.f.6: In 10 (100%), the name(s) of all alleged victims and perpetrators;
		o Metric 3.f.7: In 10 (100%), the names of all persons interviewed during the investigation;
		o Metric 3.f.8: In 10 (100%), for each person interviewed, a summary of topics discussed, a recording of the witness interview, or a summary of questions posed, and a summary of material statements made;
		o Metric 3.f.9: In 10 (100%), all documents reviewed during the investigation;
		o Metric 3.f.10: In 10 (10%), 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. While the UIRs contained summaries of the involvement of the alleged victims and alleged perpetrators in previous investigations, the Facility's files contained printouts of the prior histories.
		o Metric 3.f.11: In 10 (100%), the investigator's findings; and
		o Metric 3.f.12: In 10 (100%), the investigator's reasons for his/her conclusions.
		
		Facility Investigations
		The following summarizes the results of the review of Facility investigations:
		▪ Metric 3.f.13: In four out of four 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 Metric 3.f.14: In four (100%), each unusual/serious incident or allegations of wrongdoing;
		o Metric 3.f.15: In four (100%), the name(s) of all witnesses;	

#	Provision	Assessment of Status	Compliance
		o Metric 3.f.16: In four (100%), the name(s) of all alleged victims and perpetrators; o Metric 3.f.17: In four (100%), the names of all persons interviewed during the investigation; o Metric 3.f.18: In four (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 Metric 3.f.19: In four (100%), all documents reviewed during the investigation; o Metric 3.f.20: In four (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. Metric 3.f.21: In four (100%), the investigator's findings; and o Metric 3.f.22: In four (100%), the investigator's reasons for his/her conclusions. The Facility remained in substantial compliance with this provision.	
	(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.	Metric 3.g.1: 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. Metric 3.g.2: The Facility policy did require that any further inquiries or deficiencies be addressed promptly. To determine compliance with this requirement of the Settlement Agreement, full samples of investigations conducted by DFPS (Sample #D.1) and the Facility (Sample #D.2) were reviewed. The results of these reviews are discussed in detail below, and the findings related to the DFPS investigations and the Facility investigations are discussed separately. DFPS Investigations The following summarizes the results of the review of DFPS investigations: ▪ Metric 3.g.3: The DFPS investigations in Sample D.1 did meet at least 90% compliance with the requirements of Section D.3.e (excluding timeliness requirements) and D.3.f; ▪ Metric 3.g.4: 18 of 18 (100%) were reviewed by the Incident Management Coordinator and/or the Facility Director within five working days of receipt of the completed investigation, as evidenced by the completion date on the UIR being within five working days of the date the DFPS report was stamped in as	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		received by the Facility. In interview, it was learned that the standard practice was to review a DFPS report upon receipt. The two records that were not included in the metric were Information and Referrals that the Facility did not receive. It was noted that the IMC corresponded with DFPS to obtain authorization to begin the Facility investigation, when one of these records was not submitted timely. ▪ Metric 3.g.5: The Facility Director/Incident Management Coordinator did accept at least ninety-four percent of the investigations over the six months prior to the onsite review, based on the list supplied by the Facility and compared to the total number of allegations reported. ▪ Metric 3.g.6: For two of the DFPS investigation files the Monitoring Team noted problems with regard to Sections D.3.e, and/or D.3.f (i.e., samples #D1.9 and #D1.18, which were determined to be Information and Referrals, but the usual form was not sent to the Facility). Since these were Information and Referrals and were not received, the Facility did not review them. As noted with regard to D.3.e above, there was correspondence in the file about one. In the second no similar correspondence was noted, but the Facility did proceed with its investigation, indicating that some communication was likely to have occurred. ▪ Metric 3.g.7: The Facility returned one report (Sample #D1.13) to DFPS for reconsideration. For one (100%), there was evidence that the review had resulted in changes being made to correct deficiencies or complete further inquiry. DFPS reconsidered its finding of confirmed neglect and changed to unconfirmed neglect with regard to the alleged perpetrator, and found system neglect on the part of the Facility for failing to maintain proper Level of Supervision. Facility Investigations The following summarizes the results of the review of Facility investigations: ▪ Metric 3.g.8: Seven of seven (100%) were reviewed by the Incident Management Coordinator within five working days of receipt of the completed investigation. ▪ Metric 3.g.9: In seven out of seven investigation files reviewed (100%), there was evidence that the supervisor had conducted a review of the investigation report to determine whether or not the investigation was thorough and complete and that the report was accurate, complete, and coherent. ▪ Metric 3.g.10: For one, the supervisor had identified concerns. For this one investigation (100%), there was evidence that the review had resulted in changes being made to correct deficiencies or complete further inquiry. ▪ Metric 3.g.11: There were no investigations noted above for which the Monitoring Team identified deficiencies that would have required the supervisor to have taken further action.	

#	Provision	Assessment of Status	Compliance
		Based on this review, the Facility was in substantial compliance with this provision. However the Facility found noncompliance based on its self-assessment. This suggested that the Facility might not be able to sustain compliance during future reviews unless it addresses the issues identified in the self-assessment.	
	(h) Require that each Facility shall also prepare a written report, subject to the provisions of subparagraph g, for each unusual incident.	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., a smaller sample) for this subsection, because previous reviews showed substantial compliance. The smaller sample has been used to confirm whether or not substantial compliance continues. Metric 3.h.1: The Facility-only investigations did meet the requirements outlined in Section D.3.f.	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.	Metric D.3i.1: 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. Metric D.3.i.2: In addition, the policy and procedures did specify the Facility system for tracking and documenting such actions and the corresponding outcome. 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. A subsample of seven of the investigations included in Samples #D.1 and #D.2 was drawn for this provision. The subsample included investigation reports in which programmatic recommendations were made and/or the IMRT made recommendations, Documentation was requested and reviewed to show whether or not follow-up had been completed to address the recommendations resulting from these investigations. Metric D.3.i.3: For three out of three of the investigations reviewed in which disciplinary action was warranted (100%), prompt and adequate disciplinary action had been taken and documented. ▪ Sample #D1.12 involved unconfirmed abuse. Recommendations were made about the language a staff member had used and her familiarity with the individual's BSP. She was retrained on the BSP and counseled about use of language and civil rights. ▪ Sample #D1.17 involved staff failure to use a mechanical lift as required by the individual's PNMP. One staff was dismissed and the other received a reprimand.	Noncompliance

#	Provision	Assessment of Status	Compliance
		▪ Sample #D2.4 involved staff failing to follow the procedures in the PNMP. Before the Facility completed its investigation, DFPS intervened to investigate an allegation of abuse, and confirmed neglect for not following the PNMP. The staff was terminated. Metric D.3.i.4: Based on a review of a subsample of investigations for which recommendations for programmatic action were made, for three out of four of the investigations reviewed (75%), prompt and thorough programmatic action had been taken and documented. Those that did not included: ▪ Sample #D1.14 involved an individual with a bruise of unknown origin. Abuse was not confirmed, and it was concluded that the bruise could have resulted from striking his leg with his baseball cap. Concerns were raised that his BSP did not address hitting himself with his baseball cap, and that a previous, similar bruising incident had not been recorded in the log. The Home Supervisor responded by in-servicing staff on documentation. The response from the Director of the Behavioral Health Services indicated that the individual's BSP would be monitored to assure that a new pattern of behavior (i.e., hitting himself with his cap) had not emerged. There was no indication of how, when, or by whom such monitoring had or would take place. Those that did document prompt and thorough programmatic action included: ▪ Sample #D1.15 involved a fall by an individual. Neglect was not confirmed, but concerns were raised about a staff member using a personal cell phone while on duty and inattention to the individual on the part of two staff. Another concern raised was whether the individual's Level of Supervision was adequate due to his susceptibility to falling. The IDT met and raised the LOS to enhanced when the individual was not in bed. Staff in the home were in-serviced on meeting the needs of individuals, and on cell phone policy. ▪ Sample #D2.2 involved a fall by an individual as he was getting out of bed and caught his foot on the leg of a privacy partition, resulting in a rib fracture. Recommendations included in-service training for staff on fractures and the importance of assuring that gait belts do not ride up over the ribs, and storing the privacy screen outside his room when not in use. Documentation was presented to show the in-service training had occurred. ▪ Sample #D2.5 involved an individual who became angry when told that community activities had been cancelled due to extremely hot weather. He attempted to leave campus by climbing over the back gate. Recommendations included prompting the individual to visit friends on campus when he left the house, calling from the specified destination within five minutes, and providing staff support if he refused verbal prompts. His team met discussed the recommendations and adopted the first two, indicating the event was unusual and unlikely to recur.	

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		Metric D.3.i.5: For two of seven investigations (29%), there was documentation to show that the expected outcome had been achieved as a result of the implementation of the programmatic and/or disciplinary action, or when the outcome was not achieved, the plan was modified. Those two were samples #D1.17 and #D2.4, where staff were terminated. In the remaining five reports, there was no evident follow-up to determine if the actions taken on the recommendations had the desired results. For example, in sample #D2.2 there was no evidence of follow-up visits to determine if the privacy screen was being stored properly, or whether gait belts were being secured properly. Likewise with regard to sample #D1.15, there was no evidence that follow-up had been done to determine if staff were following the cell phone policy or whether staff were being attentive to individuals. Based on the metrics for this provision, the Facility was not in substantial compliance. To move toward substantial compliance, the Facility will need to focus on providing documentation of follow-up on outcomes achieved as a result of the actions taken to address recommendations.	
	(j) Require that records of the results of every investigation shall be maintained in a manner that permits investigators and other appropriate personnel to easily access every investigation involving a particular staff member or individual.	The parties agreed the Monitoring Team would not monitor this provision because the Facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding stands.	Substantial Compliance
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	Metric D.4.1: For all categories of unusual incidents and investigations, the Facility did have a system that allowed tracking and trending by: ▪ 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. There was a similar system for tracking and trending of all injuries including peer-to-peer injuries.	Noncompliance

#	Provision	Assessment of Status	Compliance
	incident; and outcome of investigation.	Over the past two quarters, the Facility's trend analyses: ▪ Metric D.4.2: Were conducted at least quarterly; ▪ Metric D.4.3: Did address the minimum data elements. Although information about involved staff was not made part of the reports, it was entered into the database and could be retrieved, as it was for abuse and unusual incident investigation purposes. ▪ Metric D.4.4: Did not use appropriate trend analysis procedures to show how data changed over a rolling one-year period. Data were included on unusual incidents and on abuse/neglect/ exploitation. The trend reports for unusual incidents included data by month for at least a year, but did not calculate trend lines. The Abuse/Neglect Trend Analysis report for the third quarter included data on allegations, but did not include graphs to show data trended over at least a one-year period. The Abuse/Neglect report for the fourth quarter included data and graphs, including a graph of allegations over a three-year period, and a bar graph showing allegations by type over a three-year period. However, while the report displayed data for the quarter on disposition, shift, day of the week, and other factors, these data were shown only for the quarter. ▪ Metric D.4.5: Did provide a narrative description/explanation of the results and conclusions. However, the narrative in the Unusual Incident Trend reports was sparse, and did not point out the significance of all the data. The narrative for the Injury Trend Reports was more detailed, describing changes in homes that contributed to changes in data, and plans for changes, such as reducing the population of one house that should help reduce injuries. ▪ Metric D.4.6: Did not**,** as appropriate, contain recommendations for corrective actions. The Injury Trend Reports did contain information about actions that had been taken or were planned, though they were not characterized as Action Plans or as Corrective Action Plans. The Unusual Incident Reports did not identify any trends or issues that needed attention. For example, the narrative in the third quarter unusual incident report noted that slips, trips, falls, and accidents continued to be the cause of most incidents, but did not offer recommendations to investigate or otherwise act to correct the issue. It was not clear whether the IMRT made recommendations for corrections based upon review of these reports. Metric D.4.7: Based on a review of trend reports, IMRT minutes, and QA/QI Council minutes, when a negative pattern or trend was identified, corrective action plans were not developed. Metric D.4.8: As appropriate, corrective action plans were not developed both for specific individuals and at a systemic level. However, as discussed with regard to Section D.3.i,	

#	Provision	Assessment of Status	Compliance
		some specific plans were developed as the result of investigations of serious incidents/injuries or as the result of investigations of abuse/neglect/exploitation. Metric D.4.9: The trend reports and/or minutes did not show that corrective action plans were implemented and tracked to completion. Only one corrective action plan was associated with unusual incidents (i.e., 10/3/13 plan to document injuries to parts of the body not usually associated with trauma). This did not appear to have arisen from a data analysis. Metric D.4.10: The report/minutes did not review, as appropriate, the effectiveness of previous corrective action plans. Since there were few action plans/corrective action plans to review the following metrics were not rated. They will be rated in future monitoring, based on a review of action plans related to trend analyses and documentation related to implementation: ▪ Metric D.4.11: ___ out of ___ action plans (__%) described actions to be implemented that could reasonably be expected to result in the necessary changes, and identified the person(s) responsible, timelines for completion, and the method to assess effectiveness. ▪ Metric D.4.12: For ___ out of ___ of the action plans reviewed (___%), the plan had been timely and thoroughly implemented. ▪ Metric D.4.13: For ___ out of ___ action plans (___%), there was documentation to show that the expected outcome had been achieved as a result of the implementation of the plan, or when the outcome was not achieved, the plan was modified. The Facility remained in noncompliance with this provision. To move towards substantial compliance, the Facility should: ▪ Establish trend reports for abuse/neglect/exploitation and for unusual incidents (not including A/N/E), and present both to IMRT and QA/QI Council at least quarterly; ▪ Include narrative in the reports to explain trends and issues; ▪ Include recommendations for actions or corrective action plans to address identified trends and issues; ▪ Include plans with action steps, person responsible, and timeframe for implementation in response to recommendations; and ▪ Follow up on any plans, and document implementation and effectiveness.	
D5	Before permitting a staff person (whether full-time or part-time,	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., a smaller sample) for this subsection, because previous reviews showed substantial	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	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.	compliance. The smaller sample has been used to confirm whether or not substantial compliance continues. 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 2013. Once the fingerprints were entered into the system, the Facility received a "rap-back" that provided any updated information. The registry checks were conducted annually by comparison of the employee database with that of the Registry. In addition, employees were mandated to self-report any arrests. Failure to do so was cause for disciplinary action, including termination. 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.	

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: QA Process/Plan, revised 5/22/13 (presented as still in draft); o ABSSLC QA Plan Matrix, undated (presented as draft); o ABSSLC QA Process/Plan: Appendix B Master Inventory of Data, undated (presented as draft); o Presentation Book for Section E; o ABSSLC Self-Assessment, dated 10/21/13; o Unusual Incident Trend Analysis Report 3rd Q FY 13, dated 7/1/13; o Unusual Incident Trend Analysis Report 4th Q FY 13, dated 9/16/13; o Aggression Analysis Reports, April to September 2013; o Injury Trend Analysis Report Q4 FY13 and Q4 FY13, undated; o ABSSLC Restraints Trend Analysis Reports: April and August 2013 o ABSSLC Leadership Council/Quality Assurance/Quality Improvement (QA/QI) Council meeting notes, for the months of May to September 2013; o ABSSLC Leadership Council/Quality Assurance/Quality Improvement Council meeting agenda and handouts, for meeting on 11/4/13; o Monitoring tools associated with the Quality Enhancement Plan; o Quality Assurance Monitoring Tool Matrix, undated; o QA/QI Data Summaries for: ▪ Section C: 6/27/13 and 10/8/13; ▪ Section D: 6/24/13 and 10/7/13; ▪ Section E: none; ▪ Section F: 7/2/13 and 9/11/13; ▪ Section G and H: none; ▪ Section I: 6/3/13 and 9/16/13; ▪ Section J: 5/6/13 and 7/24/13; ▪ Section K: May 2013 and 7/8/13 (date may be incorrect since report covered September) ▪ Section L: 6/3/13 and 9/3/13; ▪ Section M: 5/30/13, 6/28/13, and 8/14/13; ▪ Section N: 5/13/13 and 8/5/13; ▪ Section O: none ▪ Section P: 6/12/13; ▪ Section Q: 8/6/13; ▪ Section R: none; ▪ Section S: 5/31/13, 7/2/13, and 9/11/13; ▪ Section T: 6/6/13 and 8/21/13; ▪ Section U: none; and

- Section V: 6/25/13, 7/8/13, and 10/4/13;
- Corrective Action Plan Reporting, dated 11/1/13 (a collection of 21 individual CAPs tracking sheets); and
- Corrective Action Plans (open): The Monitoring Team reviewed all CAPs, which are listed below. The Monitoring Team assigned numbers to the 15 CAPs used as sample for Section E.2 and other sections of this report:

Sample #	CAP	Date
E2.1	Infection Control: environmental ATP levels	6/13/13
E2.2	Dental attendance	11/5/12
	Psychiatric: reduction in medication prior to treatment	9/12/13
E2.3	Medication Variance	6/26/13
E2.4	Behavioral Services: lack of progress on Behavioral Support Plans	6/18/13
	Behavioral Services: documentation of Unit and IMRT review of restraints	8/10/13
E2.5	Records: systemic documentation issues	4/30/13
E2.6	Medical Services: aspiration pneumonia	6/10/13
	Behavior Services: training for competency	8/10/13
E2.7	Behavior Services: peer review process	8/10/13
E2.8	Behavior Services: IDT reviews of repeated restraints	8/10/13
	Medical Services: AMS and physical exams	6/10/13
E2.9	Medical Services: dental services and bisphosphonate therapy	6/10/13
E2.10	Records: inter-rater reliability	4/1/12
	Records: legibility, date, time and title… of documents in charts	12/8/11
E2.11	QIDP: filing of ISPs within 30 days	9/5/13

E2.12	QIDP: timeliness of assessments	9/5/13
	Medical Services: following state guide on diabetes prevention	8/23/13
E2.13	Medical Services: PCP care for individuals with diabetes	9/20/13
E2.14	Active Treatment: inter-rater reliability for engagement monitoring	10/6/13
E2.15	Incident Management: documentation of injuries not usually vulnerable to trauma	10/3/13

- **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; and
  - Various staff in residential units, including ten direct support professionals.
- **Observations of**:
  - Quality Assurance/Quality Improvement Council Meeting, on 11/4/13;
  - Restraint Reduction Committee, on 11/7/13;
  - Unit IV Team Meeting, on 11/5/13;
  - IMT meeting, on 11/5/13;
  - Residences #6710, #6720, #6730, #6740, #6500, and #6400; and
  - Activity Centers #6390 and # 6700.

Facility Self-Assessment: The Facility submitted a Self-Assessment for Section E, dated 10/21/13. 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. Staff reported the monitoring tool had been implemented, but the resulting data was not used in the self-assessment.
- The Facility did use other relevant data sources, such as reviews of notes, minutes of meetings, and documents, such as the Corrective Action Plan list and tracking sheets.
- 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. o 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 two of the subsections of Section E: E.3 and E.4. This was not consistent with the Monitoring Team's findings with regard to E.4, where the Monitoring Team found noncompliance. ▪ The Facility's 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 CAP development in response to problems identified and CAPs were not developed as needed.
	Summary of Monitor's Assessment: Since the Monitoring Team's last visit, the Facility had made some progress with regard to Section E. The Facility had: ▪ Revised the QA Plan to add definitions, QA/QI Council process, and a number of details to create a complete and useful plan. ▪ Produced drafts of a new data inventory and QA Plan Matrix that evidenced an understanding of the need to utilize quality indicators to develop a new style of QA Matrix, and turn the data inventory into one that included the data to track the quality indicators. ▪ The draft QA Matrix included some key indicators of performance for the various sections of the Settlement Agreement, and included results obtained through monitoring tools as one of those indicators in each section. ▪ Increased the number of CAPs from five to 21. ▪ Improved the tracking of CAPs by producing a system that captured the CAP with all of its steps, designated the person with primary responsibility, and included comments about revisions. ▪ Produced a good presentation of data on infectious diseases that provided an excellent example of how to display and use data to drive CAP development and create system change. ▪ Amassed considerable data in many areas, and provided trend analyses in an increasing number of areas such as peer-to-peer aggression, infection control, and medication variance. Some of the areas the Facility will need to continue to improve to progress towards substantial compliance with the Settlement Agreement included: ▪ Using the former QA Matrix as the base to create an inventory of quality monitoring tools that can be updated each time a tool is modified, and can be used to assure that quality-monitoring tools are in place and being used. ▪ Continuing to develop the draft QA Matrix so that it includes a column for data source for each entry in the inventory and make that source column one that is searchable, so that it will be possible to sort the inventory by data sources. ▪ Refining the list of key indicators to include both outcome and process indicators, and limiting the number of key indicators addressed at any one time according to the priorities of the Facility.

	▪ Using the CAPs database to produce a tracking sheet that displays key information for each CAP on a grid to make the QA/QI Council and other committees' reviews easier. ▪ Working 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.

#	Provision	Protocol	Compliance
E1	Track data with sufficient particularity to identify trends across, among, within and/or regarding: program areas; living units; work shifts; protections, supports and services; areas of care; individual staff; and/or individuals receiving services and supports.	<u>State QA policy</u> There was a State Office policy that adequately addressed all five of the provision items in Section E of the Settlement Agreement. There were no changes to the DADS policy, entitled #003.1: Quality Assurance, dated 1/26/12. The Monitoring Teams' comments on the State Office policy are in the previous monitoring report and are not repeated here. Also, given that the statewide policy was disseminated almost two years ago, edits may be needed. State Office should consider this. <u>Facility QA policies</u> There were not adequate Facility policies that supported the State policy for quality assurance, particularly with regard to the data inventory and matrix as described below. ABSSLC had adopted a Facility policy, ABSSLC Policy: Quality Assurance #003.1, dated 10/15/12, which mirrored the State policy on quality assurance. There was no Facility policy on the maintenance of a data inventory or on updating it periodically (i.e., at least every six months). The document, "Quality Assurance Plan Process/Plan," revised 5/22/13, was written in the format of a Facility policy/procedures, but was offered as the current Quality Assurance Plan. Since the Monitoring Team's last report, the document had been modified to include additional definitions. The revised document included provision for reducing QA monitoring when compliance was sustained at 85% or greater for three consecutive reviews, set a threshold for consideration of development of CAPs when an indicator was assessed at 80% or less, added some specificity about dissemination of CAPs, and appended the QA Matrix and the Data Inventory to the QA Plan. <u>QA inventory of data</u> There was not a complete and adequate data inventory at the Facility. The data inventory was not current (since it remained in draft.) The Facility produced a draft of a data inventory that identified data for many sections of the	Noncompliance

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		Settlement Agreement that could be used to identify trends related to the requirements of those provisions of the Settlement Agreement sections. While the data inventory should include all data maintained by the Facility, it is essential that the data inventory include all data referenced in the matrix. The draft data inventory included data on most key indicators (outcome and process) of performance, selected by the QA/QI Council to track priorities, as indicated in the draft matrix. The draft data inventory included data from the Settlement Agreement self-monitoring tools, disciplines/departments; areas of care, protections, supports and services. Data in the inventory included data recorded by program areas, living units, work shifts, and individuals for most data included in the AVATAR system or linked to the AVATAR system. Not all of the data in the draft inventory included a description of the data, including the source database. However, on interview with the Director of Quality Assurance, the Settlement Agreement Coordinator, and the Data Analyst, it was clear that they understood the need to include the sources and were planning to do that as a next step in the development of the list. <u>QA Plan Narrative</u> The QA plan narrative at the Facility was current. The QA plan narrative had been reviewed and revised, as appropriate, within the last 12 months. The QA plan narrative was not complete. As noted below, work was still underway for some components of the plan. The QA Plan described the QA program, including: ▪ A description of the purpose of the QA program; ▪ The organizational structure of the QA process (including individual roles and responsibilities); ▪ The data inventory was in draft, but considerable work had been done to establish a comprehensive inventory; ▪ A QA matrix was under development to establish quality outcomes for each discipline, key indicators to measure each quality outcome, and the data that the key indicators would rely on; ▪ A description of how data were summarized and analyzed; ▪ The role of other departments in QA (including QA Department and discipline department collaboration/meetings); ▪ A list of workgroups and their relation to the QA/QI Council; ▪ QA reporting method; ▪ The QA/QI Council and its role in reviewing data and guiding the entire QA process;	

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		and ▪ Descriptions of how corrective actions (CAPs) were to be tracked. QA Plan Matrix: The QA Plan Matrix was presented in draft and in a different format than the former Quality Assurance Matrix. The draft was presented as a series of quality outcomes each of which roughly corresponded with the 20 sections of the Settlement Agreement, but were not identified as such. For each outcome, a series of key indicators were listed, including compliance with some subsections of the Settlement Agreement as one indicator. While this document resulted from a major, system wide effort to connect key indicators of performance to the quality outcomes for people, it missed the mark in several important ways: ▪ Section T related to transition to the most integrated setting appropriate did not appear in the draft. ▪ There was no crosswalk or chart showing how the draft matrix contents related to the sections of the Settlement Agreement. ▪ The draft matrix was some 50 pages long. While this was useful for understanding the key indicators and their relationship to the quality outcomes, it was less useful as a method for following the use of monitoring tools. The Monitoring Team suggested that a grid summarizing the information in the draft matrix would be helpful. During the onsite visit, a grid based on the original matrix was produced to track the number of QA monitoring tools and dates of revision, but did not array the key indicators from the draft matrix. ▪ The list of key indicators was extensive and would benefit from reduction to the most important indicators for each section. Additional editing of key indicators to produce a set of those with the highest priority would be useful. ▪ The quality outcomes, listed in the draft matrix, were not written from the perspective of the individual and how his/her life could be expected to benefit from the actions measured by the key indicators. Most outcomes read: "People are supported by the provision of effective dental services…" instead of "people have healthy teeth and gums." The former phrasing is about what the Facility will do (i.e., process indicators, which are a necessary part of a QA system). The latter is about how individuals will benefit (i.e., outcome measures, which also are a necessary part of the system). According to the Facility Self-Assessment, for the 20 sections of the Settlement Agreement, a set of key indicators was included for 11 of the 20 sections (55%). The draft QA Plan Matrix, however, appeared to list key indicators for all but section T. The key indicators were primarily process indicators. The Monitoring Team, the QA Director, and Settlement Agreement Coordinator discussed at length the differences between process and outcome indicators. It was clear that the draft matrix was still in the development stages and as a	

#	Provision	Protocol	Compliance
		result the following metrics were not assessed. However these metrics will be assessed when the matrix is complete. ▪ 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. <u>Self-monitoring tools for all Settlement Agreement provisions</u>: The QA Monitoring Tools Matrix did not include self-monitoring tools/self-monitoring procedures for the 20 sections of the Settlement Agreement. In response to requests related to Section E, copies of tools were not provided for nine Sections G, H, I, K, N, O, P, R, and U, although they were listed in the QA Monitoring Tool Matrix as having tools. • The tools for sections G and H were listed as the medical provider QA audit, but data summaries indicated that tools for these sections were under development. • While the tool was not provided, summary reports for the following sections indicated a tool was in use: Sections I and K. • For the remaining five sections (i.e., N, O, P, R and U), no tools appeared to be in use. The QA Monitoring Tools Matrix did identify the frequency of monitoring, and the persons responsible for monitoring for each tool listed. <u>All Data Collected by QA Department</u> All data that QA staff members collected were not listed on the QA Plan matrix. Trend data were listed for A/N/E investigation, UIR investigations and injuries, but not for trend data on restraints, risks, peer-to-peer aggression, dental, engagement/active treatment, infection control, medication variance, medical emergency drills, obstacles to community placement, psychiatric/polypharmacy, and skin integrity, all of which had trend reports available. Data on surveys were not listed on the matrix. <u>Includes Satisfaction Measures and Follow-up</u> Although not included in the evaluation of substantial compliance, there were surveys of families/LARs, but not of individuals, staff, and relevant community partners, done at least annually. For significant findings, a request for follow-up was sent to the appropriate department, but it was not clear whether follow-up had been completed within 90 days. <u>All Items in QA Plan Matrix Also Appear in the QA Data List/Inventory</u> All of the items in the QA plan matrix did not also appear in the QA data inventory. Both the matrix and the data inventory were in draft, and it was clear from interviews that neither	

#	Provision	Protocol	Compliance
		was complete. As discussed during onsite interviews, the data inventory needed to contain descriptions of all listed data and needed to include the source of the data. It needed to contain at least all data listed on the QA matrix. <u>All data in QA plan matrix were submitted and reviewed</u> Submitted/Received: Of the 19 items in the QA plan matrix (excluding Section E), 12 (63%) 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 included: ▪ Sections G and H, which may have been submitted as part of Section L; and ▪ Sections N, O, P, R and U, which did not have monitoring tools in place. Reviewed/Analyzed: Of the 19 items in the QA plan matrix, 12 (63%) were documented to show some review or analysis by the QA Department and/or the department section leaders for the last two reporting periods for each item (e.g., monthly, quarterly). Those that did not included: ▪ Sections G and H, which may have been submitted as part of Section L; and ▪ Sections N, O, P, R and U, which did not have monitoring tools in place. Implemented the QA Plan as Written: Of the 19 sections of the QA Plan narrative and matrix, the Facility implemented 13 (68%). As noted above, two sections may have been imbedded in section L, but documentation did not make that clear. Four sections, as noted above, did not have tools in place. <u>QA Staff Assist Disciplines/Departments in Analysis of Data</u> For the 19 sections of the Settlement Agreement (Section E excluded), for seven there was documentation indicating that QA staff had assisted the section leads with analysis. For those sections without documentation of assistance (i.e., Sections C, D, J, K, L which had been monitored; Sections N, O, P, R, and U, which had not; and Sections G and H, which might have been imbedded in Section L), there was no documentation of the reasons that assistance was not needed. While many of the reviews summarized monitoring data, 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 and in prioritizing those needed actions. 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	

#	Provision	Protocol	Compliance
		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. (Metric 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.) While there was significant progress in the development of the QA Plan, the QA Matrix, and the Data Inventory, they were still in draft and needed additional work. It was not clear that all sections of the Settlement Agreement had current monitoring tools, or that there was sufficient analysis of data to guide development of corrective actions. The Facility was not in substantial compliance with this provision. The Facility Self-Assessment found the same.	
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	<u>All data in the QA Plan Matrix are summarized, graphed, and analyzed</u> Data from the QA plan matrix for three of the 19 (16%) 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. ▪ The sections that had quarterly summaries, with graphs and analysis, as well as associated trend reports that displayed data over time, and across the a through g categories included: Sections C, and D. ▪ Sections that had quarterly summaries, with analysis and/or graphs and an associated trend report showing trends over time for a particular area, such as skin integrity or medication variance, were sections F, J, K, M, Q, S, and T.	Noncompliance

#	Provision	Protocol	Compliance
	anticipated outcome of each action step; the person(s) responsible; and the time frame in which each action step must occur.	▪ Sections that might have had some data, but that did not have monitoring tools and/or did not provide summaries at least twice during the months reviewed and did not have trend data over time included sections I, L, N, P, and V. ▪ Sections that had no summaries and no data at all included sections G, H, O, R, and U. While there has been progress in collecting and analyzing data and in trending it over time, there was still much to be done. 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** <u>Review QA-Related Actions</u> Based on a review of a sample of five of the data summaries for sections of the Settlement Agreement: Sections C, F, J, N, and S, which referenced minutes of meetings between QA staff and discipline heads for the last two quarters: ▪ Since the last onsite review, a meeting occurred at least twice for four of the sampled sections (80%) of the Settlement Agreement (the exception was Section N), and the following five topics were addressed during eight of the eight (100%) meetings that occurred: o Review of the data listing/inventory and matrix; o Discussion of the data and outcomes; o Review of the conduct of the self-monitoring tools; o Creation/proposal of corrective action plans; and o Review of previous corrective action plans. <u>Data Were Available</u> ▪ Since the last onsite review, during eight of the ten (80%) meetings, data were available to facilitate department/discipline analysis of data. <u>Data Were Reviewed/Analyzed</u> ▪ Since the last onsite review, during eight of the ten (80%) meetings, data were reviewed and analyzed. ▪ Since the last onsite review, during three of the ten (30%) meetings, action plans (and/or CAPs) were created for systemic problems and for individual problems, as identified. Those three were Section F, J, and S. While additional CAPs were developed, it was not clear whether they emerged from the meetings between PCMs and Discipline heads or from one of several committees, such as the Infection Control Committee. <u>QA Reports</u> 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 six of the six (100%) months. The QA	

#	Provision	Protocol	Compliance
		reports were in conjunction with the department reports by section according to a schedule set forth by the QA/QI Council. Of the 20 sections of the Settlement Agreement, 17 (85%) appeared in a QA report at least once in each quarter since the last onsite review. Those that did not were sections E, P, and U. Of the sections of the Settlement Agreement that were presented, none of 20 (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. **Facility QA/QI Council** <u>Design</u> There was an adequate description of the QA/QI Council in the QA plan narrative or in a separate QA/QI Council policy or procedure document. 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. <u>Schedule, Agenda, Attendance</u> ▪ Since the last onsite review, the QA/QI Council met at least once each month. ▪ Minutes from 10 of the 10 (100%) QA/QI Council meetings, between 5/6/13 and 9/16/13, indicated that meetings occurred according to schedule or reasons for changes were documented. ▪ Minutes from 10 of the 10 (100%) QA/QI Council meetings, between 5/6/13 and 9/16/13, indicated that the agenda included relevant and appropriate topics. ▪ Minutes from none of the 10 (0%) QA/QI Council meetings, between 5/6/13 and 9/16/13, indicated that there was appropriate attendance/representation from all departments. The meeting rosters contained 38 names. From 16 to 28 of those staff attended the meetings. <u>Data and Analysis Presented</u>: Minutes from none of the 10 (0%) QA/QI Council meetings since the last review documented that: ▪ Data from QA plan matrix (key indicators, self-monitoring) were presented. In general, data from self-monitoring were presented, as were trend analysis data in	

#	Provision	Protocol	Compliance
		most meetings. However, key indicator data were not available, since key indicators were still under development. ▪ The data presented were trended over time. While not all data, particularly data resulting from monitoring tools, were trended over time, other data related to trend analyses of restraints, abuse/neglect/exploitation, and injuries were trended over time. ▪ Comments/interpretation/analysis of data were presented for both monitoring data and trend data. This metric did not capture the progress that was evident in reviewing the QA/QI minutes. Where, in past reviews, it was noted that section leaders in their presentations did not use some of the QA monitoring data, this time the QA data, when available, was included in the section leads' reports. This was a positive development, and as noted earlier, work was underway to develop and utilize key indicator data. <u>Recommendations and Action Plans</u>: In three of the 10 QA/QI Council meetings (30%), recommendations and action plans were selected when appropriate to do so, and were based on the data presented. Most meetings presented opportunities to take actions, yet few meeting minutes recorded actions. For example, in the 6/17/13 meeting a discussion of the restraint trend report made several recommendations that were data-based, yet no actions were recorded in the minutes. This was true of most trend reports and QA monitoring reports. Those situations in which the Council did this appropriately included: ▪ 7/1/13, where an action was recorded in response to an engagement trend report; ▪ 8/12/13, where three CAPs were authorized for Section C in response to data; and ▪ 9/16/13, where action was taken on a recommendation to track staff who failed safety drills. **Corrective Action Plans** <u>System for generating CAPs:</u> A written description existed, indicating how CAPs would be generated. The description was found in the ABSSLC Quality Assurance Process/Plan. The description included: ▪ Criteria for a CAP; and ▪ A description of how to evaluate indicators for criteria for a CAP based on percentages of low scoring items on monitoring tools. As was indicated in the last report, the system should include a description of methods in addition to the use of percentages for evaluating data to determine when a CAP might be needed, such as: when data identifies a specific home or unit as having an issue, when issues cross over disciplines, or when issues otherwise need the oversight of the QA/QI Council. <u>CAP development</u>:	

#	Provision	Protocol	Compliance
		When considering the full set of 21 "open" CAPs, 21 (100%) appeared to have been chosen following the written description. <u>Content of each CAP:</u> Of the sample of 15 CAPs the Monitoring Team reviewed, 15 (100%) appeared to address the specific problem for which they were created. <u>CAPs contain all necessary components:</u> Based on a sample of 15 CAPs, which represented 71% of the total of 21 CAPs: ▪ 15 (100%) included the actions to be taken to remedy and/or prevent the reoccurrence; ▪ 15 (100%) included the anticipated outcome of each action step; ▪ 15 (100%) included the person(s) responsible; and ▪ Eight (53%) included the time frame in which each action step must occur. Substantial improvements were noted in the number of CAPs, the connections between CAPs and data analysis, and the inclusion of action steps in each CAP. However, as indicated above, improvements were still needed particularly with regard to adoption and use of key indicators, analyzing data to identify areas requiring improvements, capturing actions/action plans in the minutes of QA/QI Council meetings, and attendance at QA/QI Council meetings. As a result, the Facility remained in noncompliance with this provision.	
E3	Disseminate corrective action plans to all entities responsible for their implementation.	At ABSSLC, the process for disseminating CAPs was for the Quality Assurance Director to email those listed as responsible for the CAP once the QA/QI Council had approved the CAP. The date of dissemination was recorded in the CAP database. This process was adopted on 6/17/13, according to QA/QI Council minutes. Prior to that time, CAPs were disseminated by email, but it was not clear who was responsible or how the documentation was tracked. However, given that the CAPs were approved at QA/QI Council, where persons responsible were usually in attendance or at least recipients of meeting minutes, even prior to adoption of the present process, it would have been likely that responsible persons were informed of the CAP. Based on review of a sample of 15 CAPs, which represented 71% of the total of 21 CAPs: ▪ All (100%) included documentation about how the CAP was disseminated; ▪ All (100%) included documentation of when each CAP was disseminated; and ▪ All (100%) included documentation of to whom it was disseminated, including the specific person(s) responsible. The Facility was found to be in substantial compliance with this provision. The Facility Self-Assessment found the same.	Substantial Compliance

#	Provision	Protocol	Compliance
E4	Monitor and document corrective action plans to ensure that they are implemented fully and in a timely manner, to meet the desired outcome of remedying or reducing the problems originally identified.	Implementation of CAPs: It was difficult to tell whether CAPs had been implemented from the CAP Reporting that was provided. Each CAP sheet listed actions to be taken, but some did not have target dates listed for the actions. Even when they did, the status notes did not comment on whether the actions had been achieved by the specified dates. The status comments only indicated the date of the last review, the date of discussion with the QA Director, or whether the overall due date had been extended. Based on a sample of 15 in process CAPs (none that had been completed were submitted), four (27%) were implemented and three of these (20%) were implemented in a timely manner. The four with documentation indicating they were implemented were: Samples #E2.2, #E2.6, #E2.8, and #E2.10. Those with documentation of timely implementation were: Samples #E2.2, #E2.6, and #E2.8. Tracking CAP status: There was a system for tracking the status of CAPs. Of the 21 CAPs being tracked by the Facility, for all (100%), the tracking sheet indicated the status of the CAP and any action taken if a CAP had not been implemented. CAPs are Tracked and Managed: To assess compliance with the following metric, the Monitoring team reviewed the QA/QI minutes for indications of presentations of summary information about CAPs, such as the number in process, completed, and outstanding, and the number not meeting timeframes as specified in the CAP. No record of such sharing of information could be found. While the QA Director did have a tracking sheet with information about each CAP, including comments on status, the comments were not substantive enough to covey where the CAP implementation stood in relation to the expectations. The Facility QA Director: ▪ Did not maintain summary information regarding CAPs and their status (number of CAPs and number overdue) that was updated within the month prior to the onsite review; and ▪ Did not present this information to QA/QI Council at least quarterly as determined by a review of Council minutes. The Facility remained in noncompliance with this provision.	Noncompliance
E5	Modify corrective action plans, as necessary, to ensure their effectiveness.	Evaluate effectiveness of CAPs Including Outcomes and Timely Completion: There were no completed CAPs offered for this review. When completed CAPs are available the following metric will be completed. It will be important for a system to be in place to	Noncompliance

#	Provision	Protocol	Compliance
		evaluate and document the outcomes of CAPs, as well as their timely completion. ▪ For ___out of ___CAPs (%), documentation showed review of their effectiveness (i.e., outcomes), and for ___out of ___CAPs (%), documentation showed review of their timely completion. <u>CAPs were modified when needed</u>: Of the 10 CAPs in the sample that appeared to need modification, four (40%) had been modified. The CAPs that did not need modification included three, which were relatively new (Sample #E.13, #E.14, and #E.15), one (Sample #E.4 had dates that had past, but the final had not), and one (Sample #E.8 with a completion date only 15 days before the status report was drawn.) Most of the remaining CAPs that appeared to need modification did not have timeframes for their action steps, or were past the dates assigned to the action steps without indications of progress or reasons for lack of progress, and there was no documentation to indicate that modification had or would be made. The four that had some specific documentation of modifications made to CAPs included: Samples #E.2, #E.5, #E.9, and #E.11. However, even in these four, the modifications to the CAPs were not specific or well described. <u>Modifications/results are discussed at QA/QI Council</u>. Based on a sample of 15 in process CAPs (no completed ones were submitted), six (40%) had been discussed at QA/QI Council as evidenced by notations in the comments section of the tracking sheets. <u>Modifications are implemented as written</u>. For none of four (0%) modified CAPs, evidence was present to show the due dates had been met or an explanation provided for any delays. For none of the four (0%) modified CAPs, evidence was present to show that all the steps of the CAP had been implemented as written. Additional information needed to be tracked, reviewed, and acted on to assure that CAPs contained essential information such as timeframes; to require modifications when such information was missing or when dates were passed without progress; and to document when CAPs were modified and discussed at QA/QI Council meeting. The Facility remained in noncompliance with this provision.	

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 ABSSLC and Statewide Policy and Procedure Number 004.1: Individual Support Plan (ISP) Process (Integrated Protections, Service, Treatments, and Supports), 11/20/12, ABSSLC 06-13; o A list of Qualified Intellectual Disabilities Professionals (QIDPs) with their current assignments, and the number of individuals on their caseloads, undated; o Section F: Integrated Protections, Services, Treatments and Supports monitoring form, revised 6/4/13; o Section F: Integrated Protections, Services, Treatments and Supports graph of overall compliance by monitoring tool, for 6/1/13 to 7/31/13; o Inter-Rater Reliability by Question for Section F, from 6/1/13 to 7/31/13; o Settlement Agreement Compliance Report: Overall Compliance by Month for Section F, for 6/1/13 through 7/31/13; o The last 10 monitoring tools that the QIDP Department completed and the last 10 the QA Department completed; o Draft Facilitator QIDP Training Itinerary, updated 10/7/13; o Draft Home QIDP Training Itinerary, updated 10/7/13; o Draft manual on QIDP responsibilities and procedures, modified 10/7/13; o ABSSLC Policy: Most Integrated Setting Practices, dated 8/8/11; o Some Things to Remember for Referrals, dated 8/5/11; o CLDP template, undated; o ISP Facilitation Competence – Facilitator QIDPs, dated 8/14/13; o Listing of QIDPs Deemed Competent in Facilitation and Documentation of ISP Meetings, dated 8/14/13; 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 Over the last one-year period: a) the total number of ISP meetings held; b) the total number of ISP annual meetings that occurred more than 365 days after the pervious annual meeting; and c) the total number of ISPs that were filed more than 30 days after the annual ISP meeting was held; o Compliance per Individual for Annual Assessments, from 10/1/12 to 10/1/13; o Count of Assessments Filed on Time, between 10/1/12 and 10/1/13; o ISP Required Attendance Compliance graph, for 10/1/12 to 10/1/13; o Overall Facility Attendance Compliance by Month, from 10/1/12 to 10/1/13; 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 7/2/13, and 9/11/13; o CAP for Section F: Timeliness of assessments prior to the ISP, dated 9/5/13; o CAP for Section F: ISP filed in record within 30 days of ISP meeting, dated 9/5/13; 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 #158, Individual #246, Individual #253, Individual #390, Individual #306, Individual #145, Individual #183, Individual #476, Individual #237, and Individual #453; o 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; o Handouts from ISP meeting for Individual #180; o Occupational/Physical Therapy Evaluation for Individual #334, Speech-Language (SL)/ Communication Evaluation for Individual #264, and SL/Communication Assessment for Individual #395; o ISP Assessments for Individual #233, Individual #180, and Individual #397; o QIDP Caseload Assignments Beginning 9/1/13 (Tentative); o Home QIDP Check Sheet for the Individual Support Plan Process, revised 10/24/13; o QIDP Responsibilities at ABSSLC, updated 11/5/13; o ISP Circle of Life graph; o ABSSLC Self-Assessment, updated 10/21/13; and o Presentation Book for Section F. ▪ **Interviews with**: o Kristin Wyrick, QIDP Coordinator; o Jolene Willis, Assistant Director of Programs (ADOP); and o Jeff Branch, Director of Active Treatment; ▪ **Observations of**: o Individual Support Plan meeting for Individual #397, on 11/5/13 o ISP Meetings for Individual #176 and Individual #77, on 11/6/13; o ISP Meeting for Individual #180 and Individual #233, on 11/7/13; and o Activities in homes and day programs.
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section F, dated 10/21/13. 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: o 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 6/4/13. 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. o 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. For example: • 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. The Facility's Self-Assessment did not include indicators sufficient to determine substantial compliance, and/or the standards the Facility used to determine substantial compliance were not clear. As a few examples: o With regard to attendance at ISP meetings, a missing piece of the Facility's self-assessment was determining whether or not teams had properly identified the members of the team required to attend the annual ISP meeting. Without first looking at this qualitative requirement, the Facility's data regarding attendance was difficult to interpret. o Similarly, the Facility largely assessed the presence or absence of certain components of assessments (e.g., lists of strengths and preferences), and did not qualitatively review whether or not assessors had meaningfully incorporated this information into assessments. The Facility also did not assess the quality of the teams' decisions about which assessments were necessary for individuals in

	the sample. o For Section F.1.e, which relates to the development of ISPs in accordance with the Americans with Disabilities Act and Olmstead decision, the indicators the Facility was using were largely not relevant, and many necessary indicators were missing. In addition, it was unclear what standard the Facility used to determine the quality of teams' discussions about community living options. • 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, for some indicators it did, but for others 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. o The following staff/positions were responsible for completing the audit tools: the Program Compliance Monitor, the QIDP Coordinator, the QIDP Educator, and the QIDP Settlement Agreement Liaison. 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. The Facility had used data from a database containing information related to IDT member meeting attendance, as well as assessment timeliness. As discussed below, there were

	concerns about the validity of this data. ▪ 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.4, related to the identification of the methods for implementation, timeframes for completion, and staff responsible; and 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. This was not consistent with the Monitoring Team's findings. It was not clear to the Monitoring Team why these discrepancies existed, but it might have been due to the Facility not auditing for quality and completeness. Although progress was noted, the Monitoring Team continued to find significant problems with the quality of the facilitation of the meetings necessary to result in comprehensive ISPs; the full and clear identification of methods, timeframes, and staff responsible; and the full and clear identification of what data needed to be collected, who would collect it, and who would review it. 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 provided limited analysis of the information, identifying, for example, potential causes for the issues. For a few such areas, the Facility referenced the initiation of the use of ISP Facilitator QIDPs or the use of the ISP Facilitation and Documentation Guide as potential solutions, but did not reference the Facility's Action Plans, Corrective Action Plans, or other plans to facilitate improvements.
	Summary of Monitor's Assessment: Since the last review, the Facility had made a significant change in the development of Individual Support Plans (ISPs). In September 2013, the Facility had shifted to using Facilitator Qualified Intellectual Disability Professionals (QIDPs) and Home QIDPs. The Facilitator QIDPs had primary responsibility for the preparation for and facilitation of the ISP meetings and drafting of the ISP documents, and the Home QIDPs participated in the ISP process and meetings, but also had other responsibilities related to the implementation of ISPs. At the time of the Monitoring Team's onsite review, this process remained in the initial stages of implementation. However, members of the QIDP Department believed that it already had begun to assist with the timeliness of the completion of ISP documents, and hoped that, by better using various QIDPs' specific skill sets, it would result in improved ISP processes and documents, as well as provide better oversight of the implementation of ISPs. ISP meetings were being held annually, and individuals newly-admitted to the Facility were having ISP meetings within 30 days of their admission. In addition to continuing its efforts to complete ISP documents timely, the Facility needed to ensure implementation began in 30 days, and make changes to ISPs as dictated by individuals' needs. The Facility was working to develop and implement a system to train staff

	on the necessary components of the ISPs, and track this training. Timeliness of assessments prepared for the annual ISP meetings and quality of some of these assessments continued to be problematic. On a positive note, the Facility recognized the need to work with the disciplines to improve the quality of assessments, as well as the incorporation of assessment results into ISPs and skill acquisition programs. As a result, some collaboration and cross-training had begun to occur. For example, a Speech Language Pathologist (SLP) had provided training on how to incorporate recommendations into skill acquisition programs and ISPs, and this had resulted in some discussion about the need to ensure recommendations in speech language (SL) assessments were written in a way that facilitated their integration into ISPs. The Facility is encouraged to continue these collaborative efforts and pursue its plan to expand such efforts to other disciplines. 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. The Facility was using the Integrated Health Care Plan (IHCP) format, which often expanded the array of protections, supports, and services teams were discussing. However, teams were still not identifying the full configuration of supports and services necessary to address individuals' needs and preferences. Action plans included more measurable action steps, which was positive, but this was an area in which work was still needed. Although some limited improvement was seen, ISPs generally continued to lack measurable objectives necessary 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 recognized this was an area needing improvement, but 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.

#	Provision	Assessment of Status	Compliance
F1	**Interdisciplinary Teams -** Commencing within six months of the Effective Date hereof and with full implementation within two years, the IDT for each individual shall:	In 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 reviews, individual's daily schedule, Special Considerations list, and ISP Preparation Meeting documentation as available. The documents the Facility provided included the most recently developed ISPs from each residence on campus. As the parties agreed as part of the revised monitoring format for ABSSLC, a reduced	

#	Provision	Assessment of Status	Compliance
		sample size was to be used for Section F (i.e., approximately 10 ISPs from different QIDPs) with a full review completed of this limited number of plans. In September 2013, the Facility had shifted to using Facilitator QIDPs. These QIDPs had primary responsibility for the facilitation of the ISP meetings and drafting of the ISP documents, and the Home QIDPs participated in the ISP process and meetings. In order to provide the relevant feedback on this new process, the Monitoring Team selected10 plans that the QIDP Facilitators had developed with different Home QIDPs. There were four QIDP Facilitators, and at least two ISPs for each were included in the sample. This also represented various interdisciplinary teams (IDTs) across campus. This sample included plans for: Individual #158, Individual #246, Individual #253, Individual #390, Individual #306, Individual #145, Individual #183, Individual #476, Individual #237, and Individual #453.	
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 QIDP would assist the individual and LAR, as appropriate, in leading the team in an interdisciplinary discussion. ▪ In September 2013, the Facility had begun to use Facilitator QIDPs to facilitate ISP meetings, and Home QIDPs for other duties. Observations of team meetings and reviews of ISPs also illustrated that in September 2013, the QIDP Facilitators had begun to facilitate ISP meetings. As documented in minutes for a meeting on 9/19/13 of the Facilitation QIDPs, the Facility remained in the beginning stages of implementing this new system. For example, for the ISP documents included in the sample, the Facilitator QIDPs had been responsible for facilitating the ISP meetings, but not the ISP Preparation meetings. ▪ With regard to staffing, in addition to the QIDP Coordinator, a QIDP Educator, as well as a QIDP Settlement Agreement Liaison were members of the department. Based on a document entitled: "QIDP Caseload Assignments Beginning 10/1/13 (tentative)," four Facilitator QIDPs were in place, and an accurate count of the Home QIDPs could not be calculated, because only first names were provided. However, according to the document, the average caseload for Home QIDPs was 23 to 26 individuals, and the average caseload for the Facilitator QIDPs was 92 to 110 individuals. ▪ During the week of the review, the Monitoring Team observed the ISP annual team meetings for Individual #180, Individual #397, Individual #77, Individual #176 and Individual #233. ▪ Progress continued to occur with regard to the facilitation of meetings. Based on	Noncompliance

#	Provision	Assessment of Status	Compliance
		these observations and review of ISPs, some of the areas in which progress had begun included: o At annual ISP meetings ground rules were clearly set forth, and the ISP format in the revised policy provided an agenda. o Paper hung on the walls or white boards were used to track key components of the ISP process, such as the individuals' preferences, and action plans that needed to be developed. o The teams had a more comprehensive discussion than in the past about a wider variety of the protections, supports, and services. This included review of plans, such as the PNMP, with team discussion and modifications made, as necessary. o At times, efforts were made to include the individual, and focus the discussion on him or her. o During the ISP meetings on site, some of the teams had a more comprehensive discussion than in the past about a wider variety of the protections, supports, and services. o Based on observations on site, as well as review of ISP documents, QIDPs and teams were using some of the necessary data to make decisions in relation to individuals' risk areas, but some important data continued to be missing from these discussions. A number of gaps also 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. o For Individual #180, some of the positives included: ▪ The Dental Hygienist appropriately discussed the cause of Individual #180's recent refusals to cooperate with dental appointments and the need for pre-treatment sedation. More specifically, throughout Individual #180's life, most of her appointments had been for cleaning, etc., but after more major work was done, she started being resistant to even basic dental care. The Hygienist then suggested she work with the Behavioral Health Services Provider on a methodical plan to assist the individual to get back to baseline. This seemed to be an appropriate plan, and it was very good to see that the Behavioral Services Department representative saw this as part of her role. However, they did not take it a step further to discuss specific goals or objectives to measure success, short of the individual ultimately becoming cooperative with basic dental appointments. ▪ Some Skill Acquisition Programs (SAPs) were discussed to assist in potentially reducing some of Individual #180's risks.	

#	Provision	Assessment of Status	Compliance
		For example, in order to assist with her constipation, staff discussed having her learn to make her own drinks using drink mix packets, as well as to mix her Miralax. This appeared to be a good way to involve Individual #180 in the process, and hopefully provide incentive for her to drink more fluids. ▪ An example of integration of supports for Individual #180 was the incorporation of a replacement behavior in her PBSP to communicate when she is in pain. In addition to potentially reducing the target behavior of aggression, this also was an important skill to potentially reduce some of her other risk factors, such as constipation. o For Individual #233, in the meeting observed on 11/7/13, the Facilitator QIDP kept the group focused, drew participants into the discussion, and encouraged a lively exchange of ideas. Staff used data and referenced the rating scale when determining risk levels. Topics that required further discussion and follow-up were identified with meetings scheduled to ensure this occurred. Based on review of ISPs as well as during the observations of meetings held the week of the onsite review, facilitation of team meetings was improving, but for none of the 10 plans reviewed or five 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 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 QIDPs. Although it included a competency-based component, the QIDP Coordinator indicated it was no longer being used to assess competence. The Facility submitted a list of four QIDPs (i.e., the Facilitator QIDPSs) that the Facility had deemed competent in meeting facilitation. However, in discussing the methodology used, the QIDP Coordinator described a process whereby QIDPs were assessed based on a list of characteristics believed to be necessary for good facilitation of meetings. This list included: interactions professional, communication skills – verbal, communication skills – written, time management, "demonstrates [sic] of ISP process," consistently creative, flexible, demonstrates organization, and current in caseload. These were broken down into essential abilities and additional abilities, and the scores for these two categories were totaled separately. When asked what standards or criteria were used for each of the categories to ensure	

#	Provision	Assessment of Status	Compliance
		the results could be replicated consistently and used to identify specific skills or competencies that needed improvement, Facility staff agreed that more work was needed to develop an actual checklist of skills (i.e., a competency checklist). As a result of such a checklist not being submitted for the four staff the QIDP Department staff believed were competent, the Monitoring Team could not confirm that they were competent. ▪ Based on observations of meetings held the week of the onsite review, areas in which QIDPs will need to obtain full team participation and facilitate meaningful discussion included, but was not limited to: o Continuing to expand the depth of the preferences identified for individuals. QIDPs should continue to challenge teams to define what it is the individual prefers about items such as foods or activities to allow teams to offer the individual new experiences, and to expand the discussion to include preferences related to work, relationships, past experiences, future opportunities, etc. These then should be incorporated into action plans. o 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. o 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 issues related to developing adequate action plans, including appropriate methodologies. o Articulating meaningful outcomes for individuals. Often the outcome was expressed as a process (e.g., Individual will attend preferred community outings at least twice a month), rather than as a change in the individual's life (e.g., Individual will make a new piece of artwork at an arts and crafts store in the community, or Individual will participate in a bowling league in the community). o Although some improvements were seen, seeking data from various team members to assist in decision-making, and justify the teams' conclusions. For example, data should be used consistently, including when reviewing PBSPs and skill acquisition programs, as well as outcomes related to individuals' risks. In addition, as appropriate, historical information or causation should be investigated fully (e.g., causes for falls or fractures, history of issues related to previous failed community placements, etc.). This is essential information to inform planning for future training, treatment, supports, and services. o Ensuring that day and vocational options are fully discussed, and plans	

#	Provision	Assessment of Status	Compliance
		reflect individuals' strengths and needs and set forth a full day of out-of-home activities, unless justification is provided. o Setting forth clearly the methodologies or how outcomes will be accomplished. o To improve integration of supports, QIDPs 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. ▪ For Individual #180, the following were some of the problems noted for which the Facilitator QIDP did not provide guidance to the IDT to correct or clarify: o Individual #180 became restless and clearly did not want to remain in the meeting. It was appropriate for Individual #180 to be excused from the meeting. However, the direct support professional who was with her appeared to know Individual #180 well. She also left the meeting, and was not asked to return after securing coverage for Individual #180. As a result, the majority of the meeting was held without the benefit of the knowledge of a direct support professional who knew Individual #180 well. o The data included on the IRRF for Individual #180 was often confusing and/or incorrect. For example: ▪ Under the dental section, sedation was marked as "No," but in June 2013, the individual had had general anesthesia for dental work. General anesthesia is a form of sedation. ▪ Within a number of the subsections of the IRRF, information was included that had no direct connection to the risk area being discussed. As a couple of examples, under respiratory compromise, it was noted she was diagnosed with amenorrhea in 2005, and a history of prior treatment for scabies, dermatitis, eczema, and otitis media. It is unclear how any of this related to respiratory compromise. ▪ Some of the subsections of the draft IRRF appeared to include template language (e.g., dental and behavioral health). For dental, it had not been fully individualized (e.g., instead of selecting an option, all options were still listed for "present condition," "caries" and "periodontal risk" under dental). To a lesser extent, this also was a problem in the behavioral health section (e.g., no recommendations filled in, no check marks in the possible options for medications, etc.). ▪ At times, data were just listed without any analysis (e.g., lab work for diabetes). Without analysis, this information was likely difficult for many team members to interpret. For	

#	Provision	Assessment of Status	Compliance
		example, no analysis was included in the IRFF regarding whether the individual was doing better or worse from previous years, based on predetermined clinical indicators. As a result, it limited meaningful discussion. o In addition, the data on the IRRF for Individual #180 was not always complete to allow the team to make justifiable decisions. For example, the team rated Individual #180 as being at high risk for constipation. On a positive note, the draft IRRF included a significant amount of history related to constipation. However, in terms of her status, the following was included: "Does require suppository use once or twice a month. Improvement from last year when she experienced Volvulus and an Ileus. She has had regular bowel movements this past year…" No specific data was provided, and during the team's conversation, when asked about the suppository use, the nurse indicated that she thought it was better than last year. Another example was found in a couple places in the draft IRRF related to her physical activity. The IRRF stated: "[Individual #180] walks the circle in front of the cottages daily if the weather is nice twice daily." No information was provided about how long the walks were, or how often they actually had occurred. Another example was the lack of discussion or information in the IRRF related to side effects of the psychotropic medication polypharmacy. Without this information, it was not clear how the team could apply the IRRF guidelines, and no questions were asked to elicit this information. o The team did not have copies of draft IHCPs for Individual #180, and/or did not discuss them during her ISP meeting. As a result, it was not clear whether or not the plans sufficiently addressed her needs. In addition, the team did not discuss any specific clinical indicators or objectives/ outcomes. o The team for Individual #180 did not discuss the risk versus benefit of the psychotropic medication, which included polypharmacy. 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. None of the Facilitator QIDPs had been deemed competent in facilitation using a valid and reliable competency-based checklist. 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	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 QIDP;	Noncompliance

#	Provision	Assessment of Status	Compliance
	Professional, other professionals dictated by the individual's strengths, preferences, and needs, and staff who regularly and directly provide services and supports to the individual. Other persons who participate in IDT meetings shall be dictated by the individual's preferences and needs.	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. Attendance requirements continued to be determined at the ISP Preparation Meeting held 90 days prior to the annual meeting. ABSSLC maintained data on attendance at ISP meetings, and these data were shared at QA/QI Council meetings. Upon request, the Facility provided summaries of the data in different formats to the Monitoring Team. This included a summary of overall attendance rates for a 12-month period, a breakdown of overall attendance rates per discipline, the data related to attendance for each individual in the Monitoring Team's sample. Based on data the Facility provided for ISPs held between October 1, 2012 and October 1, 2013, average attendance rates were between 73% and 91%. This data was broken down by discipline, and for the same time period, showed rates ranging from 20% to 100%. However, this data was based on those disciplines the teams had identified as required to attend, and, as noted below, problems continued to exist with regard to the identification of necessary team members and/or teams' justification for not requiring their attendance. Until this is corrected, it will be difficult for the Facility to interpret its data. Also, similar to the findings in the Monitoring Team's previous report, further concerns arose regarding the validity of the data when the Monitoring Team reviewed the information the Facility provided for 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 #145 for whom the Facility's data did not identify the direct support professional or individual as required members, even though the team had; Individual #453 for whom the Facility's data did not identify the day program representative as a required member, even though the team had; and Individual #246, for whom the Facility data showed the psychologist attended, but the sign-in sheet did not). Based on discussion with the QIDP Coordinator as well as observation of the QA/QI Council during the week of the review, these data were presented to the QA/QI Council regularly, and this appeared to be helping. Efforts continued to improve attendance. Based on the sample of 10 ISPs the Monitoring Team reviewed: ▪ For 10 of 10 (100%), at the ISP Preparation Meeting, the team defined the members of the team that should attend the annual meeting.	

#	Provision	Assessment of Status	Compliance
		▪ Nine individuals had strengths, preferences, or needs that potentially required additional team member participation (i.e., the only one that did not was Individual #246, for whom the team had properly identified the required team members). For none of these nine individuals (0%), the team had adequately justified why such team members' participation was not necessary. Those that did not have adequate justification included: Individual #158, Individual #253, Individual #390, Individual #306, Individual #145, Individual #183, Individual #476, Individual #237, and Individual #453. The following concerns were noted: o As justification for not having a team member attend the ISP meeting, teams used phrases such as "assessment is sufficient," or "Not required but will be invited." These were not adequate justifications. 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. o At times, the justification was not sufficient (e.g., for Individual #253, the psychologist was not required to attend with the reason: "Not on BSP," and the SLP was not required to attend with the reason: "No speech/communication equipment." These were not sufficient, because there are many other reasons a psychologist or SLP should participate). o In addition, as noted in the last report, at times, teams left it up to Habilitation Therapies to decide which team member should attend. This was not appropriate. The team should have identified the therapy area(s) in which the individual had needs, and required the attendance of the corresponding therapist. ▪ For none of the individuals (0%), all of the team members that the team identified at the ISP Preparation meeting as required attended the meeting. Those individuals for whom this did not occur included: Individual #158, Individual #246, Individual #253, Individual #390, Individual #306, Individual #145, Individual #183, Individual #476, Individual #237, and Individual #453. ▪ For none of the 10 (0%), it appeared that a duly constituted team participated in the annual meetings. The Facility continued 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. ABSSLC was continuing to identify issues with attendance of identified team members and address them during the QA/QI Council meetings. This appeared to be having an impact in improving	

#	Provision	Assessment of Status	Compliance
		attendance for some disciplines. 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.	In terms of positive steps regarding assessments: ▪ The State Office had developed an Assessment/Report Schedule – Minimum Requirements, dated 10/15/12, which was an attachment to the revised policy. ▪ In reviewing a sample of ISPs, individuals' teams were identifying 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. ▪ The Facility recognized that problems with the timeliness and quality of assessments required attention. As a result, on 7/8/13, at the QA/QI Council meeting, an assessment workgroup was formed. Minutes were included in the Presentation Book for Section F for meetings held on 8/16/13 and 8/28/13. Based on these minutes, the group had discussed some specific action steps, particularly related to timeliness, and also had begun discussions about how to improve quality of assessments, including improving the teams' discussions at ISP Preparation meetings. It was positive that the Facility was focusing attention on this area, and it will be particularly important to identify causes for and mechanisms to improve the quality of assessments. ▪ On 9/5/13, a CAP for the timeliness of submission of assessments prior to the annual ISP meetings was initiated. The stated goal was to improve the timeliness of required assessments to 85% by 11/4/13. It involved the QIDP Department identifying late assessments, notifying the discipline heads of late assessments, and reporting timeliness data to the QA/QI Council. Although it was positive that accountability for timely assessments was part of the plan, based on the minutes of the Assessment Workgroup, it appeared there might have been other factors that needed to be addressed to improve timeliness, such as competing job responsibilities and lack of clarity regarding the window of time in which assessments could be completed. Areas of concern included: ▪ The Facility was tracking the timeliness of assessments. Based on the data generated for assessments filed between 10/1/12 and 10/1/13, 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 15% to 97%, with many falling below 50%. ▪ The validity of the Facility's data related to assessments was questionable, because the Facility did not have a mechanism to ensure that at ISP Preparation meetings, teams identified the necessary set of assessments. As discussed below, in reviewing the sample of 10 ISPs, the Monitoring Team identified	Noncompliance

#	Provision	Assessment of Status	Compliance
		assessments that appeared necessary, and teams had not provided adequate justification for not requiring them. ▪ As the Facility recognized and the Assessment Workgroup had discussed, 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. The Assessment Workgroup had discussed the need to work with specific disciplines. It was positive that at the time of the review, the QIDP Coordinator and Director of Active Treatment reported that work was being done with specific disciplines. For example, an SLP had provided some training on how to use recommendations in Speech and Language (SL) assessments to develop skill acquisition programs. Reportedly, the dialogue during this training was helpful in identifying how some of the SL assessment recommendations were not easy to incorporate into ISPs. ▪ Another issue identified was related to the listing of the individuals' strengths and needs in assessments. Although a number of assessments now listed them, there was little evidence that assessors had incorporated them in meaningful ways in the resulting recommendations. Based on the sample of 10 ISPs: ▪ At the ISP Preparation Meeting, the team defined the assessments that were needed for the annual meeting for 10 (100%). ▪ In reviewing the ISPs for 10 individuals, the teams for two individuals (20%) 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 #246, and Individual #237. For the remaining individuals, they had needs for which assessments were not requested, and the teams did not provide adequate	

#	Provision	Assessment of Status	Compliance
		justification for not requesting assessments. ▪ For none of the 10 (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. For five of the 10 individuals in the sample, some level of review of the incidents was needed (i.e., Individual #306, Individual #183, Individual #390, Individual #246, and Individual #253). However, this often appeared to involve a cursory review of the incidents and allegations, and/or such limited information was provided, that it could not be determined whether or not the team had adequately reviewed the incidents. As a result, 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. The following provide a couple of examples of concerns noted: ▪ Individual #390 had 51 documented injuries and two allegations. The two allegations were not reviewed at all, except to say DFPS investigated them with no results provided. The team did not conduct an analysis of the 51 injuries, and merely stated that the majority of injuries were related to SIB, but he "appears to be doing much better with his PBSP." ▪ For Individual #306, the team indicated there were 11 injuries and "no trends were noted." However, descriptions of the incidents were not provided to determine if this statement was correct. In addition, it appeared that were trends, because the team identified some action steps taken in apparent response to some trends, such as scratches due to a skin condition. However, the action steps were not all incorporated into the IHCPs, so it was not clear the team actually had a plan to address the trends identified. ▪ Individual #183 had 13 non-serious injuries. Although the ISP indicated a BSP was being initiated to address finger biting, no information was provided about the 13 injuries, so it was not clear if this was the only trend that needed to be addressed. Some improvements were seen with the quality of some assessments, and teams were consistently using the ISP Preparation Meeting to identify the assessments needed for the annual ISP meetings. However, more work was needed to improve teams' identification of all necessary assessments, or provide justification for not needing them, as well as improve the timeliness and quality of many assessments. Teams also needed to complete and/or document more thorough analyses of incidents and	

#	Provision	Assessment of Status	Compliance
		allegations/investigations, and incorporate findings from these analyses in ISPs and related action plans.	
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 10 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 should be written in specific, observable, measurable terms to facilitate their inclusion in action plans. On a positive note, as noted above, the Facility recognized the need to work with the disciplines to improve the quality of assessments, as well as the incorporation of assessment results into ISPs and skill acquisition programs. As a result, some collaboration and cross-training had begun to occur. For example, a SLP had provided training on how to incorporate recommendations into skill acquisition programs and ISPs, and this had resulted in some discussion about the need to ensure recommendations in SL assessments were written in a way that facilitated their integration into ISPs. The Facility is encouraged to continue these collaborative efforts and pursue its plan to expand such efforts to other disciplines. In summary, 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.	Noncompliance
F1e	Develop each ISP in accordance with the Americans with Disabilities Act ("ADA"), 42 U.S.C. § 12132 et seq., and the United	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. Based on the review of the sample of 10 ISPs, the following highlights some of the findings:	Noncompliance

#	Provision	Assessment of Status	Compliance
	States Supreme Court's decision in Olmstead v. L.C., 527 U.S. 581 (1999).	▪ 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 10 ISPs reviewed, for none (0%), all of the assessments included the applicable statement/recommendation. Recreation assessments never included a recommendation. Sometimes, dental assessments did not. In addition, for a number of individuals in the sample, assessments either were not submitted or old assessments were included in the packet (i.e., particularly for psychology, and to some extent, habilitation therapy). As a result, information had not been updated, including these recommendations. As also has been stated previously, ISPs did not clearly indicate the recommendations from all disciplines, particularly direct support professionals, residential staff, and the QIDP, who did not complete separate assessments. o Of the 10 ISPs reviewed, none of the individuals had been referred for transition to the community. For these 10 individuals, eight individuals' ISPs (80%) included a clear recommendation from the professionals on the team to the individual and LAR (i.e., those that did not were the teams for Individual #390 and Individual #453). However, for only five of these individuals (50%) was adequate justification provided (i.e., Individual #246, Individual #145, Individual #237, and Individual #476, whose teams recommended transition, but the guardians chose not to pursue transition, and Individual #306, for whom the team recommended transition, but mistakenly thought a guardian was involved, as discussed below). The following provide examples of inadequate justification for teams' conclusions and/or for whom one clear recommendation was not made: ▪ For Individual #390, the discipline members did not make one cohesive recommendation, and the team did not provide adequate justification for the conclusions it drew. Specifically, the team indicated: "The IDT considered all information and preferences identified. Based upon [Individual #390's] assessment recommendations, the facility discipline members determined that [Individual #390] could be served in a less restrictive setting. However, [Individual #390's] BCBA indicated in [Individual #390's] Behavioral Assessment that at this time [he] would not benefit from such an extreme change. He has just transitioned to a new home on campus, and he is	

#	Provision	Assessment of Status	Compliance
		still adjusting to new staff members. He has had a recent spike in target behaviors, and the team members agreed that it could be very dangerous for [Individual #390] to move again so soon because of how severe his SIB can be." This was not consistent with other information provided in the ISP. Although his IRRF indicated that he had had a spike in SIB, no specific data was provided, and the team concluded that he was at medium risk for Behavioral Health. The IRRF stated: "Behavioral data indicates a decreasing trend for SIB. There has been a slight increase in the frequency of SIB in the past 4 months. Level of severity is low. Has not had a serious injury related to SIB since 6/26/12." It also appeared from the IRRF that there were a number of factors that could have led to the "slight increase," including a move to another home, but also a change in programming and a decrease in level of supervision. Also of concern, the assessment off of which this concern was taken was out-of-date (i.e., approximately a year old), and the Behavioral Health Services Specialist was not in attendance at the meeting, despite being a required member of the team. It is unclear how the rest of the team reconciled the recommendations from their assessments with the one included in a year-old psychological assessment. ▪ For Individual #253, although there were discrepancies between the discipline members' recommendations, no reconciliation of these discrepancies was described in the ISP narrative. More specifically, the PCP recommended against community transition, and although the nurse indicated Individual #253 could be supported in the community, the assessment indicated this was with "reservations." A list of supports was then articulated in the nursing assessment that Individual #253 required, many of which were not included in the IHCP. Despite the fact that the remaining team members included recommendations in favor of community transition in their assessments, the discipline members of the team concluded: "The facility discipline members (independent of the resident and LAR/family) determined that [Individual #253] cannot be served in a less restrictive setting at this time. This determination is based on the need for 24-hour nursing and multiple medical concerns. [Individual #253] is not able to express where he wants to live, but the LAR states that they	

#	Provision	Assessment of Status	Compliance
		want [him] to live at the AbSSLC." In addition to this not being independent of the individual and LAR, it did not explain how the majority of team members changed their minds. ▪ The team for Individual #453 made two incongruent statements, and, as a result, it was not clear they had made an independent recommendation to the LAR and individual. The first indicated that Individual #453's supports and services could be provided in a less restrictive setting. The second indicated that: "Without the guardian, there would be no referral today as we are not sure what [Individual #453's] true preferences are." ▪ For Individual #183, although all of the assessments indicated that assessors believed he could be supported in a less restrictive setting, the team concluded: "The Team decided that [Individual #183] cannot be served in less restrictive environment because he requires 24 hour nursing care due medication [sic] administration, severe seizures, and his enteral feedings. Anyone fed via G-tube or receive [sic] medications via G-tube has to have their residual levels checked prior to administration or feedings. Also, if he requires seizure medication that is injectable which should [sic] only be done by a nurse and most group homes do not provide 24 hour nursing staff." No discussion was included in the ISP to reconcile the difference between team members' recommendations in their assessments and this conclusion. In addition, the team's conclusion that he had "severe seizures" and might require an injectable medication for his seizures were not supported in the medical assessment, IRRF, or IHCP. In fact, these documents did not indicate he was prescribed or had used an injectable medication for seizures, and according to the IRRF and IHCP, he had had 15 generalized tonic/clonic seizures ranging between five and 25 seconds. He was being seen by the neurologist every six months, and was prescribed one medication for the control of his seizures. Moreover, supports can be provided to individuals requiring nursing services in community settings, and both individuals with seizures and G-tubes live successfully in community settings, so it was unclear on what the team was basing its conclusion. o In ten of the ten (100%) written ISPs reviewed, a statement regarding the overall decision of the entire IDT, inclusive of the individual and	

#	Provision	Assessment of Status	Compliance
		LAR, was included. However, of these, six (60%) included appropriate justification (i.e., Individual #246, Individual #145, Individual #453, Individual #253, Individual #476, and Individual #237, whose guardians chose not to pursue transition). Examples of concerns included: ▪ For Individual #306, the team chose not to make a referral due to "LAR Choice." However, the Rights Assessment indicated the guardianship had lapsed, so Individual #306 did not have a guardian. Right above the decision not to refer due to LAR Choice, the team had identified the need to pursue guardianship for Individual #306. It appears he should have been referred. ▪ For Individual #158, the discipline members of the team appeared to make two recommendations. The first was that Individual #158 could be supported in a less restrictive setting, and the team indicated that this was based on their assessments. The second was that the entire team including the individual did not recommend referral to the community. On the page prior, the team indicated that the individual could not make decisions and had a Priority Level 1 need for a guardian. In other words, the team and/or Facility Director currently needed to make decisions for Individual #158, so the second recommendation was the discipline members' decision, not the individual's decision. As its reasons for the decision not to make the referral, the team cited the individual's lack of understanding of community living options, and the team stated: "The team feels that while [Individual #158] may do well in the community setting, it is questionable as to whether or not moving to the community would improve her quality of life. The team expressed genuine concerns regarding [Individual #158's] heart defect and how she has responded to stressful situations in the past. The AICD [Automatic Implantable Cardioverter Defibrillator] has shown increased activity during stressful periods, including moves on campus. The team feels that [Individual #158] needs more exposure to community living options and would also like to have the cardiologist's input as to whether or not he feels that [Individual #158] could benefit from moving to a less restrictive environment." No data was provided in the ISP or IRRF to justify the statement that her AICD showed increased activity during stressful periods, nor was it clear why none of	

#	Provision	Assessment of Status	Compliance
		the team members had included this in their assessments and/or recommended against community transition. It also showed a lack of understanding on the team's part about the possibilities of a slow transition that would not result in and "extreme environmental change." ▪ For Individual #390, the team indicated the individual's preferences were not known, but it was not clear whether the individual could express a specific preference with regard to living options. In addition, his father, who was not his guardian, wanted him to remain at ABSSLC. The concerns of the BCBA listed above also were noted as part of the rationale for not making a referral. As discussed above, the data and other information in the IRRF and ISP did not support this position. ▪ Individual #183 is discussed above. ▪ 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. 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 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		

#	Provision	Assessment of Status	Compliance
	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 and strengths. As part of the new ISP process, the Facility had begun to utilize the Preferences and Strengths Inventory. Based on review of the sample of ISP: ▪ All 10 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. As just one of many examples: o Although some of Individual #246's preferences were incorporated into some action steps, they were not used to develop specific methodologies to expand his horizons. For example, he continued to prefer to play in sand, but the team did not document any discussion of the methods or other preferences that would be used to provide him with more functional opportunities. The objective related to expanding his leisure skills beyond playing with sand read: "His parents have reported that	Noncompliance

#	Provision	Assessment of Status	Compliance
		since he was a small child he has preferred playing in sand. Continue to actively participate in activities in and around campus. Continue to offer him more activities to distract him. There will be times that he does go to the sand." This offered staff no specific methodologies, including no description of other preferences that would be built upon, or ways in which his preference for playing with sand could be used in a functional way. ▪ One of the individuals' teams (10%) had effectively incorporated their preferences into related action plans (i.e., Individual #237), 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 loose weight) or to expand individuals' horizons. ▪ None of the individuals' teams (0%) had effectively incorporated their strengths into related action plans. At times, lists of strengths were limited to activities of daily living or communication (e.g., Individual #476 and Individual #253). 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 10 ISPs reviewed (0%) were barriers identified and addressed. The ISP for Individual #453 identified a barrier, but did not include a plan to address it. Specifically, the team identified staffing and transportation as barriers to more community goals/objectives. This was identified in the narrative of the ISP, but no particular plan to overcome it was identified, except to reduce the amount of trips and try to schedule some community trips with her specific friend. Although anecdotally, staff 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 lack of specific skills or capacities as preventing them from participating vocational activities, but teams had not clearly defined such issues as barriers (i.e., the type of work offered on campus and lack of other alternatives were the barriers), and/or implemented plans to address them.	

#	Provision	Assessment of Status	Compliance
		Identification of Supports Needed to Encourage Community Integration Based on a review of individuals' ISPs: ▪ Three of the 10 ISPs (30%) reviewed included specific skill acquisition plans for implementation in the community (i.e., Individual #237, Individual #158, and Individual #253). An additional four individuals had skill acquisition plans that could be implemented in either the community or at the Facility, but there was no requirement that training regularly occur in a community setting (i.e., Individual #246, Individual #453, Individual #390, and Individual #306). ▪ Ten of the 10 individuals' ISPs (100%) included at least one measurable objective to enhance individuals' general participation in the community. Some plans (e.g., Individual #453, Individual #476, Individual #237, Individual #145, and Individual #246) included a number of objectives designed to provide community opportunities. However, some of these were quite limited [e.g., for Individual #145, although a number of objectives were included, many were for a one-time event (e.g., the rodeo, or concert), or were for quarterly outings with his peers; for Individual #158, the only objective was the skill acquisition program related to making a weekly purchase in a store; and Individual #390 only had two action steps that addressed community participation, including one for bowling once in the next year, and one for purchasing ice cream twice in the next year]. Beyond some of the skill acquisition programs that required involvement with community members (e.g., making purchases), none of the goals included in the sample of ISPs were designed to proactively increase individuals' involvement with nondisabled peers in the community (i.e., encourage the development of relationships with nondisabled peers). For one individual, some of the objectives had the potential to do so, but methodologies were not included to promote such interactions. More specifically, Individual #476 had a number of objectives related to community activities (e.g., attending a football game, taking walks in the local park, going out to eat, and playing ball at a local gym). These had the potential to increase his involvement with nondisabled peers, but depending on the skills of the individual, the individual might require training on how to make introductions, request involvement (e.g., in a basketball game at the local gym), etc., and such methodologies were not defined. 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 often 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	

#	Provision	Assessment of Status	Compliance
		comprehensively addressed in action plans. Some of the ISPs reviewed had action plans that addressed community skill acquisition and all had some objective that required some level of community outings or involvement, but they generally did not include methodologies to proactively expand individuals' 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 identified barriers to living in the most integrated setting appropriate to his/her needs;	The action plan section of the ISP was where measurable goals/objectives, the treatments or strategies to be employed, and the necessary supports were to be detailed to attain identified outcomes related to each preference, meet needs, and overcome identified barriers to living in the most integrated setting appropriate to the individual's needs. The following summarizes the findings related to action plans: ▪ None of the 10 plans reviewed (0%) included a full complement of 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 to transition 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 were developing the Integrated Health Care Plans. However, based on observations while on site, it was not clear that teams were reviewing draft IHCPs and making necessary changes to them during ISP meetings. Generally, specific PBSP objectives were not included, and often only a reference was made to implementation of the PBSP. Similarly, psychiatric and medical treatment plans generally were not incorporated into the ISP through the inclusion of measurable goals or objectives. ▪ Clearly, efforts were being made to make ISP action plans and IHCPs more	Noncompliance

#	Provision	Assessment of Status	Compliance
		measurable, but substantially more work was needed in this regard. All plans in the sample included objectives that could not be measured (e.g., for Individual #253, "will participate in music therapy" with the frequency of weekly did not define the expectation for "participation;" for Individual #246, some of the missing measurable objectives included: he had a desensitization plan according to the IRRF, but no measurable objective to determine its effectiveness; he had a PBSP and the objective read: "will have optimal behavioral health as indicated by a decrease in the target behaviors for the next year," but without a baseline, and specific goal, this objective had little meaning. In addition, he had more than one target behavior, and each should be measured separately; and for Individual #390, "will increase the amount of time he works at the workshops" with no baseline provided or delineation of a goal, or in the IHCP, "DSP will also insure proper hand washing is be completed [sic]"). ▪ The plans had begun to include some clinical indicators in the form of 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. For example, in some limited cases, IHCPs included goals/objectives to allow the team to determine whether the individual was improving [e.g., the following goal was measurable, and had a mechanism for measurement: "[Individual #145] will be provided with effective supports to maintain a body temperature of 97.0 or greater." An action step was included for nursing to monitor and record his temperature every shift]. However, in other instances, it was unclear how the goal would be measured, by whom, and/or how often (e.g., for Individual #476, "With supports provided, [Individual #476] will have regular bowel elimination or increase in frequency of bowel movements with no increase in GI symptoms as evidenced by a decrease in episodes of constipation throughout the year." Given that little data was included in the IRRF, including few specifics about these issues (e.g., number of episodes of constipation in the year with only some information for last three months, number of "GI symptoms," etc.), it was not clear how the team was planning to determine if there was a decrease;" for Individual #145, "All staff will follow safety precautions and gentle handling techniques at all times..." with no monitoring frequency provided, or "[Individual #145] will continue with an ambulation program as noted by Habilitation Therapies" with no measurable objective to determine success of the program set forth; and for Individual #453, one example of an objective that was not measureable was: "will show improvement on ambulation with strengthening," with no baseline and no definition of how "improvement" would be measured). ▪ Of ongoing concern, the objectives or actions steps for vocational and day program activities were extremely limited, and usually related to attending	

#	Provision	Assessment of Status	Compliance
		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. ▪ 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 (e.g., the IHCP for Individual #145 included a considerable number of action steps. However, many of them were reiterations of the nursing protocols without individualization, and the nursing protocols were generally being used reactively as opposed to proactively). ▪ In most plans, objectives were not seen in relation to staff training requirements. 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., medical treatment plans, PBSP, psychiatric treatment plans, desensitization plans, respiratory therapy plans, walking plans, etc.) in a measurable way into the ISPs, through, for example, measurable objectives was generally not seen. Although the PNMPs and PBSPs were sometimes identified in action 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 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	Noncompliance

#	Provision	Assessment of Status	Compliance
		the IRRF. Disturbingly, when supports were discussed as necessary for risk factors rated as low, the team did not include these in action plans. ▪ 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. ▪ Rights restrictions were another area in which very limited action plans were identified to assist in potentially reducing the need for the restriction. None of the 10 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. Some limited improvements were seen. However, as noted above, teams will need additional coaching and mentoring to 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 10 ISPs (0%), action plans included adequate timeframes for completion. ▪ For none of the 10 ISPs (0%), the roles of the persons identified as responsible were clearly defined. This most recent review showed some improvement, and as noted above, it was clear that efforts were being made to improve the measurability of action plans. However, the following summarizes some of the problems noted: ▪ Often two positions were identified as responsible for the completion of action steps, but it was not clear who was responsible for what. ▪ Although some improvement was seen, the use of terms such as "as scheduled" or "as requested" sometimes continued to be used as the timeframe for completion or frequency. These generally were not sufficient to make the objectives measurable and/or clearly define staff's responsibilities. Timeframes that clearly should be known based on the teams' discussion of the IRRFs were not included, such as "will attend dental as requested." ▪ In other cases, timeframes were missing for the frequency of review. For example, in many ISPs, a number of action steps required direct support professionals and nursing staff to "monitor for signs and symptoms of..." However, a frequency was not provided and the location of documentation was	Noncompliance

#	Provision	Assessment of Status	Compliance
		listed as something like: "acute issues will be addressed and documentation in IPN will be completed." As a result, the frequency of monitoring was unclear, and it was not clear how the team would know that proactive monitoring was occurring. ▪ In IHCPs, in some very limited cases, overall goals now included measurable indicators to allow measurement of an individual's status. However, the methods for measuring or the staff responsible for measuring them generally were not provided. ▪ 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. ▪ Although persons responsible generally were identified, many steps were missing, so it was unclear who was responsible for specifics such as wheelchair/adaptive equipment maintenance, role of Respiratory Therapist, etc. ▪ 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 10 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, and in many cases, no methodology was provided at all [e.g., for Individual #246, an objective related to expanding his leisure skills beyond playing with sand read: "His parents have reported that since he was a small child he has preferred playing in sand. Continue to actively participate in activities in and around campus. Continue to offer him more activities to distract him. There will be times that he does go to the sand." This offered staff no specific methodologies. Similarly, although it was positive that the team was trying to expand his vocational opportunities, the following did not set forth a	

#	Provision	Assessment of Status	Compliance
		methodology: "[Individual #246] will continue to experience Vocational Training to make new relationships;" for Individual #145, methods were frequently included, but some were completely missing (e.g., BSP), or not defined (e.g., walking program); for Individual #476, direct support professionals and nursing staff were to "Observe for abdominal distention or rigidity," and "observe for edema at the stoma." In addition to not identifying how direct support professionals would be trained to do this, the IHCP did not define whether or not nursing and/or direct support professionals would have different responsibilities (e.g., would nursing staff be expected to actually measure abdominal girth on a specific schedule, would each shift of direct support professionals be expected to proactively "observe" and if so, what were they to report to they nurse) and beyond "daily" what was the frequency with which observations and reporting would occur (e.g., each shift, at a particular time of day, several times each shift, etc.); and for Individual #390, the methods were often missing, for example, with ISP action plan: "will increase the amount of time he works at the workshops," it was not clear how this would be accomplished]. ▪ Methodologies were often reactive as opposed to proactive. For example, nursing protocols were to be implemented: "when signs and symptoms of respiratory distress, gastrointestinal issues, etc. are reported," as opposed to using nursing protocols proactively. Parameters often were provided for signs and symptoms of illness that should be reported to the PCP, or for other actions that should be taken. In addition, most often, the etiology of the healthcare concern was missing, so it was unclear what steps reasonably could have assisted with these risk areas. ▪ 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,	All plans included some practical and functional interventions. In fact, the vast majority	Noncompliance

#	Provision	Assessment of Status	Compliance
	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	of skill acquisition plans identified functional skills to be taught. Some examples included training on the washing hands, bathing, tooth brushing, making purchases, etc. However, many of the same skill acquisition programs were found in multiple ISPs, and as discussed above, information was not found in the ISPs or ISP Preparation documentation to show why one skill over another was selected for each individual. As a result, it was difficult to determine if these training programs were individualized to improve functional skills that were meaningful for the individual. None of the 10 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 the lack of inclusion in ISPs of plans to address conditions that placed individuals at-risk, psychiatric treatment plans, nursing care plans, OT/PT treatment plans, speech therapy 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. One of the 10 plans reviewed included a goal related to cooking (i.e., the plan for Individual #237). 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. Individual #246 had a pedestrian safety skill that could be taught in either the community or at the Facility. 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.	

#	Provision	Assessment of Status	Compliance
	6. Identifies the data to be collected and/or documentation to be maintained and the frequency of data collection in order to permit the objective analysis of the individual's progress, the person(s) responsible for the data collection, and the person(s) responsible for the data review.	Based on the review of the sample of ISPs: ▪ None of the 10 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 collection, but not the specific person responsible or 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," did not identify the "Frequency of Review," and often only identified the discipline, and not the title of the person responsible for review (e.g., Nursing, as opposed to RN Case Manager; or "Habilitation Therapies" versus the OT, PT, or SLP). In addition, often times, more than one person/entity was responsible for review of progress and efficacy, and it was unclear who was responsible for what. It also was not clear where these reviews would be documented. 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 the IHCPs often required the collection of some data, very little data was identified that would tell the team whether or not the individual was doing better or worse or remaining stable. As just one example of many, for Individual #253, the overall goals in the IHCP were no episodes of aspiration, and no fractures or other serious injuries and "maintain optimal levels of Vitamin D." In addition to providing no mechanism to determine a change in status other than when a hospitalization, or serious illness or injury occurred. Goals should be based on baseline measurements and should be individualized. They also should provide teams with a mechanism to measure the individual's status, before a significant event occurs, such as a hospitalization or fracture. Based on the Monitoring Team's observations of ISPs during the onsite review, particularly for clinical plans (i.e., IHCPs, PBSPs, counseling plans, therapy plans, etc.), teams did not discuss the data to be collected or reviewed, or the frequency of review. For example, at the ISP meeting for Individual #180, the IHCPs were not specifically discussed, so the team did not review and modify drafts, or work out the details of the data that would be collected, and who would be responsible for its collection and review. 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	Noncompliance

#	Provision	Assessment of Status	Compliance
		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. Although teams were using some data to inform the at-risk discussions, data continued to be missing from these discussions. In addition, 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; 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 the Effective Date hereof and with full implementation within two years, the Facility shall ensure that each ISP is accessible and comprehensible to the staff responsible for implementing it.	DADS Policy #004.1 at I.C.22 required the ISP to be accessible and comprehensible to staff who must implement it. At the time of the review, the ISP was located on the residential unit, but locked in a cabinet or office for security reasons. Given privacy and security requirements, this was appropriate. It appeared that if staff needed access to the locked records, a key was easily available. Individual Notebooks were available that included some of the key components of the ISP that direct support professionals might need to quickly access, such as skill acquisition plans. 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 16 ISPs reviewed, ISPs were found to have been written in the Flesch-Kincaid Readability Level range of 8.9 to 11.4, with an average score of 10.24… ISPs are written in a manner that may be difficult for staff to comprehend, as plans are being written at a higher grade level than the hiring requirements." The Facility was working on ways to meet an appropriate reading level, while maintaining the necessary	Noncompliance

#	Provision	Assessment of Status	Compliance
		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 staff recognized the need to ensure training occurred for all of the various components of the ISPs, including placing more focused efforts on training direct support professionals on the ISP action plans and skill acquisition plans, with a focus on what their specific responsibilities were. Tracking systems for these training requirements also were needed. 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 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	DADS Policy #004 at III.A addressed individual support plan monitoring. This included the requirements of the Settlement Agreement for monthly reviews and action, as appropriate. It required that within 10 calendar days after the end of the review period, the monthly reports would be filed in the individual's record. Monthly reviews were being completed more consistently than in past reviews. More specifically: ▪ Based on the sample of 10 records, five (50%) had timely monthly reviews each month for the previous three months. This included: Individual #183, Individual #158, Individual #145, Individual #246, and Individual #253. ▪ For none of the monthly reviews completed (0%), the responsible 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 QIDPs' review of skill acquisition programs, other service	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	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 four of the 10 individuals, a lack of expected progress was noted requiring action. For none of the four (0%) did it appear action was taken, and/or that the actions were sufficient to be reasonably expected to remedy the issues. For example: o For Individual #253, when the reports indicated that supports that should have been implemented had not (e.g., shopping trips consecutively for three months), no action was noted. o For Individual #145, the follow-up was difficult to follow. One indication was provided that a SAP had been modified. Another note was included that at an upcoming ISP meeting, the SAPs for which no progression had been noted would be discussed. However, based on the Monitoring Team's review of the ISP document, related changes did not appear to have occurred. For several action steps that had not been implemented effectively, the team just continued them into the next year without discussing what would change to improve implementation (e.g., writing to sister). o For Individual #390, no action was documented when the ISP was not being implemented as written (e.g., community outings). o For Individual #183, it appeared the QIDP intended to take action in response to monthly review findings for action plans that were not implemented (e.g., community activities). The statement was made "will be rescheduled." However, across the three months, no action was documented as having been taken to effectively reschedule the activities, and as a result, the ISP action step was not implemented as written. As noted above, the reviews conducted did not comprehensively address all action plans included in individuals' ISPs. Therefore, it remained unclear if additional 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 summarize the data and provide a description/analysis of the data, so it is clear to the reader what the data means.	

#	Provision	Assessment of Status	Compliance
		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 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.	Previous reports have described training ABSSLC staff underwent with regard to the ISP process. Highlights 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 during the Monitoring Team's last review, it was first developed in July 2010, rolled out at ABSSLC in October 2010, and new employees continued to attend the training. ▪ The Q Construction: Facilitating for Success training was still provided to new QIDPs. This training included a written test that each participant completed at the end of the classroom training. It also included a competency checklist. However, the QIDP Coordinator indicated that this competency checklist was no longer used. This is discussed in further detail below. ▪ ABSSLC was in the process of developing/updating training for the Facilitator QIDPs, as well as the Home QIDPs. Drafts were submitted of both of these training itineraries, as well as a Table of Contents of a procedure manual. ▪ A QIDP Educator was part of the QIDP Department, and available to provide training to new QIDPs, as well as provide training and ongoing technical assistance to QIDPs. Areas in which additional work was needed to reach compliance with the Settlement Agreement included: ▪ As indicated in previous reports, QIDPs 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. The Facility submitted a list of four QIDPs that had been deemed competent in meeting facilitation. However, in discussing the methodology used, the QIDP Coordinator described a process whereby QIDPs were assessed based on a list of characteristics believed to be necessary for good facilitation of meetings. This list included: interactions professional, communication skills – verbal, communication skills – written, time management, "demonstrates [sic] of ISP process," consistently creative, flexible, demonstrates organization, and current in caseload. These were broken down	Noncompliance

#	Provision	Assessment of Status	Compliance
		into essential abilities and additional abilities, and the scores for these two categories were totaled separately. When asked what standards or criteria were used for each of the categories to ensure the results could be replicated consistently and used to identify specific skills or competencies that needed improvement, Facility staff agreed that more work was needed to develop an actual checklist of skills (i.e., a competency checklist). As discussed, using the current monitoring tool as a place to start would make sense. However, the specific responsibilities for the Facilitator QIDP would need to be identified in terms of facilitation and documentation, and separated from responsibilities of the team as a whole. Other indicators might need to be added. ▪ Competency measures for other team members also should be identified and 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 a step that recently had begun was holding monthly meetings with the Facilitator QIDPs to work on improving the creation of meaningful, measurable, and observable 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." As discussed above, this was an area requiring focused efforts, particularly in ensuring direct support professionals had training on the portions of plans for which they were responsible. ▪ The Facility's action plans indicated that they had begun to contact other SSLCs to identify potential resources for annual refresher training on the ISP process. 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, Facilitator QIDPs' competence with meeting facilitation as well as the development of the ISP documents should be assessed using a standardized tool that is valid and reliable, and the Facility should ensure that staff responsible for the implementation of the plans successfully complete competency-based training. In addition, the Facility should complete its search for curricula to provide annual refresher training on ISPs	

#	Provision	Assessment of Status	Compliance
		commensurate with their duties, as the Settlement Agreement requires.	
F2f	Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall prepare an ISP for each individual within thirty days of admission. The ISP shall be revised annually and more often as needed, and shall be put into effect within thirty days of its preparation, unless, because of extraordinary circumstances, the Facility Superintendent grants a written extension.	Based on data the Facility provided, between April 2013 and September 2013, 12 individuals had been admitted or readmitted to the Facility. All 12 individuals' 30-day ISP meetings (100%) had been held within 30 days of their admission. Based on data the Facility provided, 381 ISP meetings were held over the last one-year period. One ISP meeting occurred after the 365-day timeline, and it was only one day late. This resulted in a compliance rate of slightly less than 100%. The Facility tracked the dates that ISPs were completed and filed. For the last one-year period, of the 381 ISP meetings held, 117 of the plans were filed more than 30 days after the ISP meeting. An additional four ISPs did not have the file date stamped on them. The compliance rate was approximately 68%. On 9/5/13, the Facility had begun implementation of a CAP to address filing of ISPs in the record within 30 days. In addition to action steps related to the logistics of filing the ISPs, as discussed above, the Facility had assigned Facilitator QIDPs and Home QIDPs. Beginning in September 2013, the Facilitator QIDPs became responsible for facilitating the ISP meetings, and finalizing the ISP documents. According to the QIDP Coordinator, in August 2013, the compliance rates for filing ISPs within 30 days was 75%, and in September 2013, with the introduction of the Facilitator QIDPs, it improved to 92%. 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. As noted in the past report, he 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. In addition, Facility staff recognized the need to train staff on the implementation of ISPs. Some of this already was in process through various disciplines' efforts. However, a process was needed to train staff on some of the components of ISP action plans and IHCPs that were not captured in other training. A system also was needed for documenting which staff had been trained on which individuals' ISPs. As is noted in other sections of this report, IDTs did not consistently meet or make needed 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 had made progress in the month prior to the Monitoring Team's onsite review in terms of the timeliness of the completion and filing ISPs. However, it remained	Noncompliance

#	Provision	Assessment of Status	Compliance
		out of compliance with this provision. The Facility needed to ensure implementation began in 30 days, and make changes to ISPs as dictated by individuals' needs. The Facility was working to develop and implement a system to train staff on the necessary components of the ISPs, and track this training.	
F2g	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall develop and implement quality assurance processes that identify and remediate problems to ensure that the ISPs are developed and implemented consistent with the provisions of this section.	Progress had been sustained with regard to the implementation of quality assurance processes that identify and remediate problems to ensure that ISPs are developed and implemented 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. ▪ A Program Compliance Monitor (PCM) from the QA Department, as well as the QIDP Coordinator, QIDP Educator, and QIDP Settlement Agreement Liaison were conducting the reviews. At the time of the review, the PCM selected a sample of four ISP meetings per month with the goal of monitoring each Facilitator QIDP once per month. 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. ▪ ABSSLC had continued to revise its monitoring/audit tools for Section F. At the time of the review, ABSSLC was using a revised version of the Section F: Integrated Protections, Services, Treatments, and Supports audit tool, dated 6/4/13. This audit tool focused on facilitation and documentation requirements, and required the auditor to attend the ISP meeting, and review the ISP document. ▪ 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. This information was being shared with the QA/QI Council. ▪ The PCM continued to complete a QA/QI Data Summary, and the QIDP Coordinator also presented a summary on a quarterly basis to the QA/QI Council. Documentation of each for the previous two quarters was submitted for review. Based on data collected through monitoring, both identified issues that required attention. As discussed during the onsite review, Facility staff expected the initiation of the use of Facilitator QIDPs, and delineation of responsibilities of Facilitator QIDPs and Home QIDPs would address some of the issues, including the underlying issue related to high turnover and the need for fairly constant re-training. At the time of the Monitoring Team's onsite review, it was too early in the process to determine if this potential solution would be successful. ▪ As discussed in relevant sections above, in early September 2013, the QA/QI	Noncompliance

#	Provision	Assessment of Status	Compliance
		Council had initiated Corrective Action Plans related to the timely completion and filing of ISPs, and the timely submission of assessments. These CAPs were still being implemented, but it was positive that the QA/QI Council had focused on these areas. 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 – Integrated Protections, Services, Treatments, and Supports audit tool. 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 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. According to the QA/QI Summary, dated 9/11/13, there had been challenges completing side-by-side monitoring of the assigned ISP meetings due to scheduling conflicts. ▪ 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 Section F, dated 7/2/13 and 9/11/12; as well as Quarterly Section Review of Progress Section F, dated 4/8/13, and 7/8/13. On a positive note, the QA/QI Data Summaries summarized data from both the QIDP 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	

#	Provision	Assessment of Status	Compliance
		included some broad recommendations, such as continuing to meet to address inter-rater reliability, and developing corrective action plans to address deficient areas. However, the report dated 9/11/13 included some more specific recommendations, such as making data on community involvement available to teams to make their discussion of this subject more meaningful, and focusing efforts on developing measurable action plans. ▪ 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 had been made since the last review, the Facility remained out of compliance with this provision. It was positive that data was being collected, and some 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.	

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 For one individual from each residence, copies of all consultant reports (medicine and surgery inclusive of subspecialties) since the Monitoring Team's last visit and all integrated progress notes (IPN) commenting on consultant reports (agreeing or reason not agreeing) and any ISP addendum related to the consultant report: Individual #530 Optometry 4/10/13, Individual #530 Endocrinology 4/26/13, Individual #530 Endocrinology 7/15/13, Individual #159 Rheumatology 4/23/13, Individual #159 Rheumatology 9/12/13, Individual #159 Podiatry 8/20/13, Individual #159 Rheumatology 6/12/13, Individual #159 4/8/13, Individual #87 Optometry 6/12/13, Individual #234 Dermatology 7/31/13, Individual #234 Dermatology 5/15/13, Individual #234 Podiatry 9/17/13, Individual #234 Podiatry 8/20/13, Individual #234 Podiatry 6/17/13, Individual #234 Gastroenterology 6/26/13, Individual #192 Neurology 7/8/13, Individual #192 Neurology 6/24/13, Individual #192 Optometry 4/10/13, Individual #192 Urology 5/3/13, Individual #18 Neurology 6/27/13, Individual #18 Hematology Oncology 8/29/13, Individual #18 Hematology Oncology 8/6/13, Individual #18 Podiatry 4/16/13, Individual #330 Cardiology 9/13/13, Individual #330 Optometry 7/10/13, Individual #330 Podiatry 8/20/13, Individual #368 Urology 7/5/13, Individual #368 Urology 5/3/13, Individual #368 Urology 9/6/13, Individual #368 Neurology 6/10/13, Individual #368 Podiatry 8/20/13, Individual #349 Hematology Oncology 4/18/13, Individual #349 Hematology Oncology 7/11/13, Individual #349 Iron Infusion 8/6/13, Individual #349 Hematology Oncology 8/26/13, Individual #349 Neurology 6/27/13, Individual #349 Optometry 9/11/13, Individual #349 Hematology Oncology 4/4/13, Individual #507 Optometry 9/11/13, Individual #464 Gastroenterology 7/23/13, Individual #464 Neurology 8/26/13, Individual #354 Neurology 8/12/13, Individual #354 Optometry 8/14/13, Individual #447 Neurology 9/9/13, Individual #447 Podiatry 5/21/13, Individual #447 Podiatry 9/17/13, Individual #447 Urology 4/5/13, Individual #287 Cardiology 7/1/13, Individual #377 Gastroenterology 8/26/13, Individual #377 Neurology 8/12/13, Individual #377 Neurology 7/22/13, Individual #377 General Surgery 7/10/13, Individual #377 General Surgery 5/29/13, Individual #377 Neurology 7/8/13, Individual #377 Dermatology 4/17/13, Individual #377 Optometry 4/10/13, Individual #19 Neurology 8/12/13, Individual #19 Neurology 6/10/13, Individual #19 Podiatry 7/16/13, Individual #19 Urology 5/3/13, Individual #19 Neurology 9/9/13, Individual #157 Pacemaker clinic 9/16/13, Individual #157 Hematology Oncology 8/26/13, Individual #157 Neurology 5/23/13, Individual #157 Optometry 4/10/13, Individual #353 Podiatry 9/17/13, Individual #353 Podiatry 6/18/13, Individual #353 Podiatry 4/16/13, Individual #353 Neurology 4/25/13, Individual #353 Wound care 5/30/13, Individual #353 Wound care 5/15/13, Individual #353 Wound care 5/8/13, Individual #61 Gynecologic Oncology 8/7/13, Individual #61 Neurology 8/12/13,

	Individual #61 Hematology Oncology 7/30/13, Individual #74 Neurology 7/8/13, Individual #74 Podiatry 8/20/13, Individual #74 Podiatry 7/16/13, Individual #74 Optometry 4/10/13, Individual #74 Otolaryngology 4/12/13, Individual #74 Otolaryngology 6/4/13, Individual #74 Otolaryngology 9/24/13, Individual #74 Optometry 4/10/13, Individual #230 General Surgery 5/9/13, Individual #230 Surgery 6/24/13, Individual #230 Gastroenterology 6/11/13, Individual #230 Surgery 8/28/13, Individual #230 Otolaryngology 5/14/13, Individual #230 Neurology 4/11/13, Individual #437 Podiatry 4/16/13, Individual #437 Neurology 4/11/13, Individual #437 Optometry 9/11/13, Individual #437 Rheumatology 7/23/13, and Individual #437 Rheumatology 6/14/13. ▪ **Interviews with**: o Richard Chengson, MD, Medical Director; o Edward Craig, MD, Settlement Agreement Compliance Physician; and o Elizabeth Greer, RN, Medical Program Compliance Nurse.
	Facility Self-Assessment: Based on the agreement of the parties, a modified review was conducted of Section G. The Monitoring Team only reviewed the Facility's status with regard to Section G.2. In the Facility's Self-Assessment, dated 10/21/13, the Facility found itself to be in noncompliance with Section G.2. This was consistent with the Monitoring Team's finding for this subsection. However, the basis for the finding was different. The Facility looked at results of internal general medical audits. In the Self-Assessment, the Facility combined two scores (i.e., one for timely review of consultations, and one for documentation of reasons for any disagreement). This was not helpful in determining where the problems existed. In addition, the Facility did not look at the other indicators necessary to determine compliance with Section G.2, such as the determination of whether to refer the recommendations to the IDT, and whether, as appropriate, the recommendations were integrated with existing supports and services. The Facility should review the indicators included in the Monitoring Team's report to identify additional areas where review/auditing is necessary.
	Summary of Monitor's Assessment: Based on the Monitoring Team's limited review of only Section G.2, primary care practitioners were generally reviewing and documenting their review of consultation reports. However, Integrated Progress Notes were not consistently found with documentation of the PCP's agreement or disagreement with the recommendations. The Facility also needed a system to determine for which consultation reports the interdisciplinary team needed to complete a follow-up Individual Support Plan Addenda, and which reports the IDTs needed to review to ensure they had updated information.

#	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	The parties agreed the Monitoring Team would not monitor this provision, because the Facility had made limited to no progress. The noncompliance finding from the last review stands.	Noncompliance

#	Provision	Assessment of Status	Compliance
	integrated clinical services (i.e., general medicine, psychology, psychiatry, nursing, dentistry, pharmacy, physical therapy, speech therapy, dietary, and occupational therapy) to ensure that individuals receive the clinical services they need.		
G2	Commencing within six months of the Effective Date hereof and with full implementation within two years, the appropriate clinician shall review recommendations from non-Facility clinicians. The review and documentation shall include whether or not to adopt the recommendations or whether to refer the recommendations to the IDT for integration with existing supports and services.	The Facility submitted consultant reports for one individual from each residence, as well as any Integrated Progress Notes commenting on the consultant reports. Consultations for 23 individuals were submitted, with a range of one to eight consultations per individual. A total of 94 consultant reports were submitted. These are listed above in the documents reviewed section. Review of these documents revealed the following: ▪ Of the 94 reviewed, 89 (95%) included the PCP's initials, indicating review by the PCP. ▪ Of the 94 reviewed, 90 (96%) included the date on which the PCP conducted the review. ▪ To determine whether there was agreement or not concerning consultant recommendations, follow-up IPNs and Individual Support Plan Addendums (ISPAs) were requested. When submitted, these were reviewed. Of the 94 reviewed, no recommendation was made for one consultation. Of the remaining 93 consultations, 76 (82%) consults included documentation of agreement or not with the consultant recommendations. ▪ Of these 94, 75 (80%) included PCP IPN entries. o Of these 94, eight indicated no need for an Interdisciplinary Team meeting. Two indicated the need for an IDT to meet. o No information was provided whether or not an IDT meeting and/or ISPA were needed for 84 consultations. o There was no information to determine if the IDT members had reviewed the content of the consultations to ensure team members were updated. o Of these, zero ISPAs documented the discussion of the contents of the consultant reports, and the PCP's recommendation. It is recommended that a system be in place to determine which consultation reports need a follow-up ISPA, and which need only to be reviewed by the IDT for updated information. Tracking of this process would ensure it is in place. The Facility remained in noncompliance with this provision.	Noncompliance

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 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 #9, Individual #117, Individual #21, Individual #110, Individual #86, Individual #444, Individual #94, Individual #530, Individual #264, Individual #388, Individual #289, Individual #426, Individual #54, Individual #409, Individual #349, Individual #414, Individual #55, Individual #214, Individual #139, and Individual #431; and 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) Human Rights Committee (HRC) section; and p) documentation and consultations regarding the use of pre-treatment sedation medication (i.e., Treatment Plan, guardian approval, HRC approval, etc.), for the following individuals: • The Facility selected the records of the following nine individuals and submitted them as part of the pre-review document request: Individual #320, Individual #518, Individual #461, Individual #168, Individual #355, Individual #462, Individual #478, Individual #460, and Individual #4; and • During the onsite review, a member of the Monitoring Team selected the following 16 individuals: Individual #51, Individual #247, Individual #146, Individual #201, Individual #468, Individual #2, Individual #323, Individual #216, Individual, #94, Individual #471; Individual #207, Individual #278, Individual #147, Individual #463, Individual #284, and Individual #170. ▪ **Interviews with**: o Richard Chengson, MD, Medical Director; o Edward Craig, MD, Settlement Agreement Compliance Physician; and o Elizabeth Greer, RN, Medical Program Compliance Nurse.
	Facility Self-Assessment: Based on the agreement of the parties, a modified review was conducted of Section H. The Monitoring Team only reviewed the Facility's status with regard to Section H.2. In the Facility's Self-Assessment, dated 10/21/13, the Facility found itself to be in substantial compliance with

	Section H.2. This was consistent with the Monitoring Team's finding for this subsection. The Facility Self-Assessment also documented that the Facility had used essentially identical methodologies to that of the Monitoring Team in conducting its review.
	Summary of Monitor's Assessment: Based on the Monitoring Team's limited review of Section H, the Facility remained in substantial compliance with Section H.2, which required diagnoses to clinically fit the assessments/evaluations, and be consistent with current diagnostic criteria. The Facility was found to be in substantial compliance for both medical and psychiatric diagnoses.

#	Provision	Assessment of Status	Compliance
H1	Commencing within six months of the Effective Date hereof and with full implementation within two years, assessments or evaluations shall be performed on a regular basis and in response to developments or changes in an individual's status to ensure the timely detection of individuals' needs.	The parties agreed the Monitoring Team would not monitor this provision, because the Facility had made limited to no progress. The noncompliance finding from the last review stands.	Noncompliance
H2	Commencing within six months of the Effective Date hereof and with full implementation within one year, diagnoses shall clinically fit the corresponding assessments or evaluations and shall be consistent with the current version of the Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems.	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. The PCPs were asked to provide the criteria or evidence ensuring the diagnoses clinically fit the information in the corresponding assessments or evaluations. Evidence was provided through various sources (e.g., consultant reports, test reports, etc.). Four significant diagnoses were submitted for each of 20 individuals. This was a total of 80 diagnoses. For 80 of 80 (100%) diagnoses submitted, the criteria listed and documentation provided were consistent with the diagnosis listed. Although not a requirement for compliance, the Facility documented that there was no in-service provided to the PCPs concerning International Classification of Diseases (ICD) and Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR) diagnostic criteria in the prior six months. 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 25 of the 25 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 maintained the	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		improvements in its diagnostic practices related to psychiatric disorders. The Facility remained 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.	The parties agreed the Monitoring Team would not monitor this provision, because the Facility had made limited to no progress. The noncompliance finding from the last review stands.	Noncompliance
H4	Commencing within six months of the Effective Date hereof and with full implementation within two years, clinical indicators of the efficacy of treatments and interventions shall be determined in a clinically justified manner.	The parties agreed the Monitoring Team would not monitor this provision, because the Facility had made limited to no progress. The noncompliance finding from the last review stands.	Noncompliance
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.	The parties agreed the Monitoring Team would not monitor this provision, because the Facility had made limited to no progress. The noncompliance finding from the last review stands.	Noncompliance
H6	Commencing within six months of the Effective Date hereof and with full implementation within two years, treatments and interventions shall be modified in response to clinical indicators.	The parties agreed the Monitoring Team would not monitor this provision, because the Facility had made limited to no progress. The noncompliance finding from the last review stands.	Noncompliance
H7	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall establish and implement integrated clinical services policies, procedures, and guidelines to implement the provisions of Section H.	The parties agreed the Monitoring Team would not monitor this provision, because the Facility had made limited to no progress. The noncompliance finding from the last review stands.	Noncompliance

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 #216, and Individual #429 for aspiration; Individual #479 for dental issues; Individual #545 for constipation; Individual #139, and Individual #8 for cardiac issues; Individual #245, and Individual #37 for weight issues; and Individual #311, and Individual #285 for urinary tract infections; 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 IPN, past one year of lab results, x-rays, scans, MRIs, ultrasound reports, hospital discharge summaries for past one year, ER report for past one year, consults and procedure reports for past one year, Do Not Resuscitate (DNR) forms if applicable, physician orders for past one year, most recent ISP and subsequent addendums, most recent BSP, past three medical quarterly reviews, integrated risk rating forms for past one year, risk action plans for past one year for the following individuals: Individual #27, Individual #162, Individual #212, Individual #140, Individual #382, Individual #297, Individual #378, Individual #385, Individual #515, Individual #452, Individual #435, and Individual #236; o Annual Assessments Filed 10 Days Prior to ISP by Assessment data; o Compliance per Individual-Annual Assessment data; o ISP Required Attendance Compliance data; o Facilitation QIDP Check Sheet for the Individual Support Plan Process form; and o QA/QI Quarterly Section Review of Settlement Agreement Progress Section I: At Risk Individuals meeting minutes, dated 9/16/13. ▪ **Interviews with**: o Amy Jo Bramlett, LVN, At-Risk Coordinator; and o Mary White, RN, MSN, Chief Nurse Executive. ▪ **Observations of**: o ISP Meeting for Individual #397, on 11/5/13; o ISP Meetings for Individual #176 and Individual #77, on 11/6/13; and o ISP Meeting for Individual #180 and Individual #233, on 11/7/13.
	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 some of its monitoring tools for Section I. In doing so, the Facility had included many of the provisions of the Settlement Agreement for the different subsections of Section I. Based on a review of the Facility's Self-Assessment: o Many of the indicators the Facility used for this section were in alignment with the Monitoring Team's indicators. This was a significant improvement from the last review. 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, especially those addressing the quality of the documentation. 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. o 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.) was provided for the Facility's Self-Assessment data in most areas. 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. o 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 that a number of disciplines conducted 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. o 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, 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. o The Facility needs to be clear regarding what specific criteria were 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. o The quality of the supports provided to individuals and the documentation should be audited and not just 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 address 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 indicated that a new Section Lead had been designated for Section I. In addition, an Assessment Workgroup was established to focus on improving the timeliness and quality of the discipline assessments. The Facility's documentation indicated that the Workgroup conducted a time study in order to identify issues/barriers that the different disciplines might be experiencing that hampered assessments from being completed timely. At the time of the review, the Assessment Workgroup had completed the time study. However, the data had not yet been analyzed nor recommendations developed. In addition, since the last review, the Facility had spent considerable time assessing its compliance with the At Risk policy and had identified a number of areas that were in need of attention, such as misunderstandings of the At Risk policy, communication deficits between departments, and the lack of review by IDT members regarding the IRRFs and IHCPs within 14 days after the ISP. As the Facility works through these issues, it is recommended that attention be paid to the implementation of the IHCPs to ensure individuals receive the needed care determined by the teams. In September 2013, the Facility restructured the QIDP Department by designating four QIDPs as Facilitators with caseloads of approximately 95 individuals for whom they were responsible for developing their ISPs. These Facilitator QIDPs worked with the Home QIDPs, but had primary responsibility for the ISP preparation meetings, as well as populating the ISP guide 10 days prior to the ISP meeting, and facilitating the ISP meeting. The Facility reported that since the initiation of the QIDP Facilitators, compliance regarding filing the ISPs in the record 30 days after the ISP meeting had increased from 65% to 92%. Regarding the Facility's auditing for Section I, the Monitoring Team noted that the Facility had incorporated many of the indicators the Monitoring Team used for this area, and noted a number of the Facility's findings were in alignment with the findings of the Monitoring Team. The Facility clearly had invested a great deal of effort in reviewing the requirements and their overall systems regarding the At-Risk system at ABSSLC. However, the lack of clear documentation included in the ISPs, IRRFs, IHCPs, and the associated disciplines' assessments regarding what actions were taken in response to pertinent events or health issues, and the lack of dates and supporting documentation addressing actions and completion of action plans made it difficult to sequentially follow the assessment

	and action plan processes. Consequently at the time of the review, the Facility's efforts had not yet translated into any consistent measurable progress. 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 plans with 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.

#	Provision	Assessment of Status	Compliance
I1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, each Facility shall implement a regular risk screening, assessment and management system to identify individuals whose health or well-being is at risk.	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., a smaller sample) for this subsection, because the Facility had made limited progress, due to turnover in leadership. The noncompliance finding from the last review stands. 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. 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: ▪ The Facility indicated that a new Section Lead had been designated for Section I. ▪ In addition, an Assessment Workgroup was established to focus on improving the timeliness and quality of the discipline assessments. The Facility's documentation indicated that the Workgroup conducted a time study in order to identify issues/barriers that the different disciplines might be experiencing that hampered assessments from being completed timely. At the time of the review, the Assessment Workgroup had completed the time study. However, the data had not yet been analyzed nor recommendations developed. ▪ A review of the QA/QI Quarterly Section Review of Settlement Agreement Progress for Section I: At Risk Individuals in the meeting minutes, dated 9/16/13, indicated that since the last review, the Facility had spent considerable time assessing its compliance with the At Risk policy and had identified a number of areas that were in need of attention, such as misunderstandings of the At Risk policy, communication deficits between departments, and the lack of review by IDT members regarding the IRRFs and IHCPs within 14 days after the ISP. As noted above, it is recommended that attention be paid to the implementation of the IHCPs to ensure individuals receive the needed care determined by the teams. ▪ In September 2013, the Facility restructured the QIDP Department by designating four QIDPs as Facilitators with caseloads of approximately 95 individuals for whom they were responsible for developing their ISPs. These Facilitator QIDPs worked with the Home QIDPs, but had primary responsibility for the ISP preparation meetings, as well as populating the ISP guide 10 days prior to the ISP meeting, and facilitating the ISP meeting. The Facility reported that since the initiation of the QIDP Facilitators, compliance regarding filing the ISPs in the record 30 days after the ISP meeting had increased from 65% to 92%.	Noncompliance

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- In addition, the Facility indicated that the Risk Coordinator had begun to attend two ISPs each month, and had developed an extensive monitoring tool for this area. However, at the time of the review, the Risk Coordinator indicated that the newly developed tool would have to be modified due to the significant time it required in order to complete all items.
- The Facility's Self-Assessment indicated that a review was conducted for a sample of 69 IRRFs from March through August to ensure all individuals had a current risk rating for each category (updated annually or as needed). The Self-Assessment indicated that the monitoring tool that was used to generate the data was the same since the Monitoring Team's last visit, so that there would be consistency in the data collection and reporting. The Facility's data addressing this area is noted below:

	Mar-13 N=31 n=12	Apr-13 N=39 n=13	May-13 N=38 n=11	June-13 N=31 n=11	July-13 N=38 n=10	Aug-13 N=35 n=10
Review of Risks occurred during Annual ISP	83%	77%	64%	92%	100%	90%
IDT members provided background information concerning risk category	58%	54%	64%	92%	80%	70%
IDT Deliberations was synopsis and supported risk rating	0%	8%	0%	0%	0%	10%
Rationale & Risk Rating were supported by IDT Deliberations	0%	8%	0%	0%	0%	10%
Annual Medical Assessment was current and available for IDT members review 10 days prior to annual ISP	8%	0%	27%	33%	10%	50%
Annual Nursing Assessment was current and available for IDT members review 10 days prior to annual ISP	75%	23%	36%	42%	60%	50%
APEN was completed due to new diagnosis of aspiration pneumonia or receives enteral nutrition	0%	8%	13%	60%	100%	100%
IDT discussed medical necessity for continued enteral eating	0%	17%	33%	20%	100%	100%

- In addition, the Facility's Self-Assessment indicated that a review of the assessment

#	Provision	Assessment of Status	Compliance

database was conducted from March through August 2013 to determine if assessments were completed prior to the ISP and posted in the shared drive within 10 business days of the ISP per policy. The Facility's findings are noted below:

Annual Assessments Filed 10 days Prior to Annual ISP	Mar-13	Apr-13	May-13	June-13	July-13	Aug-13
Activity Center Assessment	86%	80%	**76%**	**58%**	**79%**	**53%**
APEN	100%	**50%**	**60%**	**30%**	**25%**	**29%**
Audiological Assessment	80%	100%	**63%**	100%	**67%**	**69%**
Behavioral/Functional Assessment	**6%**	**47%**	**26%**	**41%**	**30%**	**23%**
Dental Assessment	90%	100%	97%	97%	94%	100%
Functional Skills Assessment (FSA)	**50%**	**67%**	**58%**	**67%**	**54%**	**74%**
Annual Medical Assessment	**33%**	**31%**	**47%**	**71%**	**34%**	**51%**
Annual Nursing Assessment	**77%**	**72%**	84%	**58%**	**69%**	**77%**
Annual Nutritional Assessment	93%	90%	100%	100%	94%	100%
Annual OT/PT Assessment	**0%**	**11%**	**14%**	**29%**	**27%**	**38%**
Psychiatric Assessment	**9%**	**38%**	**27%**	86%	81%	**78%**
Quarterly Pharmacy Report	100%	100%	96%	100%	93%	97%
Recreational Assessment	**0%**	**58%**	100%	100%	94%	100%
Rights Assessment	**19%**	**33%**	**37%**	**19%**	**26%**	**29%**
Self-Administration of Medications (SAMS)	**10%**	**10%**	**22%**	**23%**	**9%**	**20%**
Speech & Language Assessment	**6%**	**5%**	**38%**	**21%**	**32%**	**57%**
Vocational Assessment	**55%**	83%	81%	**67%**	**58%**	**57%**
Water Safety Assessment	**15%**	**23%**	**31%**	**24%**	**17%**	**11%**

The Facility indicted that the low compliance scores were due to the assessments not being consistently saved in the appropriate shared location. The Facility's Self-Assessment indicated that they had begun a new process in which the QIDP Coordinator reported to the Incident Management Review Team the assessments that were not available by the 10-day deadline.

- Also, the Self-Assessment indicated that in June 2013, the At-Risk Coordinator began to monitor annual ISP meetings to determine the rationale for lack of compliance found in the monitoring data. In addition, it was very positive to note that the auditing indicators the

#	Provision	Assessment of Status	Compliance
		Facility used were those the Monitoring Team used for this area. One ISP was randomly selected for monitoring during June, July, and August 2013 (three total) with the findings noted below: o ISPs began on time at none (0%) of the observed ISPs; o All appropriate disciplines were present at none (0%) of the observed ISP meetings; o 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 [sic] (100%) of the ISPs; o The individual was present at all (100%) of the ISPs meetings observed; o The IDT consistently used the Risk Level Guidelines when determining risk levels at none (0%) of the ISP meetings; o The IDT consistently used supporting clinical data when determining risks levels for none (0%) of ISPs observed; o 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; o There was adequate and appropriate clinical discussion among appropriate team members in decisions regarding risk levels in none (0%) of the ISPs meetings observed; o Team disagreements regarding risk levels were noted in none (0%) of the ISP meetings; and o Based on all ISPs observed, the ISP facilitators kept the team focused in one (50%) of the ISPs meetings observed. <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 any of the subsections of Section I. The center recognizes the need to have regular risk screening, assessment and management system to identify individuals whose health or well-being is at risk. The center identifies the need to improve assessments that guide IDT members to improve the IRRF content in the areas of background risk information, adequate documentation of IDT deliberation synopsis that supports risk rating, current and timely clinical assessments. IDT meetings continue to demonstrate inadequate integrated discussion and use of risk guidelines; inadequate availability and use of clinical data, and effective facilitation of the At Risk process." The Facility clearly had invested a great deal of effort in reviewing the requirements and their overall systems regarding the At-Risk system at ABSSLC. However, the lack of clear documentation included in the ISPs, IRRFs, IHCPs, and the associated disciplines' assessments regarding what actions were taken in response to pertinent events or health issues, and the lack of dates and supporting documentation addressing actions and completion of action plans made it difficult to sequentially follow the assessment and action plan processes for the sample of 10 individuals discussed with regard to Sections I.2, and I.3. Consequently at the time of the review, the Facility's	

#	Provision	Assessment of Status	Compliance
		efforts had not yet translated into any consistent measurable progress. To assess the Facility's revised risk screening process, members of the Monitoring Team observed five individuals' ISPs meetings (i.e., Individual #397, Individual #176, Individual #77, Individual #180, and Individual #233) while on site. Specifically, the observations of the ISP meetings indicated that: ▪ All appropriate disciplines were present at four (80%) of the observed ISP meetings. The direct support professional was only present for the first half hour of the meeting, and left when Individual #180 left. In addition, the PCP did not attend the ISP for Individual #180. ▪ 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 all (100%) of the ISP meetings. ▪ The individual was present at all (100%) of the ISPs meetings observed. Individual # 180 and Individual #77 were present at their ISP meetings until they indicated through gestures or behaviors that they wanted to leave. ▪ The IDT consistently used the Risk Level Guidelines when determining risk levels at one (20%) of the ISP meetings. Although it appeared that the teams for Individual #77, Individual #233, Individual #180, and Individual #397 were familiar with the Risk Level Guidelines, the team members generally did not ask for the additional data from the Guidelines to make decisions. ▪ The IDT consistently used supporting clinical data when determining risks levels for one (20%) of ISPs observed. There was a lack of supporting clinical data presented at the ISP meetings for Individual #77, Individual #397, Individual #176, and Individual #180 when determining risk levels. ▪ Overall, the risk levels the IDT designated were appropriate for each category for one of the ISPs observed (20%) from information and data provided by the IDTs. The individuals' IDTs that did not consistently designate appropriate risk levels for each risk category included Individual #77, Individual #176, Individual #180, and Individual #397. ▪ There was adequate and appropriate clinical discussion among appropriate team members in decisions regarding risk levels in two (40%) of the ISPs meetings observed. The individuals' IDTs that did not have adequate and appropriate clinical discussion among team members included Individual #77, Individual #180, and Individual #397. ▪ Team disagreements regarding risk levels were noted in two of the ISP meetings (i.e., Individual #180, and Individual #77) and appropriately resolved in both (100%). ▪ Based on all ISPs observed by the Monitoring Team, the ISP facilitators kept the team focused in all five (100%) of the ISPs meetings observed. In addition, other positive observations from the Monitoring Team regarding the ISP meetings included: ▪ Team members spent time discussing the potential for Individual #176's ability to transition to the community and discussed different residential options. ▪ The Direct Support Professional was very knowledgeable about Individual #176's	

#	Provision	Assessment of Status	Compliance
		preferences. ▪ The Dental Hygienist appropriately discussed the cause of Individual #180's recent refusals to cooperate with dental appointments and the need for pre-treatment sedation. More specifically, throughout her life, most of her appointments had been for cleaning, etc., but after more major work was done, she started being resistant to even basic dental care. The Hygienist then suggested she work with the Behavioral Health Services Provider on a methodical plan to assist the individual to get back to baseline. This seemed to be an appropriate plan, and it was very good to see that the Behavioral Services Department representative saw this as part of her role. However, they did not take it a step further to discuss specific goals or objectives to measure success, short of the individual ultimately becoming cooperative with basic dental appointments. ▪ Some Skill Acquisition Programs (SAPs) were discussed to assist in potentially reducing some of Individual #180's risks. For example, in order to assist with her constipation, staff discussed having her learn to make her own drinks using drink mix packets, as well as to mix her Miralax. This appeared to be a good way to involve her in the process, and hopefully provide incentive for her to drink more fluids. ▪ An example of integration of supports for Individual #180 was the incorporation of a replacement behavior in her PBSP to communicate when she is in pain. In addition to potentially reducing the target behavior of aggression, this also was an important skill to potentially reduce some of her other risk factors, such as constipation. ▪ The Facilitator for the ISP for Individual #77 was very animated, included the individual in discussions, and appeared well prepared. ▪ Good interdisciplinary discussions were observed in the ISP for Individual #233. ▪ Good interdisciplinary discussions were observed particularly between the Dietician and the Physician regarding the need to increase a calcium supplement for Individual #397. Problematic areas needing focus or improvement included: ▪ The Current Supports section in Individual #176's IRRF did not mention if any PNMP monitoring had occurred during mealtimes and/or during other PNMP activities, and if so, what the results were. ▪ The IRRF Fluid Imbalance section indicated that Individual #176 had: "an order for fluids 2000 ml every 24 hours." The IRRF did not indicate the date of the order or the reason for the order. In addition, there was no verification that Individual #176 received the fluids as ordered on a daily basis. ▪ The IRRF Infection section for Individual #176 indicated that: "she was treated for congestion and allergies four times during the months of May, June, September, and October." However, this information was not presented during the respiratory compromise section. Additional information should have been provided for these events to assess her current risk level. For example, information regarding the type of allergies she had and how her environment impacted her allergies would have been helpful in assessing her risk level. ▪ Under the Dental section, sedation was marked as "No," but in June 2013, Individual #180	

#	Provision	Assessment of Status	Compliance
		had had general anesthesia for dental work. General anesthesia is a form of sedation. ▪ Within a number of the subsections of the IRRF for Individual #180, information was included that had no direct connection to the risk area being discussed. As one example, under respiratory compromise, it was noted she was diagnosed with amenorrhea in 2005, and a history of prior treatment for scabies, dermatitis, eczema, and otitis media. It is unclear how any of this related to respiratory compromise. ▪ Some of the subsections of the IRRF for Individual #180 appeared to include template language (e.g., dental and behavioral health). For dental, it had not been fully individualized (e.g., instead of selecting an option, all options were still listed for "present condition," "caries" and "periodontal risk" under dental). To a lesser extent, this also was a problem in the behavioral health section (e.g., no recommendations filled in, no check marks in the possible options for medications, etc.). ▪ At times, data for Individual #180 were just listed without any analysis (e.g., lab work for diabetes). Without analysis, this information was difficult for many team members to interpret. For example, no analysis was included in the IRFF regarding whether the individual was doing better or worse from previous years, based on predetermined clinical indicators. As a result, it limited meaningful discussion. ▪ In addition, the data on the IRRF for Individual #180 was not always complete to allow the team to make justifiable decisions. For example, the team rated Individual #180 as being at high risk for constipation. On a positive note, the draft IRRF included a significant amount of history related to constipation. However, in terms of her status, the following was included: "Does require suppository use once or twice a month. Improvement from last year when she experienced Volvulus and an Ileus. She has had regular bowel movements this past year…" No specific data were provided, and during the team's conversation, when asked about the suppository use, the nurse indicated that she thought it was better than last year. Another example was found in a couple places in the draft IRRF related to her physical activity. The IRRF stated: "[Individual #180] walks the circle in front of the cottages daily if the weather is nice twice daily." No information was provided about how long the walks were, or how often they actually had occurred. Another example was the lack of discussion or information in the IRRF related to side effects of the psychotropic medication polypharmacy. Without this information, it was not clear how the team could apply the IRRF guidelines. ▪ The team did not have copies of draft IHCPs for Individual #180, and/or did not discuss them during her ISP meeting. As a result, it was not clear whether or not the plans sufficiently addressed her needs. In addition, no specific clinical indicators or objectives/outcomes were discussed. ▪ It was not clear that the team for Individual #180 consistently considered the need for additional assessments. With regard to osteoporosis, the draft IRRF indicated that she had not had a DEXA scan, because she was too young. The Dietician had indicated that she was prescribed a medication that could result in bone loss, and she was on lower doses of calcium, due to its potential to cause constipation. The team did not discuss this issue fully,	

#	Provision	Assessment of Status	Compliance
		and did not appear to consider the need for a baseline DEXA scan. ▪ The team for Individual #180 did not discuss the risk versus benefit of the psychotropic medication, which included polypharmacy. ▪ The IDT for Individual #77 initially reported the individual was blind, and spent a great deal of time discussing strategies to be used for community visits regarding this vision issue. After a period of time, the PCP interrupted the team and reported that the individual was not blind. It was concerning to the Monitoring Team that the individual's IDT did not know the status of her vision. ▪ There were sections of the IRRF for Individual #77 that were incomplete or had minimal information included. The lack of information contained in the IRRF made it difficult to determine if the risks levels assigned were actually appropriate. ▪ There was limited discussion and input from the team member for Individual #397. The goals developed were quite limited as was the Functional Skills Assessment summary. The team appeared to be satisfied with continuing the activities that were already in place. ▪ There were discrepancies between what staff reported and what was contained in the Functional Skills Assessment summary for Individual #233 that needed to be reconciled. 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 are needed to ensure the risk levels are accurate, the IHCPs reflect the needed clinical intensity in alignment with the appropriately designated risk levels, objectives included are functional and/or measurable, 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	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., a smaller sample) for this subsection, because the Facility had made limited progress, due to turnover in leadership. The noncompliance finding from the last review stands. 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. The Facility's Self-Assessment for this provision indicated the following: ▪ The Facility's Self-Assessment indicated that a review was conducted of a sample of 69 Annual Medical Assessment Summaries (AMA) and Annual Comprehensive Nursing Assessments (ANA) from March through August 2013 to ensure individuals' assessments were completed and addressed the individuals' at-risk conditions. However, although important, the data that was presented in the Self-Assessment for Section I.2 noted below, only addressed the timely completion of the assessments:	Noncompliance

#	Provision	Assessment of Status	Compliance

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.

	Mar-13 N=31 n=12	Apr-13 N=39 n=13	May-13 N=38 n=11	June-13 N=31 n=11	July-13 N=38 n=10	Aug-13 N=35 n=10
1. Current AMA was completed & transcribed 10 days prior to ISP	8%	0%	27%	33%	10%	50%
2. Current ANA was completed 10 days prior to ISP	75%	23%	36%	42%	60%	50%

Self-rating:
"Based on the results of the self-assessment, the ABSSLC facility is not in compliance with any of the subsections of Section I.2. The facility recognizes need [sic] to improve activities to utilize to conduct [sic] in the self-assessment in order to determine if the facility has performed 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. The facility has experienced change in department lead for Section I. With the new changes, the facility anticipates efforts for more progression and ultimately compliance."

Based on a review of records for 10 individuals determined to be at risk (i.e., Individual #216, and Individual #429 for aspiration; Individual #479 for dental issues; Individual #545 for constipation; Individual #139, and Individual #8 for cardiac issues; Individual #245, and Individual #37 for weight issues; and Individual #311, and Individual #285 for urinary tract 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 (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; and
- 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

#	Provision	Assessment of Status	Compliance
		assessment, and if it was actually timely completed. <u>Nursing Assessments</u> Based on a review of 10 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 #216, and Individual #429 for aspiration; Individual #479 for dental issues; Individual #545 for constipation; Individual #139, and Individual #8 for cardiac issues; Individual #245, and Individual #37 for weight issues; and Individual #311, and Individual #285 for urinary tract 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 10 individuals found that the Summary Section for 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. 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 indicated in past reports, the nursing assessments for the At-Risk individuals were not adequate in addressing the health risks of the individuals reviewed. In addition, regarding the Integrated Risk Rating forms, a review of these 10 individuals' records was conducted to assess nursing staff's role in the assessment of the health categories for which nursing was responsible. 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> Twelve records were reviewed to determine adequacy of risk assessment and completeness of risk reduction plans. These included the records for: Individual #27, Individual #162, Individual #212, Individual #140, Individual #382, Individual #297, Individual #378, Individual #385, Individual #515, Individual #452, Individual #435, and Individual #236. The following provides some examples of the problems identified as a result of these reviews: ▪ Individual #162 had a long history of gastroesophageal reflux disease (GERD), diagnosed by pH probe in 2002. This individual underwent a fundoplication at that time and gastrostomy-tube (G-tube) placement. In 2004, an esophagogastroduodenoscopy (EGD) was done for vomiting, but showed no Barrett's esophagus. Due to an upper gastrointestinal bleed in 2008, an EGD was done and revealed erosive esophagitis. In November 2011, the	

#	Provision	Assessment of Status	Compliance
		individual was found to have a large gastric residual and was started on Reglan. In February 2012, the individual had an upper gastrointestinal bleed. An EGD of 1/9/13 continued to show esophagitis without Barrett's esophagus. It also showed a partial unraveling of the fundoplication and a hiatal hernia. In April and May 2013, the Reglan was tapered. The individual remained on a proton pump inhibitor. The documents reviewed did not indicate how the gastric residual was followed to ensure this had resolved or whether or not there were plans for further evaluation and treatment, given the Reglan had been discontinued. There was no further information or plan documented for follow-up of the unraveling of the fundoplication and hiatal hernia. An EGD in 2013 continued to indicate GERD, at times associated with bleeding. The history of increased gastric residual, GERD, and partially unraveled fundoplication are identified risks for reflux aspiration and aspiration pneumonia/pneumonitis, but there was no aggressive evaluation and treatment of these concerns in the documents reviewed. ▪ Individual #212 was prescribed Zantac to reduce stomach acid production, as well as Reglan, and medications for bronchospasm. The individual was noted to have aspiration on an upper gastrointestinal radiologic study in the past, as well as severe GERD, and a hiatal hernia. In 1982, a G-tube was placed, and in 1986, a fundoplication was completed. The individual had had numerous aspiration pneumonias (11 from 1989 to 2011), and additional recorded acute respiratory distress without further definitive diagnosis. In February 2012, the individual underwent an EGD, and esophagitis, gastritis, and H. pylori were found and treated. A jejunostomy (J-tube) was recommended/suggested, but the guardian did not agree to this option. Since that time the individual had numerous hospital admissions or ER visits due to respiratory distress (i.e., 3/23/12, 10/18/12, 1/6/13, 3/17/13, 3/23/13, and 9/9/13). The history noted in the ISPA of 9/18/13 in which it was described that the individual: "shows signs of respiratory issues very quickly and they disappear just as fast" is consistent with bronchospasm from acute reflux of gastric acid. A chest x-ray of 9/13/13 did not indicate pneumonia, and the diagnosis of acute bronchitis was made with no further evaluation of the history of multiple episodes of respiratory distress. There was documentation of environmental allergens, as well as gynecologic discomfort as etiology of the respiratory distress. However, the documentation did not indicate an aggressive evaluation as to cause of the frequent respiratory distress. There was no further evaluation of the functional status of the fundoplication to determine if it had become unraveled, nor a determination by consultants whether the individual would benefit from repair of the hiatal hernia. There was no information concerning a plan to determine the possible contribution of GERD to the many episodes of respiratory distress. There was also one acute illness on 11/30/12, associated with unusually warm, red skin, tachycardia, and wheezing, findings which might indicate an additional diagnosis is present, but there was no discussion in the record as to the cause of these cluster of findings, a differential diagnosis, or a planned evaluation or work-up. Until there is an aggressive evaluation for the GERD and other conditions, which might require a number of consultations and diagnostic tests, the recurrence of respiratory distress likely will continue. The record	

#	Provision	Assessment of Status	Compliance
		review identified a number of clinical concerns that remained unresolved. ▪ Individual #382 developed respiratory distress requiring either hospitalization and/or Infirmary admission on 10/30/12 (Infirmary), 11/3/12 (Infirmary), 2/25/13 (Infirmary), 3/10/13 (hospital), and 8/19/13 (hospital). Pneumonia was diagnosed on the latter three admissions to the Infirmary or hospital. On 3/20/13, a Modified Barium Swallow Study (MBSS) was completed, and demonstrated aspiration on thin liquids, but not thickened liquids. On 8/20/13, a bedside swallow study completed in the hospital indicated the individual safely swallowed nectar thick liquids and pureed food. The individual was placed on nectar thick liquids and foods thinned to applesauce consistency. On 4/17/13, four non-restorable teeth were extracted. The individual used vacuum tooth brushing. Due to the pneumonia of 8/19/13, and continued infiltrate on chest x-ray of 9/3/13, another MBSS was ordered. The head of bed had been elevated at all times from 20 degrees to 30 degrees. There was no documentation concerning whether GERD was a contributing factor in the recurrences of pulmonary illness until a gastroenterology (GI) consult was requested on 10/3/13, specifically requesting consideration of an EGD and need for fundoplication. The individual was prescribed a proton pump inhibitor. It was noted that the individual had five episodes of respiratory distress before consideration of a GERD evaluation. Until the most recent hospitalization, the evaluation and treatment of this individual did not appear to be aggressive in meeting the needs of the individual's health. ▪ Individual #297 had numerous hospitalizations and Infirmary admissions for respiratory distress/hypoxia [i.e., 2/12/12, 2/24/12, 4/14/12, 5/1/12, 5/8/12, 8/19/12, 8/26/12, 9/13/12, 10/10/12, 10/15/12, 11/21/12, 1/8/13, 1/16/13 (coded during this hospital admission with successful resuscitation), 2/9/13, 3/15/13, 4/7/13, 7/17/13, and 9/23/13]. The individual was prescribed a proton pump inhibitor, underwent G-tube placement in 2001, and a fundoplication in the past. On 6/28/12, Gastroenterology was consulted, and recommended a J-tube, but the PCP did not agree with the recommendation, because the individual was considered stable at that time. On 8/17/12, the individual was seen by pulmonology. On 12/12/12, the individual underwent an EGD with findings of an incompetent lower esophageal sphincter, and chronic gastritis. On 3/15/13, an allergy consultant indicated there were no significant environmental allergens found on testing. On 4/15/13, the individual underwent a revision of the fundoplication with lysis of adhesions. There were no complications. Given the number of respiratory events, including, at one point coding, there appeared to be a significant delay in evaluation. Although there was concern about allergies causing respiratory distress and increased secretions, this had been ruled out in the past (1998). Although this was again part of the differential diagnosis, the reason for not completing a GERD evaluation at the same time was not clear. When reviewing the Avatar pneumonia data, there were additional observations. For those with G-tubes, there were instances in which there was no recent EGD to rule out GERD as a cause of aspiration pneumonia or pneumonia (i.e., no EGD recorded in four of seven, and two individuals with EGDs done 15 to 20 years prior). For those taking nutrition by mouth (PO), three of seven had an	

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>MBSS recorded (i.e., one in 1996, one in 2010, and one in 2011), and one of seven had an EGD recorded in 2009. There appeared to be an interpretation that normal chest x-rays ruled out reflux and aspiration. There appeared to be a nonaggressive approach to the many respiratory distress events recorded in the documents. Further, it appeared that few or none of these other respiratory events were recorded in a database, similar to pneumonias or aspiration pneumonias. It is recommended that reactive airway disease and acute respiratory distress be monitored and followed through creation of a complete and accurate data collection mechanism. The number of such cases leading to Infirmary admissions, ER visits, and hospitalizations should be tracked, and available for the Medical Department administration's review, as well as for the Monitoring Team. Because of the severity of the illness and the frequency of illness noted for the individuals discussed above, the Avatar data, as well as cases discussed at the morning medical meeting, it is recommended that any event of respiratory distress, reactive airway disease, or pneumonia (whether diagnosed as aspiration pneumonia or not) have documentation of thorough and timely evaluation of aspiration due to dysphagia and GERD for those taking food by mouth, and thorough and timely evaluation for aspiration due to GERD for those with feeding tubes. For this population, the cause of reactive airway disease, acute respiratory distress, pneumonia, or aspiration pneumonia should be sought, and GERD should not be ruled out without clear evidence in the record that GERD was not occurring, or if diagnosed, was treated and prevented aggressively medically and surgically. The current approach appeared to delay evaluations or dismiss the need for evaluation in a timely manner. It is suggested that a more aggressive and safer approach is to assume GERD is occurring in these cases until it is ruled out. The Medical Department has considerable challenge ahead in resolving the problems noted with this area of clinical care.

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.</td><td></td></tr>
<tr><td>I3</td><td>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</td><td>The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., a smaller sample) for this subsection, because the Facility had made limited progress, due to turnover in leadership. The noncompliance finding from the last review stands.

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. The Facility's Self-Assessment for this provision indicated the following:
▪ The Facility's Self-Assessment indicated that a review was conducted for a sample of 69 integrated health care plans from March through August 2013 for individuals rated at medium or high risk. The data graph below demonstrated the Facility's findings:

<table><tr><th></th><th>Mar-13 N=31</th><th>Apr-13 N=39</th><th>May-13 N=38</th><th>June-13 N=31</th><th>July-13 N=38</th><th>Aug-13 N=35</th></tr></table></td><td>Noncompliance</td></tr>
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#	Provision	Assessment of Status	Compliance

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.

	n=12	n=13	n=11	n=11	n=10	n=10
1a. IHCP was created during annual ISP	0%	8%	0%	0%	0%	0%
1b. IHCP identifies all medium & high risks	0%	8%	0%	0%	0%	0%
2. IHCP has implementation date not more than 14 days after IHCP finalization for every medium and high risk action step	0%	8%	0%	0%	0%	0%
3a. IHCP has interventions for all medium & high risks	0%	8%	0%	0%	0%	0%
3b. IHCP goals are person centered and measurable.	0%	8%	0%	0%	0%	0%
3c. IHCP has clinical indicators to be monitored for all medium & high risk	0%	8%	0%	0%	0%	0%
3d. IHCP has prevention interventions for all medium & high risks	0%	0%	0%	0%	0%	0%
3e. IHCP has frequency of monitoring for all medium and high risk	0%	8%	0%	0%	0%	0%
3f. IHCP has location of documentation for every medium and high risk action step	0%	8%	0%	0%	0%	0%
4. IHCP is integrated into the ISP	0%	8%	0%	0%	0%	0%
5. There is IHCP competency evidence	0%	0%	0%	0%	0%	0%

Although there were some slight problematic issues found in the monitoring tool, such as including more than one element in an item (i.e., IHCP goals are person centered and measurable), which will confound the findings and make it impossible to determine the compliance regarding person centered goals and the compliance regarding measurable goals, the Facility's progress regarding the monitoring and presenting their data for this area was impressive. In addition, the Facility's monitoring data in many areas was in alignment with the Monitoring Team's findings indicating that they were identifying similar problematic issues as those the Monitoring Team identified. This

#	Provision	Assessment of Status	Compliance
		should facilitate the development of specific action plans to address these areas. Self-rating: The Facility indicated that based on the results of the self-assessment, it was not in compliance with any of the provisions of Section I.3. Based on a review of 10 records for individuals determined to be at risk (i.e., Individual #216, and Individual #429 for aspiration; Individual #479 for dental issues; Individual #545 for constipation; Individual #139, and Individual #8 for cardiac issues; Individual #245, and Individual #37 for weight issues; and Individual #311, and Individual #285 for urinary tract 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%). Although all 10 individuals (100%) were found to have a care plan addressing their high or medium health/mental risk indicator in the Active Record, only one (10%) sufficiently addressed the health risk in accordance with applicable nursing protocols (i.e., Individual #545 addressing constipation). ▪ Implemented a plan within fourteen days for each individual, as appropriate in none (0%) of the cases reviewed. The 10 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 one of these cases (10%) (i.e., Individual #545 addressing constipation). ▪ Included preventative interventions in the plan to minimize the condition of risk in one of the cases (10%) (i.e., Individual #545 addressing constipation). Although some generic interventions were found in some IHCPs addressing, for example, the need to encourage adequate fluids and exercise, 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 IHCP/Risk Action Plans into the ISPs in 10 of the 10 cases (100%). ▪ None (0%) of the plans reviewed showed adequate integration between all of the appropriate disciplines, as dictated by the individual's needs. ▪ One of the plans (10%) had appropriate, functional, and measurable objectives incorporated into the ISP to allow the team to measure the efficacy of the plan (i.e., Individual #545 addressing constipation). ▪ One of the plans (10%) included the specific clinical indicators to be monitored (i.e., Individual #545 addressing constipation).	

#	Provision	Assessment of Status	Compliance
		▪ The frequency of monitoring was included in the plans for one of the individuals (10%) (i.e., Individual #545 addressing constipation). Although the other 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.	

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 last six months; o List of individuals currently prescribed Reglan; o MOSES and DISCUS assessments for the past year for the following four individuals prescribed Reglan: Individual #385, Individual #261, Individual #19, and Individual #226; 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 last 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; 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 Documents related to the following Psychiatric Clinic: 5971 Service Avenue on 11/4/13, 6720 Circle Drive on 11/5/13, and 6400 Plum Avenue on 11/6/13; 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, as of November 2013; o For the past six months, minutes from the committee that addresses polypharmacy; o Chemical Restraint trend analysis; o Documentation related to the administration of chemical restraint for the following five episodes of chemical restraint: Individual #379 on 10/19/13, Individual #304 on 10/12/13; Individual #298 on 8/8/13; Individual #199 on 7/4/13; and Individual #231 on 5/13/13; o Documents reviewed in the context of the 11/5/13 Psychotropic Polypharmacy Committee Meeting; o Minutes reviewed and discussed at the 11/6/13 Pharmacy and Therapeutics (P&T) 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 CPEs for the individuals admitted in the last six months that were prescribed psychiatric medications; 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 residential 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 Most up-to-date Psychiatric caseload distribution list, by Practitioner with Unit numbers; o The three recent examples of ISP documentation for individuals the Psychiatry Department believes best reflects the Facility's attempts to comply with Sections J.8, J.9, and J.10, including those for: Individual #147, Individual #463, and Individual #284; o Copies of Chemical Restraint documentation for those individuals who received chemical restraints in September and October of 2013; o Reports for general anesthesia, oral sedation, and mechanical restraint for 2013; o The most recent desensitization tracking worksheet and related summary documents; o Flow sheet or narrative description that provides an overview of the steps involved in developing the PTP for the annual ISP; o List of individuals transferred to a psychiatric hospital in the last six months; o List of individuals that have returned from a psychiatry hospital in the last six months; 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) Human Rights Committee (HRC) section; and p) documentation and consultations regarding the use of pre-treatment sedation medication (i.e. Treatment Plan, guardian approval, HRC approval, etc.), for the following individuals: • The Facility selected the records of the following nine individuals and submitted them as part of the pre-review document request: Individual #320, Individual #518, Individual #461, Individual #168, Individual #355, Individual #462, Individual #478, Individual #460, and Individual #4; and • During the onsite review, a member of the Monitoring Team selected the following 16 individuals: Individual #51, Individual #247, Individual #146, Individual #201, Individual #468, Individual #2, Individual #323, Individual #216, Individual, #94, Individual #471; Individual #207, Individual #278, Individual #147, Individual #463, Individual #284, and Individual #170. ▪ **Interviews with**: o Marla Knight, Pharm.D., Michael Murray, M.D., and Bonnie Burroughs, Pharm.D., on 11/5/13; o Michael Murray, M.D., Chief Psychiatrist, on 11/4/13, 11/5/13, and 11/6/13; o Jerry Griffen, D.D.S., Director of Dental Services, and Michael Murray, M.D., on 11/5/13; o Ron Manns, Director of Behavioral Services, Kathy Theiss, BCBA, Clinical Supervisor, and Michael Murray, M.D., on 11/5/13; o Shae Butts, Human Rights Officer, on 11/6/13; o Brian Luster, System Analyst Two, in conjunction with Michael Murray, M.D. to review Facility Self-Assessment, on 11/6/13; o Stephen Milstead, RN, DM, MHNP, on 11/4/13; o John Crowley, M.D., on 11/5/13; and o Lynn Outlaw, APRN, PMHMP, BC, on 11/6/13. ▪ **Observations of**: o Psychiatric Clinic for Residence 5971 Service Avenue, on 11/4/13; o Psychiatric Clinic for Residence 6720 Circle Drive, on 11/5/13; o Psychiatric Clinic for Residence 6400 Plum Avenue, on 11/6/13; o Pharmacy and Therapeutics Committee Meeting, on 11/6/13; o HRC Meeting, on 11/5/13; o Psychotropic Polypharmacy Committee Meeting, on 11/5/13, and o The following individuals during the Psychiatric Clinics, and visits to the vocational areas, and residences: Individual #170, Individual #278, Individual #339, Individual #462, Individual #510, Individual #424, Individual #478, Individual #151, Individual #540, Individual #305, Individual #301, Individual #414, Individual #51, Individual #246,

	Individual #168, Individual #198, Individual #215, Individual #165, Individual #533, Individual #105, Individual #242, Individual #276, Individual #315, Individual #33, Individual #284, Individual #218, and Individual #150.
	Facility Self-Assessment: The review of ABSSLC's Self-Assessment was facilitated by an interview with the former Program Compliance Monitor and the Chief Psychiatrist, on 11/6/13. The Psychiatry Department continued with the system that had changed in February 2013, in response to guidance from the DADS State Office. This system provided a new monitoring tool as well as a new sampling strategy. As a result of these changes, the PCM no longer reviewed individual records, but continued to be involved in the selection of the random sample. During the monthly meetings, the Psychiatry Team focused on ways to improve the inter-rater reliability data. 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, through June 2013. 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, 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 PCM selected two individuals that had a Quarterly Review that month. The others were randomly selected from the entire Psychiatry caseload. The reviews accounted for two percent of individual records of those receiving psychotropic medication each month, which equated to ten 10 percent of the individuals receiving psychotropic medications from February to June 2013. As of July 2013, the number of independent reviews per month decreased to three, due to the departure of the Psychiatric Nurse Practitioner, who subsequently returned in October 2013. The Chief Psychiatrist continued to review one record per month in conjunction with a blind review of the same record by another member of the Psychiatry Team. The number of individuals prescribed psychotropic medications had decreased from 185 in February 2013, to 168 in November 2013, helping offset the decrease in independent reviews per month. The total of nine reviews from July to September 2013 accounted for five percent of individuals receiving psychotropic medications, which would equate to 20 percent per year. The audit tool encompassed 34 items related to 13 of the 15 subsections of Section J. The two not covered were Sections J.1 and J.5. 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 resided at ABSSLC. The Program Compliance Monitor entered the data obtained with the audit tool, and prepared monthly reports in the form of graphs and printouts based on the monthly results. The reports could be customized to report by subsection 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 "Yes – No – or NA." Any variation in the 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 (Section J Lead). 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. For Section J.11, they analyzed their progress in decreasing the rates of polypharmacy using specific data collected for that purpose, 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 following table summarizes the different methodologies the Psychiatry Department utilized for each of the subsections of Section J:

Subsection	Monthly Audits	Additional Methods Used to Assess Each Provision
J.1	No	Review of credentials the Medical Department maintained
J.2	No	CPE/PTP Tracking Log the Psychiatry Department maintained (included with evidence for Section J.6)
J.3	Yes	1. Section N Lead's Review of Chemical Restraints for Behavioral Emergencies 2. Section N Lead's Review of Use of Psychotropic Medications at ABSSLC for a three-year span
J.4	Yes	Graph generated from data entered into the State AVATAR program related to Pre-Treatment Sedation from 10/1/12 to 9/30/13
J.5	No	1. Board Eligibility certification of each Psychiatrist (included in evidence for Section J.1) 2. Updated Time Study based on original Time Study, dated 4/1/2013
J.6	Yes	CPE/PTP Tracking Log the Psychiatry Department maintained
J.7	Yes	1. Reiss Screen Tracking Log Behavioral Services Department maintained 2. List of admissions as the Admissions Placement Coordinator maintained
J.8	Yes	
J.9	Yes	
J.10	Yes	
J.11	Yes	Monthly tracking data the Psychiatric Polypharmacy Committee generated
J.12	Yes	
J.13	Yes	
J.14	Yes	
J.15	No	Section J.15 Tracking Log the Psychiatry Department maintained

	The results of the above-referenced interviews, coupled with the review of the Facility Self-Assessment, indicated the following: ▪ The audit tools the Facility utilized to conduct its Facility Self-Assessment were the specific instruments the DADS State Office developed for Section J; ▪ The audit tools provided useful information the Facility could use in improving its compliance with the Settlement Agreement; ▪ The audit tools primarily assessed the presence or absence of specific items related to the Settlement Agreement. A prior concern was that the quality of psychiatric services often was not assessed. The Psychiatry Department had developed specifications for its audit process of CPEs and the PTP to assess not only the presence of a psychiatric diagnosis, but also the presence of the symptoms to support that diagnosis. ▪ The self-assessment process was based on adequate sample sizes, as the goal was to review 20 percent of the records of individuals receiving psychotropic medications every year; ▪ 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/no or present/absent nature. However, as noted, the Facility was moving beyond this simple yes/no approach for the psychiatric diagnosis. In addition, when scoring the CPE, the internal tool that had been developed assessed not just for the presence of a response under each of the sub-headings, but also used specific items that should be discussed in that section; ▪ The staff members responsible for completing the audit tools were all members of the Psychiatry Department, and included the Psychiatrists, Psychiatric Nurses, and the Psychiatry Assistants. Although there was no formal process for assessing an individual's competence to perform the audit, all of these Psychiatry Department Team members were well versed regarding the issues involved. The Psychiatry Assistants coordinated the logistics for and attended all of the Psychiatry Clinics on their caseload, and, thus, were familiar with the items referred to in the Settlement Agreement; ▪ The Psychiatry Team, working in conjunction with the PCM, had developed a system 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 PCM would meet with the Psychiatry Team and provide feedback on the results of the inter-rater reliability scores; ▪ The primary methodology the Facility used to augment the auditing of individual records was the utilization of databases and spreadsheets that tracked the overall completion rates for all individuals receiving psychotropic medication. The spreadsheets tracked 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 Tracking Spreadsheet the Dental Department maintained; 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 scored, accompanied the Facility assessment for each subsection of Section J. A Results section followed, 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 of the internal review, and the Monitoring Team's review for 12 of the 15 subsections. The three subsections for which the ratings diverged, and the reasons for those differences, 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 Psychiatry Department did not take into account the requirement that the Risk-Benefit Analysis must also be included in the ISP and related documentation. ▪ Section J.4: The Facility focused on the decrease in the number of administrations of pre-treatment sedation, rather than the number of individuals for whom plans to reduce to the extent possible the use of pre-treatment sedation had been developed. The observation, that ABSSLC utilized a different subset of records each month, should over time, strengthen the reliability of their results. The efforts to continually reassess for inter-rater reliability should also contribute to the overall reliability of the self-assessment process in the future.
	Summary of Monitor's Assessment: ABSSLC employed one full-time Psychiatrist, one full-time advanced Nurse Practitioner (with prescribing privileges), one full-time locum tenens advanced Nurse Practitioner, 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 providers that took into account the requirements of the Settlement Agreement, and it appeared that this number of Psychiatrists should be adequate. The data available indicated there had been continued progress in completing the Comprehensive Psychiatric Evaluations. The Psychiatry Department also had developed a Psychiatric Treatment Plan, which was to serve as both a compilation of material for the individuals' annual ISP and the annual update to the CPE. These annual updates were completed to coincide with the annual ISP, which should make the process self-sustaining. The Facility's data indicated the completion rate for a CPE and/or a PTP within the last year was 100 percent, although the results of the Monitoring Team's current review revealed a few omissions. Observation of the Psychiatric Clinics indicated that the Psychiatric Assistant, the Nurse Case Manager, the QIDP, and the Behavioral Health Services Provider, who played an important 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 had 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. The data they had assembled indicated that the adjusted rate (i.e., for unjustified polypharmacy) was currently in the six percent range. The Facility had made incremental progress in implementing Pre-treatment Sedation Desensitization Plans for dental procedures, but there was still little progress in developing these procedures for medical procedures. The Monitoring Team's prior reviews stressed the importance of making sure the information required in Sections J.8, J.9, and J.10 were represented in the ISP. The Facility had acted on these recommendations, but work was still needed to ensure that the teams discussed and documented their discussions of the use of psychotropic medications in combination with other therapy/treatment, as appropriate. More specifically: ▪ During the prior six months, a member of the Psychiatry Department had attended the annual ISP meetings for 81 of the 85 individuals prescribed psychotropic medication, which was positive. ▪ The Psychiatry Department had begun to integrate the material related to Sections J.8, J.9, and J.10 in the Integrated Risk Rating Form. During this review, it was possible to review three recent examples that the Psychiatry Department felt represented a thorough discussion of this material. Suggestions based on a preliminary review indicated that subjective observations should be identified as such, and that objective data should be accompanied by a graph or summary. ▪ In addition, the risk-benefit review, which currently was presented with a schematic, numerically based chart, should be replaced or augmented with a brief narrative summary that is straightforward and specific to the individual. The side effect discussion should make a clear distinction between potential and/or realized side effects. ▪ Placing this material in the IRRF helped to ensure that the discussion would actually take place, as opposed to simply being referenced in the ISP and potentially not discussed. In this regard, it would also be useful to include a brief section entitled "Deliberations," which would summarize the major points discussed during the ISP meeting as an outgrowth of the review of this material. In summary, the Psychiatry Department had continued to make progress in fulfilling the requirements of many of the provisions of Section J of the Settlement Agreement.

#	Provision	Assessment of Status	Compliance
J1	Effective immediately, each Facility shall provide psychiatric services only by persons who are qualified professionals.	The parties agreed the Monitoring Team would not monitor this provision, because ABSSLC was in substantial compliance for more than three consecutive reviews. There was no indication that this status had changed. The finding of substantial compliance was carried forward from prior reviews.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
J2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall ensure that no individual shall receive psychotropic medication without having been evaluated and diagnosed, in a clinically justifiable manner, by a board-certified or board-eligible psychiatrist.	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. In addition, the Psychiatrists had prior experience in the diagnosis and treatment of psychiatric disorders in individuals with Intellectual Disabilities/Developmental Disabilities (ID/DD). The documents within the individual records that provided the most complete description of the psychiatric evaluation process required by this provision of the Settlement Agreement were the: a) Psychiatric Quarterly Reviews; b) Psychiatric Treatment Plan, which functioned as a Treatment Plan for psychotropic medication, as well as the annual update to the CPE; and c) the CPE. The Psychiatric Quarterly Review Forms contained sections that discussed: ▪ The diagnosis, including the Diagnostic Standards Manual (DSM) criteria for that diagnosis; ▪ Past psychotropic medication trials; ▪ Non-psychiatric medications the individual was prescribed; ▪ Pertinent laboratory and/or other medical information; ▪ Results of the most recent MOSES and DISCUS side effect monitoring; ▪ The mental status examination the Attending Psychiatrist performed at the time of the review; ▪ The current psychotropic medications, including a discussion of the specific symptoms or diagnosis that each psychotropic medication was prescribed to address, and evidence for the efficacy of that medication; and ▪ Evidence of collaboration between the Psychiatry and Neurology Departments, and the IDT, where this was relevant. Subsequent to the Monitoring Team's last review, the only significant changes were moving the risk-versus-benefit analysis and the derivation of the target behaviors of the psychotropic medication to the Psychiatric Treatment Plan. As noted above, the Facility also had 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 the teams were still seeking further evidence. This information was updated on a continuous basis. The current Quarterly Review documentation also included a section entitled: "Psych[iatric] Med[ication] Concerns per Clinical Pharmacist, (date of most recent Pharm.D. Review)." This was the section in which the Psychiatrist would address any concerns the Pharm.D. raised during the last Quarterly Review.	Substantial Compliance

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		The annual PTP contained a comprehensive list of symptoms related to the individual's 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 annually in conjunction with the individual's ISP. The CPE also contained a listing of the psychiatric diagnoses for the individual, as well as the Bio-Psycho-Social-Spiritual formulation. The latter section discussed the differential diagnosis and provided detailed information concerning the rationale for the diagnosis of record, and included important data that detailed the impact of the individual's psychiatric diagnosis on his/her overt behavior. This was essential for differentiating between those behaviors that were derived from the psychiatric disorder, as opposed to 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 25 of the 168 (15%) individuals prescribed psychotropic medication, all three of the aforementioned sources of clinical information were taken into account, as they complemented each other in the manner described above. The CPE, coupled with the PTP, provided the most comprehensive perspective of the individual's history and current status. However, the Quarterly Psychiatric Review Forms also provided documentation of the diagnostic criteria, as 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 25 (100%) individuals contained in the sample. As noted with regard to Section J.6, the records of two individuals did not have a PTP completed within the last year, but they did contain a CPE from 2012 that contained the diagnostic formulation. ABSSLC did not use the "Deferred" or "Rule Out" qualifiers when establishing an individual's psychiatric diagnosis, except in those instances when an individual had recently been admitted and/or the diagnosis was still being clarified. The Facility rarely utilized the "NOS" (Not Otherwise Specified) qualifier in their diagnoses. However, it should be noted this is an accepted designation that is acknowledged and defined in the Diagnostic Standards Manual, Fifth Edition (DSM-V), although this edition of the manual has changed the terminology to "Other Specified" or "Unspecified." 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 list of diagnostic changes the Facility presented in response to the Monitoring Team's request identified 16 individuals for	

#	Provision	Assessment of Status	Compliance
		whom there had been a change in their psychiatric diagnosis. The spreadsheet that contained this information was not dated. However, the attached supporting documentation for each individual indicated that the earliest of these changes occurred in January of 2013, and the most recent occurred in September 2013. The majority of the changes had taken place within the last few months. The documentation of the changes primarily appeared in the Quarterly Review Notes. Other sources were the PTP or the Physician's Progress Notes. Nine of the 16 changes consisted of changing the diagnosis of "Pervasive Developmental Disorder" to "Autism Spectrum Disorder," which was consistent with the change in the corresponding nomenclature in the DSM-V. The rationale for all of the diagnostic changes appeared appropriate. As noted above, the Facility had created an impressive mechanism for documenting the clinical rationale for an individual's psychiatric diagnosis, which was consistent 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. 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 on a quarterly basis for all (100%) of the 25 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 with regard to Section J.6 indicated that either a CPE or a PTP had been completed for 23 of the 25 (92%) individuals within the prior year, and that the diagnosis contained in those documents was consistent with the diagnosis in the most recent Quarterly Review material. Thus, the Facility remained in substantial compliance with this provision.	
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 25 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 16 percent of the 168 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, which 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.	Noncompliance

#	Provision	Assessment of Status	Compliance
		The 25 records reviewed included an active Positive Behavior Support Plan for each individual prescribed psychotropic medication. The Monitoring Team's initial reviews indicated that the behaviors identified as the "target behaviors" of the psychotropic medication also often were identified in the Functional Analysis and related PBSP as being present on a behavioral basis and/or related to environmental factors. For these individuals, the dual classification of behaviors suggested that 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 potentially were being used in the absence of adequate behavioral treatments or interventions, which could be construed as being "a substitute for a treatment program." The Facility had made substantial progress in this area, which is discussed in greater detail below with regard to Sections J.8, 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 also could be construed as punishment, because it frequently involved the intramuscular (IM) injection of a psychotropic medication against an individual's will. Thus, the description of the circumstances surrounding the involuntary administration of chemical restraint was extremely important in differentiating between the necessary utilization of these interventions to prevent physical harm to the individual and/or others, as opposed to being used to punish an individual for aggressive behavior, or for the convenience of staff in responding to a difficult situation. In order to further investigate the use of mechanical restraint at ABSSLC, the following sample of chemical restraint documentation was reviewed: **Individual # / Date / Time / Medication and Dosage / Route of Administration** Individual #379 / 10/19/13 / 21:00 / Ativan 2 milligrams (mg) / IM Individual #304 / 10/12/13 / 13:30 / Thorazine 50mg / IM Individual #298 / 8/8/13 / 14:20 / Thorazine 100mg / IM Individual #199 / 7/4/13 / 16:33 / Ativan 2mg / IM Individual #231 / 5/13/13 / 15:30 / Zyprexa 1mg / By Mouth (PO) The individual restraint data was reviewed for the presence and quality of the six documentation components the Facility utilized to record the events preceding, during, and following the administration of chemical restraint: 1. The information contained in the section of the form following the primary	

#	Provision	Assessment of Status	Compliance
		prompt: "Description of behaviors prior to 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 all of these individuals only described the overt behavior that necessitated the restraint, and not the "events" precipitating the behavior. For example, the material contained in this section for Individual #379 (10/19/13) indicated only: "[Individual #379] was displaying aggression toward staff, SIB, and suicidal behaviors for over one hour." The material for Individual #304 (10/12/13) indicated that: "[Individual #304] aggressive and SIB, screaming in dining room." Thus, the documentation was completed correctly for none of the five (0%) individuals. This finding was consistent with information gained through the interviews with the Director of Behavioral Services, which occurred during the course of the Monitoring Team's previous and current onsite reviews. Specifically, he expressed concern as to whether or not the direct support professionals were adequately providing this information in the context of the restraint episode. Accordingly, the Behavioral Health Services Providers had been asked to provide more information concerning the antecedent conditions that led to the restraint in the post-restraint debriefing section of documentation. This material augmented the deficient brief descriptions from the direct support professionals, but did not adequately address the environmental context for the incident in a manner that would make it possible to prevent a future occurrence. 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 of these five (100%) episodes of restraint. 3. The portion of the documentation in which the physiological post-restraint monitoring was recorded was completed for all (100%) of the individuals in this sample. 4. The face-to-face post-restraint debriefing was present in the documentation for all (100%) of these episodes. 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 all (100%) of the episodes. 6. The "Post-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. The checklist format indicated that a narrative response was only prompted by a specific yes-or-no answer,	

#	Provision	Assessment of Status	Compliance
		depending on the question. The Pharmacist had completed the section with regard to "Potential medication-related risks" for each individual, and the Psychiatrist routinely referred back to the Pharmacist's comments. This form was completed for all (100%) of the individuals in this sample. However, as discussed below, there were concerns related to the quality of these reviews. The form was structured in the format below: POST-CHEMICAL RESTRAINT CLINICAL REVIEW <u>Pharmacist Review</u>: Documentation shows medication used in a clinically justified manner? ☐ Yes ☐ No ☐ N/A If No, explain: Potential medication-related risks? ☐ Yes ☐ No ☐ N/A If Yes, explain: Actions/Recommendations: ☐ Yes ☐ No ☐ N/A <u>Psychiatrist Review</u>: Description of behaviors and prior steps taken before the chemical restraint was used are described on the Restraint Debriefing Form of this document. Documentation shows medication used in a clinically justified manner? ☐ Yes ☐ No ☐N/A If No, explain: Potential medication-related risks? ☐ Yes ☐ No ☐N/A If Yes, explain: Was the restraint effective: ☐ Yes ☐ No ☐ N/A If No, explain: Actions/Recommendations: ☐ Yes ☐ No ☐ N/A Agree/Disagree with any Pharmacy recommendations: ☐ Agree ☐ Disagree ☐ N/A If Disagree, explain: Other than the Pharmacist's description of potential side effects, the responses provided little or no insight regarding treatment interventions, including those that might prevent	

#	Provision	Assessment of Status	Compliance
		another episode that required chemical restraint. Therefore, the essential elements of the documentation needed to verify the appropriate utilization of the involuntary administration of chemical restraint were entirely completed for none of the five (0%) individuals in this sample. This was primarily due to the deficits in the initial section, which was designed to describe the antecedent events that led up to the restraint. The Post-restraint Clinical Review by the Pharmacist and Psychiatrist also did not adequately address this issue. This information was needed to ascertain if the restraint could have been avoided, and to inform future interventions, which might make it possible to avoid restraint moving forward. 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. In addition, problems continued to exist with regard to PBSPs and their implementation (as described with regard to Section K.9). Accordingly, ABSSLC remained in noncompliance with this provision.	
J4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, if pre-treatment sedation is to be used for routine medical or dental care for an individual, the ISP for that individual shall include treatments or strategies to minimize or eliminate the need for pre-treatment sedation. The pre-treatment sedation shall be coordinated with other medications, supports and services including as appropriate psychiatric, pharmacy and medical services, and shall be monitored and assessed, including for side effects.	The Dental Department was coordinating the implementation of the Behavioral Desensitization Plans for dental appointments at ABSSLC. However, the Behavioral Health Services Department was responsible for actually developing the Desensitization Plans. The Dental 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 the Dental Department prepared for this review indicated that from 1/1/13 through 9/30/13, there had been 1,918 visits to the Dental Clinic, of which 1,853 (97%) had been accomplished without any oral or general sedation. During this same time period, there were 13 (0.7%) dental appointments for which the individual received oral pre-treatment sedation, and 52 (3%) 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 4/1/13 through 10/18/13) indicated that the orders were primarily for Halcion 0.5mg, or Ativan in a range of 1mg 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 those procedures. The monitoring for the physiological effects of the oral pre-treatment sedation occurred in three different settings. The	Noncompliance

#	Provision	Assessment of Status	Compliance
		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 back 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 with regard to 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. However, review of the raw data related to the utilization of pre-treatment sedation for medical procedures (from 4/1/13 through 10/18/13) indicated that the 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. The ABSSLC Desensitization Tracking Worksheet indicated that as of 9/30/13, 75 individuals had been evaluated, and there were 19 "formal written plans," as well as 23 "written strategies." The term "written strategies" was 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 should also be noted that the Department utilized other informal techniques, which were not part of the written plans. In 2010, the Facility compiled a list of 100 individuals who were determined to be candidates for further assessment for Desensitization Plans. The Facility indicated that this was an arbitrary number designed to be a reasonable starting point. Thus, it was not meant to represent a comprehensive analysis of all of the individuals who reside at ABSSLC who might be appropriate candidates for a pre-treatment Desensitization Plan. The quality of these plans is discussed in further detail with regard to Section C.4. The Facility should expand the assessment of the need for, as well as the development of,	

#	Provision	Assessment of Status	Compliance
		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. ABSSLC was found to be in noncompliance with this provision of the Settlement Agreement.	
J5	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall employ or contract with a sufficient number of full-time equivalent board certified or board eligible psychiatrists to ensure the provision of services necessary for implementation of this section of the Agreement.	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 ID/DD. This experience involved inpatient work at 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. Dr. Murray had been at ABSSLC for three years. During that time, his clinical work had focused on individuals with ID/DD. Dr. John Crowley continued as a Consulting Psychiatrist for 84 hours per month. As discussed in the Monitoring Team's previous reports, the American Board of Psychiatry had 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. Soon thereafter, his caseload expanded to include 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 he also had 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 regarding clinical work with individuals with developmental disabilities had been limited. However, his collaborating Psychiatrist was Dr. Murray, who had extensive experience with this population. In the interval since the prior review, his clinical experience with individuals with ID/DD had increased.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		In September 2013, Lynn Outlaw, who was Board Certified as a Psychiatric Mental Health Nurse Practitioner (NP) by the Board of Advanced Practice Nursing, joined the Psychiatry staff on a locum tenens basis for a six-month commitment, which could be extended. Her prior experience with this population included one year of full-time outpatient psychiatric experience working with individuals with ID/DD who were living in the community, and several years during which approximately 10 percent of her work was devoted to this population. Dr. Murray was also her collaborating Psychiatrist. At the time of the November 2013 onsite review, 168 individuals were prescribed psychotropic medication at ABSSLC. This number had continued to decline over the past three years, as indicated below: Number of Individuals Prescribed Psychotropic Medication (Date) 225 (August 2010) 222 (February 2011) 219 (August 2011) 199 (February 2012) 189 (August 2012) 182 (May 2013) The Psychiatry Department currently employed one full-time Psychiatrist and two full-time Advanced Nurse Practitioners with prescribing privileges. In addition, the Facility continued to employ a Consulting Psychiatrist, who was present at the Facility during two consecutive weeks per month, for a total of seven days (84 hours) per month. The current part-time Consulting Psychiatrist, essentially, worked full-time during two weeks each month. Thus, this equated to approximately 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, the Facility had performed an analysis of the number of psychiatric practitioners necessary to provide direct clinical care to the individuals prescribed psychotropic medication, including fulfilling all of the requirements of the Settlement Agreement. The Chief Psychiatrist had updated the previous detailed document, dated 4/1/13, which outlined the time distribution required to fulfill these requirements. This analysis took into account the time required to carry out the direct clinical care of the individuals, as well as those duties related to coordinating this care with the other members of the clinical team, such as preparing for and attending the ISP meetings. The prior analysis contained the following conclusion:	

#	Provision	Assessment of Status	Compliance
		"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 two full-time and one 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 through the prior analysis appeared to be reasonable, and the Facility had the staffing identified as necessary. At the time of the current review, the Chief Psychiatrist presented a revised document entitled "Updated Time Study for the Provision of Psychiatric Services," dated 10/1/13. This analysis indicated that the completion of the initial CPEs for all of the individuals had decreased the time requirements of the Psychiatric Practitioners, because the preparation of the annual updates was not as time consuming as the initial CPEs, which now were only required for those individuals who were newly admitted to the Facility on psychotropic medications. This new calculation concluded that approximately 12 hours of psychiatric provider time per individual (or one hour/month) would be sufficient. The calculations derived from this analysis would indicate that three FTE Psychiatric Providers plus the Consulting Psychiatrist would be adequate to fulfill the clinical needs of the individuals who resided at the Facility, as well as the administrative requirements necessary to comply with the Settlement Agreement. As noted above, the Department had three FTE psychiatric providers in the form of the full-time Chief Psychiatrist, and two full-time, Board Certified Nurse Practitioners who were licensed to practice independently with a supervising Psychiatrist. In addition, the Consulting Psychiatrist continued at a rate that was approximately half time. The Chief Psychiatrist devoted most of his time to administrative duties, so the direct care of the individuals prescribed psychotropic medication was distributed between the other practitioners, the two advanced Practice Nurses, each maintained similar caseloads of 47 to 48, while the Consulting Psychiatrist was responsible for 74 individuals. The finding of substantial compliance was carried forward from the Monitoring Team's previous review, because the evidence the Department submitted indicated that the current number of Psychiatric Practitioners should be sufficient to provide direct clinical services to the individuals who reside at ABSSLC, including the requirements set forth in the Settlement Agreement.	
J6	Commencing within six months of the Effective Date hereof and with	The Facility developed a Psychiatric Treatment Plan, which was designed to serve as an annual update to the CPE, and would also form the basis for the discussion of the	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	full implementation within two years, each Facility shall develop and implement procedures for psychiatric assessment, diagnosis, and case formulation, consistent with current, generally accepted professional standards of care, as described in Appendix B.	individuals' 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 25 individuals (15% of the 168 individuals prescribed psychotropic medication) indicated that a CPE had been completed within the prior year and/or an updated annual PTP had been completed within the past year that met both the quality and timeliness criteria as set forth in the Settlement Agreement for 23 of the 25 (92%) individuals in the sample. Specifically, Individual #470 had a CPE dated 8/20/11, and a PTP could not be located in the record. Individual #170 had a CPE dated 8/20/12, and a PTP could not be located. The CPEs followed exactly 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 template was four pages in length and contained the following major section headings and sub-headings: <u>Section I: Annual Psychiatric Update</u> A table that covered the prior year, with separate columns for the following sub-headings: o Current Psychiatric Medication o Target Behaviors (TB) o Psychiatric Medications o Chemical Restraints o Physical Restraints o Psychiatric Hospitalization o Medical Hospitalization o Suicidal Ideation o Homicidal Ideation o Substance Abuse o Summary of the Psychiatric Quarterly Reviews and Significant Events in the Past Year <u>Section II: Formulation and Integration</u> o PBSP Target Behavior (TB) o Definitions and/or Comments o Function per Functional Analysis - This section also contained a sub-section to discuss the derivation of the target behaviors. o Medical Treatment that relates to psychiatric concerns: • Do Psychiatry and Neurology share seizure meds? ☐ Yes ☐ No • If Yes, has coordination been documented? ☐ Yes ☐ No ☐ N/A • Psychiatric symptoms: ☐ Stable ☐ Unstable	

#	Provision	Assessment of Status	Compliance
		• Response to treatment/supports: ☐ Adequate ☐ Inadequate • Factors that may cause decompensation (medical, environmental, etc.) • Combined formulation in narrative form <u>Section III: Psychiatric Medications and Monitoring</u> o Psychiatric Medication with Indication o Starting Dose (if new med) o Dosage Range: FDA/FDR/DADS/Stahl o Duration of medication use This section addresses the following parameters: o Psychiatric Medication with Indication o Time for response to change o Symptoms to monitor for response to medication or should medication be decreased There was also a section for the following: o Emergency Medication Recommendations (EMRs) o Dose and Route o Daily Maximum Dose o Indication o Side Effects to monitor if administered <u>Section IV: Benefit versus Risk of Psychiatric Medications and Placement Recommendations</u> o Summary of Benefit versus Risk Analysis of Psychiatric Medication(s) by the IDT o Initial Severity of Concern(s): ☐ Low ☐ Med ☐ High ☐ Severe o Current Severity: ☐ Low ☐ Med ☐ High o Assessed Risk of Psychotropic Medications: ☐ Low ☐ Med ☐ High o Benefit outweighs Risk? ☐ Yes ☐ No Community Placement: ☐ Psychiatric needs of the Individual cannot be met in the community at this time. ☐ Individual can be successful in the community if current interventions and supports are continued. <u>Monitoring Recommendations for Individuals Placed in the Community:</u>	

#	Provision	Assessment of Status	Compliance
		Psychiatric follow-up: Lab work: Psychiatrist's name/signature: There were also sub-headings below the major headings, which prompted the addition of relevant information. The Facility's internal compilation of data for individuals with completed CPEs (including the corresponding data for PTPs that served as annual CPE updates) indicated that for the time period 5/1/13 through 9/30/13, a CPE and/or PTP had been completed within the prior year for 169 (97%) of the 175 individuals prescribed psychotropic medications. The corresponding updated data for October indicated that, as of 10/30/13, the completion rate was at 100% (173 of 173 individuals). The spreadsheet was continuously updated, and thus, always represented the totals for the prior year. The discrepancy between the 173 on 10/30/13, and the 168 individuals at the time of the Monitoring Team's onsite review was that there were discharges to the community, and also one death within that timeframe. This provision of the Settlement Agreement also stipulates that a CPE should be completed for those individuals prescribed psychotropic medication at the time of admission. Accordingly, the CPE was requested and reviewed for each of the following six individuals who had been admitted since the Monitoring Team's prior review, and were prescribed psychotropic medication at the time of admission:	

Individual	Date of Admission (DOA)	Date of CPE
Individual #298	6/27/13	7/12/13
Individual #455	7/17/13	8/13/13
Individual #379	7/30/13	8/13/13
Individual #81	8/14/13	9/19/13
Individual #299	8/22/13	9/19/13
Individual #334	9/5/13	9/19/13

The review of each of the CPEs indicated that they complied with the specifications contained in the Settlement Agreement.

The Facility was found to be in substantial compliance with this provision, as the review of the PTP documentation indicated that they contained sufficient information to be considered a comprehensive annual update to the CPEs, as well as a summary for the annual ISP. The review of the Facility's data, as well as the Monitoring Team's independent review also indicated that this documentation was being routinely completed for those individuals who resided at ABSSLC, and CPEs were being completed for newly admitted individuals.

#	Provision	Assessment of Status	Compliance
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, which the Psychiatry Department maintained, covered the time period from 5/15/13 through 9/26/13. During this timeframe, there were ten admissions to the Facility. Eight of these ten individuals were prescribed psychotropic medication, and thus, were evaluated with a CPE. The two individuals not receiving psychotropic medications received a Reiss Screening evaluation. The individuals who had been administered the Reiss Screening instrument within the timeframe described above were as follows: ▪ Individual #336: This individual was admitted on 7/2/13. Reiss Screen administered 7/29/13 (Total Reiss Score = 3.5) The Reiss Score was below the clinical cut-off, and there was no need for further psychiatric evaluation. ▪ Individual #406: This individual was admitted on 6/6/13. Reiss Screen administered 6/24/13 (Total Reiss Score = 2) The Reiss Score was below the clinical cut-off, and there was no reason for subsequent psychiatric evaluation. The Monitoring Team's prior reports had recommended 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,	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		and/or if it was elevated above the clinical cut-off score. The following individuals were evaluated with a Reiss Screen during this timeframe, due to a change in status:	

Individual	Reason for Reiss	Reiss Score	Psychiatry Consult Generated	Seen By Psychiatry	Date of CPE
Individual #391	Sleep disturbance	24	5/28/13	6/25/13	6/25/13
Individual #486	Sleep disturbance	9.5	5/21/13	5/28/13	6/25/13
Individual #518	Agitation/ Movement	19	N/A*	6/13/13 6/20/13	N/A*
Individual #377**	Eating Disturbance	10			N/A
Individual #70	Aggression/ SIB	6	N/A	N/A	N/A

*N/A due to fact that individual was already seen in Psychiatric Services and the Reiss Screen was simply performed to help evaluate a change in status.
** Psychiatry Consult cancelled due to pending gall bladder surgery and eating disturbance improved after surgery. Accordingly, it was determined that the gall bladder disease had caused the eating disturbance.

This data indicated the Reiss Screen was being utilized when an individual's team developed concerns about a change in an individual's clinical status. However, at the time of the Monitoring Team's last review, there was no formal written policy that would indicate under what specific circumstance an individual should be considered for a Reiss evaluation. The review of 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 be made as to whether or not they were being performed in all such situations.

During the current review, this issue was discussed with the Chief Psychiatrist, who indicated that the Facility did have a procedure that outlined the specific process for

#	Provision	Assessment of Status	Compliance
		prompting a Reiss Screen, which proceeded in the following manner: ▪ Emerging Behavior or Emotional Distress ↓ ▪ IDT Referral Form - For use by all Staff, Guardians/LARs, Family Members Does not require a physician's order ↓ ▪ QIDP ↓ ▪ IDT Meeting to discuss: o Reiss Screen (new referrals) o Behavioral Data o Habilitation Therapy and Health Data o Psychosocial Input o Family Input There was also evidence of in-service training on 6/20/13, 6/21/13, and 6/25/13, during which the Chief Psychiatrist provided information concerning this process. Specifically, members of the Behavioral Services Department attended the 6/20/13 presentation; medical providers attended the 6/25/13 training; and the 6/21/13 audience consisted of both medical and psychological providers. ABSSLC remained in substantial compliance with this provision, because there was evidence of ongoing monitoring of the status of the individuals not prescribed psychotropic medication that could lead to the administration of the Reiss Screen, as well as the administration of the instrument to all newly admitted individuals not prescribed 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.	
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 Behavioral Health Services was apparent in the interviews with the four psychiatric providers, as well as the interview with the Director of Behavioral Health Services. These interactions were visible in the observation of the Psychiatry Clinics, where it was apparent that the Behavioral Health Services Provider 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	Noncompliance

#	Provision	Assessment of Status	Compliance
		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 Assessment 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 also discussed. This review indicated this subject was discussed adequately in the psychiatric and psychological sections of 24 of the 25 (96%) individuals' records. The exception to this was the record of Individual #51. The discussion in both the psychiatric notes and the psychological material consistently indicated that the rationale for the use of the antipsychotic medication (Zyprexa) was to treat the individual's aggressive behavior, and no rationale was provided for this behavior being co-determined by both biological and behavioral factors. Section J.8 also contains the terminology "integrate pharmacological treatments with behavioral and other interventions through combined assessments and case formulation." The primary setting during which the active collaboration between the Psychiatry and Behavioral Health Departments was the most visible was within the context of the Psychiatry Clinics. The subject of the collaboration between Psychiatry and Behavioral Health also is discussed with regard to Section J.9. The primary disciplines that attended the Psychiatry Clinics were Nursing, Psychiatry, Behavioral Health, Direct Support Professionals, and the Qualified Developmental Disabilities Professionals. The Behavioral Health Services Provider played an active role in this process, and it was clear that the Psychiatrist and other members of the IDT relied heavily upon the behavioral data and other information provided by the Behavioral Health Services Provider. 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 individuals' ISP meetings. At the time of the Monitoring Team's prior review, the members of the Psychiatry Department had begun attending the ISP meetings to the extent possible. The Monitoring Team's previous review found evidence that a member of the Psychiatry team had attended 12 of the 27 (44%) ISP meetings in the months preceding that review. The attendance at these meetings, as well as the content, was reviewed for the 25 individuals in the current sample. This review indicated that a member of the Psychiatry Department had attended a recent individual ISP meeting for 22 of the 25 (88%) individuals in this sample. The records that did not indicate the attendance of a member	

#	Provision	Assessment of Status	Compliance
		of the Psychiatry Team, and the date of the ISP, were as follows: Individual #146 (7/25/13), Individual #4 (5/15/13), and Individual #462 (5/22/13). The Department was also making an effort to have the direct provider of the psychiatric services attend the meeting. The documentation described above indicated that the Psychiatrist, Nurse Practitioner, or the Psychiatric Nurse was present at 19 of the 22 (86) ISPs, at which the Department was represented. The Psychiatric Assistant attended the ISPs of Individual #94 (8/1/13), Individual #355 (12/4/12), and Individual #216 (6/5/13). The Psychiatry Department also maintained data to track their participation in the annual ISPs. The summary of this information was as follows: "The Psychiatry Department attended and participated in 95 percent (81 of 85 meetings) of annual ISPs for individuals receiving psychiatric services from 05/01/2013 through 09/30/2013. The average time spent participating in an annual ISP was one hour and 22 minutes during the 5-month span. Of the 81 ISPs attended, a psychiatric provider attended 74 (91%) meetings and the Psychiatry Assistants attended seven. When looking at the 85 meetings as a whole, a psychiatric provider attended 87 percent." At the time of the prior review, the Facility's documentation indicated that the PTP was included in the final ISP documentation for some individuals. However, this material was not consistently being incorporated into the final ISP, even though the Psychiatry Department stated they had made it available to the IDT. Accordingly, in May 2013, the Psychiatry Department began to integrate their material into the Behavioral Health section of the IRRF, unless polypharmacy was also present (which would then be discussed in that section). The material in the Behavioral Health section of the IRRF followed prompts that DADS State Office developed. The outline for this material was as follows: **"Psychiatric portion of the Behavioral Health Section in the IRRF to be also added to the PTP:** Demographics: Diagnosis: *DSM-5* Current psychiatric medications (Name, dose, frequency, indication, route of administration): Change in a medication in the last 6 months due to increased symptoms: Restraints: More than 3 restraints during any 30-day period over the past 6 months: Chemical Restraints for a behavioral crisis within the past 6 months:	

#	Provision	Assessment of Status	Compliance
		Hospitalizations for a psychiatric diagnosis within the past 6 months: Review of status ad psychiatric symptom data during follow-up and quarterly visits: PBSP: Target Behaviors: FAST/Functional Analysis: Overlap with PBSP: Structured daily activities: Supports: *Use supports & Interventions from RAPPORT* [Risk Analysis of Psychiatric Plan and Other Reasonable Treatments] Psychiatric symptoms: Response to Treatment and Supports: Factors that may cause decompensation: Proposed Recommendations/Rationale (include antecedents, triggers, etc.): Use rating/rationale from the RAPPORT." The current review of 25 individual records found a considerable amount of written documentation relevant to the individual's PTP in the IRRF. The extent of this material varied considerably between individual records. This could be expected to occur, based on the change from attempting to have the material contained in the PTP reflected in the narrative section of the ISP to the current model, where this material was discussed in the expanded Behavioral Health section of the IRRF. In order to track this variability for the sample of 25 individual records reviewed, parameters were recorded for each set of ISP documentation. Based on this review, the following clusters of individuals were identified (date of ISP): ▪ Extensive narrative discussion of the PTP (four to seven pages), accompanied by a lengthy review of this material in the IRRF (four to seven pages) as well (n=4; 16%), including: Individual #323 (7/10/13), Individual #2 (7/2/13), Individual #207 (7/16/13), and Individual #518 (6/13/13); ▪ Extensive review of the psychiatric treatment described in the IRRF, with brief reference to the PTP in the narrative section (n=9; 36%), including: Individual #201 (7/17/13), Individual #216 (6/5/13), Individual #94 (8/11/13), Individual #471 (8/7/13), Individual #147 (9/19/13), Individual #463 (10/3/13), Individual #170 (7/20/13), Individual #51 (6/13/13), and Individual #247 (5/28/13); ▪ Extensive review of the PTP in the narrative section of the review, accompanied by a brief review in the IRRF (n=5; 20%), including: Individual #461 (1/26/13), Individual #320 (2/12/13), Individual #168 (1/15/13), Individual #478 (12/5/12), and Individual #460 (1/22/13); and ▪ The final category related to those ISPs where there was only a minimal discussion in the narrative section, accompanied by a brief review in the IRRF	

#	Provision	Assessment of Status	Compliance
		(n=7; 28%), including: Individual #468 (11/8/12), Individual #355 (12/4/12), Individual #462 (5/22/13), Individual #146 (7/25/13), Individual #278 (4/30/13), Individual #284 (11/7/12), and Individual #4 (5/15/13). During this onsite review, members of the Monitoring Team were able to review three examples (i.e., for Individual #147, ISP 9/19/13; Individual #463, ISP 10/3/13; and Individual #284, ISP 10/16/13) of material recently developed so that it could be incorporated into the ISP. This material was contained in the Behavioral Health section of the IRRF. The material was quite detailed and referenced those topics identified in the language of this provision. However, although the topics were included, the quality of the material was of concern, as well as its understandability to IDT members. In terms of quality, in addition to some information not being complete, data often was not presented to support what appeared to be subjective conclusions regarding individuals' psychiatric symptoms (e.g., "doing better," "increase reported," etc.), clear information was not provided about the actual or realized side effects, and alternative treatment/strategy information was difficult to decipher. In addition, the documentation generally did not reflect that the teams had meaningfully discussed the information the Psychiatry Department presented, and/or describe what the teams' conclusions were with regard to the treatment plans and risk-versus-benefit analyses. These findings are similar to those for the 18 Individuals identified above for whom there was a great deal of information in the ISPs that did address the specific points relevant to this section of the ISP. However, the format was not consistent throughout the sample of individual records reviewed, and there were qualitative problems as described above. In addition it was not possible to determine if the team actually had discussed this material at the ISP meeting, and if so, to what degree. The following recommendations were discussed with the Chief Psychiatrist at the time of the onsite review and the Monitoring Team believes these should be areas of focus over the next six months: ▪ The Psychiatry Department should ensure that objective data is included, whenever possible with regard to individuals target behaviors for psychiatric symptoms, and identify subjective observations so that the reader is clear about the nature of these comments; ▪ Consistent inclusion of graphs in the material would be helpful; ▪ The schematic presentation of the risk-versus-benefit considerations in chart form, referred to as the RAPPORT, should be augmented or replaced with a narrative description that captures the salient points and would be easier for the reader to comprehend; and ▪ There should be a discrete section in the narrative discussion entitled "Deliberations" to capture the input of the Psychiatry Department representative that attended the meeting, as well as the main points from other IDT members'	

#	Provision	Assessment of Status	Compliance
		discussion, with particular reference to specific factors identified with regard to Sections J.8, J.9, and J.10 of the Settlement Agreement. ABSSLC was found to be in noncompliance with this provision, because 28 percent of the ISPs reviewed contained only a minimal reference to the psychiatric aspects of the individual's service plan. Those ISPs with more detailed documentation contained qualitative deficits as described above. In addition it was not possible to ascertain if the material that was present had been thoroughly discussed with the complete IDT during the course of the ISP meeting.	
J9	Commencing within six months of the Effective Date hereof and with full implementation within two years, before a proposed PBSP for individuals receiving psychiatric care and services is implemented, the IDT, including the psychiatrist, shall determine the least intrusive and most positive interventions to treat the behavioral or psychiatric condition, and whether the individual will best be served primarily through behavioral, pharmacology, or other interventions, in combination or alone. If it is concluded that the individual is best served through use of psychotropic medication, the ISP must also specify non-pharmacological treatment, interventions, or supports to address signs and symptoms in order to minimize the need for psychotropic medication to the degree possible.	As noted above with regard to Section J.8 of the Settlement Agreement, the integration of psychiatric and behavioral services was evident in the conduct of the Psychiatric Clinics, as well as in the documentation found in the sample of 25 records of individuals receiving psychotropic medication. The Psychiatrist relied upon the data provided by the Behavioral Health Services Department when making decisions about potential changes in an individual's psychotropic medication. Previously, a significant deficiency in this process, which had been identified in the Monitoring Team's prior reports, related to the degree to which behaviors identified as being targets of a psychotropic medication also were identified in the Functional Assessment 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 Positive Behavior Support Plans were developed through parallel processes that were not fully integrated. ABSSLC had developed systemic approaches to rectify these deficits. These were integrated into the Quarterly Review documentation, as well as 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 annually, in conjunction with the individual's ISP. The Psychotropic Medication Initiation 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, was a major contribution to the differentiation of	Noncompliance

#	Provision	Assessment of Status	Compliance
		learned behaviors from those that were derived from the individual's psychiatric disorder. The second page of this document contained a distinct narrative section that proposed the least restrictive intervention. This was followed by another section that prompted a specific discussion of the differentiation of psychiatric symptoms from learned behaviors, as well as the combined formulation that would elaborate further on these issues. The review of the 25 records contained in this sample indicated that these areas were completed in all (100%) of the documents reviewed, in a manner that was responsive to the prompts. The 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 for 24 of the 25 (96%) individuals. The exception was Individual #51, as was discussed with regard to Section J.8. The interaction of the biological and behavioral-based aspects of the individual's presentation also was discussed in the Bio-Psycho-Social-Spiritual formulation section of the CPEs. That information 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. During the Monitoring Team's current and prior reviews, the observations of the Psychiatry Clinics indicated the discussions upon which the documentation in the Psychiatry Quarterly Reviews and PTP were based occurred in the context of these Clinics and represented contributions from all of the disciplines that were present, including the direct support professionals. The differentiation of the maladaptive behaviors with which the individual presented was 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 appropriate to address the problem. This process' contributions to the determination of the least intrusive interventions are obvious. As noted above with regard to Section J.8, a review of the sample of 25 records identified significant differences in the documentation contained in the ISPs, which could be subsumed under four categories, as detailed with regard to Section J.8. In addition to the concerns noted above, in the sample reviewed, the documentation in the ISP of the IDTs' deliberations did not address the specific points relevant to this section of the Settlement Agreement. The documentation of the teams' deliberations should include the following points:	

#	Provision	Assessment of Status	Compliance
		▪ A determination and clear description of 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 determines the use of psychotropic medication is necessary, the ISP also should specify 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 Psychiatry Department had made progress in addressing these issues, ABSSLC remained in noncompliance with this provision. This was due to the deficits in the ISP documentation, including specifically the need to document the teams' discussion of and conclusions about the specific requirements of Section J.9 of the Settlement Agreement.	
J10	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, before the non-emergency administration of psychotropic medication, the IDT, including the psychiatrist, primary care physician, and nurse, shall determine whether the harmful effects of the individual's mental illness outweigh the possible harmful effects of psychotropic medication and whether reasonable alternative treatment strategies are likely to be less effective or potentially more dangerous than the medications.	This 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 that these discussions always concluded that the benefits of the proposed medications outweighed the risks presented by their side effects. The descriptions of the benefits were formulaic in nature, and the benefits were uniformly described as a reduction in the behaviors 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 individual's psychiatric illness, if it was not treated. The observations of the Psychiatry Clinics, HRC Meeting, and interviews with the Chief Psychiatrist during the current review indicated the process had been fully integrated into the clinical review process and was operating efficiently. The Monitoring Team's current review found there was an adequate discussion of the risk-versus-benefit analysis in each of the 25 (100%) individual records in the sample. Supporting documentation for these decisions was contained in the Quarterly Psychiatric Reviews, as well as the PTPs. The Quarterly Psychiatry Review form contained specific	Noncompliance

#	Provision	Assessment of Status	Compliance
		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 Drug Regimen 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, which 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. The risk-versus-benefit considerations were recorded in the documentation that contained the following sections: <u>Risk Analysis of Psychiatric Plan and Other Reasonable Treatments (RAPPORT)</u> ▪ Severity of Psychiatric Concern(s) Prior to Interventions; ▪ Assessing Current Severity of Concerns for the Behavioral Health Section of the IRRF; ▪ "Risk vs. Risk" Analysis (Individual Can Benefit from Psychiatric Meds); ▪ Assessing Potential and Realized Risks (Use Also in Polypharmacy/Side Effects Section of the IRRF); ▪ Validating MOSES by Item Ratings of 3 or 4 as Side Effects versus Symptoms/ Pathology; ▪ Results of IDT Deliberation of Benefit versus Risk Analysis of Psychiatric Medication(s); ▪ Supports and Interventions to Reduce the Reliance on Psychiatric Medication(s); ▪ Psychiatric Treatments Considered to be of Higher Risk Reviewed by the IDT; and ▪ Summary of Benefit versus Risk Analysis of Psychiatric Medication(s) by the IDT. This document was designed to guide the deliberations of the IDT, and was completed in a psychiatric Medication Quarterly Review prior to the individual's annual ISP meeting. Observations of the Psychiatry Clinics during the Monitoring Team's onsite reviews indicated there was an active discussion of these issues during the Quarterly Reviews, in	

#	Provision	Assessment of Status	Compliance
		which many of the IDT members participated. Specifically, the Psychiatric Provider completed the Risk-versus-Benefit Analysis within the context of the Quarterly Review that preceded the ISP meeting with active input from the other members of the IDT that routinely attended these meetings. This process was observed both during the Monitoring Team's current and prior reviews. The degree to which these deliberations also took place at the annual ISP meeting was less obvious due to the lack of documentation of the deliberations that actually took place at the ISP meeting. The discussions between the Psychiatry Team and members of the HRC during the Monitoring Team's prior reviews indicated there had been some initial confusion regarding the implementation of the new risk-versus-benefit analysis system. At the time of the most recent review, 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 several of the meetings following the implementation of the new system. As noted above, this review found that there was adequate documentation of a risk-versus-benefit analysis in the entire sample of 25 (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 fully integrated into the ISP process, as mandated by the requirements of this provision, which stipulates that it must be approved by the IDT. As indicated in the discussion of Section J.8, the review of the ISP documents contained in the sample of 25 individuals found that the documentation for seven of the 25 (28%) individuals contained only a minimal discussion of the psychiatric aspects of the individuals' overall service plans. The Risk-versus-Benefit material that was contained in the RAPPORT and elsewhere in the ISP documentation for the remaining 18 individuals was extremely detailed and thorough. However, it was not possible to determine to what degree this material was actually discussed in a deliberative manner during the individuals' ISP meetings. The integration into the IRRF process of the relevant material related to the risk-versus-benefit considerations for the use of psychotropic medication needs to occur, and then, the teams need to discuss the information during each individual's ISP meeting. As discussed with regard to Section J.8, the chart currently utilized to document the team's risk-versus-benefit deliberations (the RAPPORT) should be augmented or replaced by a narrative discussion that would be easier for the reader to readily comprehend.	

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>Accordingly, although progress had been made in some of the preparation that the Psychiatry Department was doing for ISP meetings, ABSSLC was found to be in noncompliance with this provision.</td><td></td></tr>
<tr><td>J11</td><td>Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall develop and implement a Facility- level review system to monitor at least monthly the prescriptions of two or more psychotropic medications from the same general class (e.g., two antipsychotics) to the same individual, and the prescription of three or more psychotropic medications, regardless of class, to the same individual, to ensure that the use of such medications is clinically justified, and that medications that are not clinically justified are eliminated.</td><td>ABSSLC had continued its policy of reviewing every individual whose psychotropic medication regimens met the criteria for polypharmacy on a monthly basis. The "Monthly Psychiatric Polypharmacy Committee Meeting Notes," were reviewed for the prior six months. The Chief Psychiatrist, Consulting Psychiatrist, Director of Pharmacy Services, Director of Behavioral Health 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 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 those individuals in the Stable Polypharmacy group, who were reviewed quarterly, which appeared clinically appropriate.

On 11/5/13, a member of the Monitoring Team observed the November 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 11/5/13 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 49 (29%) of the 168 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. Tabular representation of that data is as follows:

<table>
<tr><th>Definitions of Polypharmacy</th><th>8/10</th><th>5/13</th><th>11/13</th></tr>
<tr><td>Number of individuals receiving two or more medications from the same class</td><td>16</td><td>10</td><td>11</td></tr>
<tr><td>Number of individuals receiving three or more medications, regardless of class or indication</td><td>108</td><td>46</td><td>46</td></tr>
<tr><td>Total number of individuals on polypharmacy</td><td>108</td><td>50*</td><td>49*</td></tr>
<tr><td>Total number of individuals receiving psychotropic medication</td><td>224</td><td>182</td><td>168</td></tr>
<tr><td>Percentage of individuals receiving psychotropic medication whose medication regimen met the</td><td>48%</td><td>27%</td><td>29%</td></tr>
</table>
</td><td>Substantial Compliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		criteria for polypharmacy	

*This number is less than the sum of the preceding two numbers, due to individuals prescribed three or more psychotropic medications, who also were prescribed two medications from the same class only being 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 many of these medications were essential for the individuals' stability. Accordingly, 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 11/5/13 Polypharmacy Committee Meeting, the number of individuals in the AP category was 17, while 32 were classified as SP. Thus, the Facility felt there was adequate information to support the efficacy of the existing medications for 32 of the 49 (65%) individuals prescribed medication regimens that met the criteria for polypharmacy, which equates to 19 percent of the total number of individuals prescribed psychotropic medication (168).

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 for the 17 individuals they had placed in the AP category, and by definition the medications for these individuals had not been justified. However, the latter number also included individuals who had recently been admitted to the Facility. Specifically, six of the eight individuals who had been admitted to the Facility since September of 2012 were categorized in the AP group. The number of medications these six individuals had been prescribed at the time of admission were as follows:

One individual = seven medications;
One individual = six medications;
Two individuals = five medications; and
Two individuals = three medications.

The process of sequentially challenging the multiple medications of an individual

#	Provision	Assessment of Status	Compliance
		recently admitted is a difficult process that has to be performed carefully, over several months. When these six individuals were taken into account, the number of individuals in the AP polypharmacy category (as yet unjustified) was reduced to 11 out of 168 (7%) individuals. ABSSLC clearly had made a great deal of progress in reducing unnecessary polypharmacy. This effort was reflected in the observations of the Psychiatric Clinics that took place during the Monitoring Team's 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 AP group, and also continued to actively challenge the medications for these individuals. 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 of the Polypharmacy Committee the Monitoring Team member observed, and since then, a member of the Monitoring Team had further reviewed the information. 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 described in the minutes of the Polypharmacy Committee Meeting. The individuals the Facility placed in the AP grouping had more complex psychiatric presentations and also had historically been prescribed more psychotropic medications. This group 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. Thus, it is possible that the medications for these individuals were effective, but it had not yet been possible to empirically prove this. 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 seven percent, and was continuing to make progress in either reducing the medications of the remaining individuals and/or compiling the necessary data to support efficacy. It is essential that the Facility continue to provide empirical evidence to support efficacy wherever possible.	

#	Provision	Assessment of Status	Compliance
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. 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 practitioner. The review of the sample of the records for 25 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 for 24 of the 25 (96%) individuals. The documentation for Individual #462 contained a gap in the MOSES completion from 4/10/12 to 4/23/13. The records of 24 of the 25 (96%) individuals contained documentation that the prescribing practitioner 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 #2. This record contained a gap from 9/30/13 to 10/24/13. 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 25 individuals indicated that the Facility carried out quarterly evaluations with the DISCUS of all individuals receiving psychotropic medications, regardless of whether or not one of these medications was an antipsychotic agent. This was similar to the findings of the Monitoring Team's previous reviews, 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 reflected an internal mechanism to routinely administer these evaluations to ensure completion for all who required 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. The DISCUS had been performed quarterly for 24 of the 25 (96%) individuals. The exception was Individual #478, for whom there was a gap between the 8/20/13 and the 2/5/13 DISCUS. The documentation related to the DISCUS was reviewed with regard to the length of time between when the nurse performed the evaluation, and when the prescribing	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		practitioner reviewed the results. The individual whose records indicated there was a significant delay was Individual #2 (9/30/13 to 10/24/13). Thus, the prescribing practitioner reviewed the DISCUS in a timely manner for 24 of the 25 (96%) 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 eight individuals receiving Reglan who were not also prescribed a psychotropic medication. This was a significant decrease in the use of Reglan, as there were 18 such individuals at the time of the May 2013 review. The following sample included four of the eight (50%) individuals who fit the above criteria, including: Individual #19, Individual #226, Individual #385, and Individual #261. 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 (100%) of the four individuals in the sample. 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 the review by the prescriber had been completed in a timely manner for all (100%) of the four individuals. With regard to the completion of the DISCUS for the individuals in the sample, these evaluations were completed as specified for two of the four (50%) individuals. Once completed, the prescribing physician had reviewed the DISCUS evaluations in a timely manner for all (100%) of the four individuals in the sample. The individuals for whom there was a gap of greater than three months between evaluations were: Individual #26 (gap between 3/14/13 and 9/5/13) and Individual #220 (gap between 10/5/12 and 8/19/13). 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. The scheduling of these evaluations, in conjunction with these meetings, also facilitated	

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		the timely review with the Psychiatrist at the time of the meeting. During the Monitoring Team's previous review, a nurse 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. Since the Monitoring Team's prior review, there was evidence of training for the nurses on the appropriate use of the DISCUS, which occurred on 6/18/13, and for the PCPs on 6/25/13. ABSSLC had made significant progress in both the completion of the MOSES and DISCUS evaluations on schedule, and the timely review by the prescribing practitioner. ABSSLC was found to be in substantial compliance with this provision at the time of the prior review. 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 25 individual records of those prescribed psychotropic medication indicated that the MOSES was completed as specified for 96 percent of the individuals, and also had been reviewed in a timely manner for 96 percent. The corresponding review of the DISCUS for those 25 individuals in the sample indicated that it had been performed as specified for 96 percent of individuals and reviewed in a timely manner for 96 percent. Review of the administration and timely review of the MOSES for the sample of individuals prescribed Reglan indicated that the evaluations had been conducted at least every six months, and reviewed in a timely manner by the prescriber for 100 percent of the individual records reviewed. However, this was not the case for the administration of the DISCUS, which indicated that it had only been administered every three months for two of the four (50%) individuals, although all of the examinations completed had been reviewed by the prescriber in a timely manner. The specific individual information for the evaluation with the DISCUS for individuals prescribed Reglan is detailed above. The Facility can determine if this finding was related to filing or other administrative errors. The deficits in the administration of the DISCUS reduced the overall completion rate for the DISCUS from 24 of the 25 (96%) to 26 of 29 (90%) individuals. Based on the Facility's overall compliance rates with these evaluations, the finding of	

#	Provision	Assessment of Status	Compliance
		substantial compliance was continued from the prior review. However, the Facility is encouraged to ascertain the reasons for the deficits in the administration of the DISCUS to those individuals prescribed Reglan, and make corrections, if necessary.	
J13	Commencing within six months of the Effective Date hereof and with full implementation in 18 months, for every individual receiving psychotropic medication as part of an ISP, the IDT, including the psychiatrist, shall ensure that the treatment plan for the psychotropic medication identifies a clinically justifiable diagnosis or a specific behavioral-pharmacological hypothesis; the expected timeline for the therapeutic effects of the medication to occur; the objective psychiatric symptoms or behavioral characteristics that will be monitored to assess the treatment's efficacy, by whom, when, and how this monitoring will occur, and shall provide ongoing monitoring of the psychiatric treatment identified in the treatment plan, as often as necessary, based on the individual's current status and/or changing needs, but no less often than quarterly.	This provision of the Settlement Agreement addresses processes essential for the appropriate use of psychotropic medication for individuals with ID/DD. The first of these relates to the integrity of the psychiatric diagnosis, as indicated by the following terminology: "The Treatment Plan for the psychotropic medication identifies a clinically justified diagnosis or a specific behavioral-pharmacological hypothesis." The review of the records of a sample of 25 (15%) of the 168 individuals prescribed psychotropic medication indicated that adequate documentation to support the psychiatric diagnosis of record could be identified for all (100%) of the individuals. The other factors referenced in this provision, such as the ongoing monitoring of these symptoms or behaviors, was discussed in the quarterly documentation, summarized in those ISPs and identified as meeting the quality standards of the Settlement Agreement. 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 Sections J.8 and J.9. This important issue was addressed in the Psychiatry and Psychology sections in 24 of the 25 records selected for review (96%). The only exception was Individual #51, for whom the documentation in the sections of both disciplines primarily described the function of the Zyprexa as the suppression of aggressive behavior, without a clear linkage to the individual's underlying Autism Spectrum Disorder. 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 observed during the course of the Monitoring Team's onsite review. The Behavioral Health Services Provider led this aspect of the discussion during the meeting, but there was active input from all of the professional disciplines present. The Behavioral Health Services Provider 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	Noncompliance

#	Provision	Assessment of Status	Compliance
		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 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 Behavioral Health Services Provider during the meeting. Each individual review lasted for greater than 30 minutes, and there was ample time for additional discussion. There was no sense of time pressure to complete the discussion, or 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. There were no urgent Consultations during the Monitoring Team's present onsite review that required a visit to the individual's residence. At the time of the prior review, a member of the Monitoring Team was able to observe the clinical evaluations performed by the Consulting Psychiatrist for two individuals that had undergone psychotic decompensations. The evaluations were thorough, and the findings were clearly communicated to both the residential Nursing staff and the Direct Support Professionals who worked with the individuals. These discussions also indicated that the Consulting Psychiatrist previously had been contacted by telephone during the hours when he was not at the Facility with regard to one of these individuals, and that he 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, and 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. This material 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	

#	Provision	Assessment of Status	Compliance
		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 meeting of the Polypharmacy Committee; Mental Status evaluation conducted at the time of the meeting; the psychiatric diagnosis and the primary identified symptoms of that disorder; a description of the individuals' 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 25 (100%). The information related to the timeliness 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 PTP, which was currently performed yearly in conjunction with the ISP. The contents and structure of this document is described in detail above with regard to Section J.6. This section also addresses the question of ABSSLC's capacity to monitor the efficacy of the prescribed psychotropic medication. As indicated in the discussion related to Section J.11, the Facility had 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 contained in a separate section of the Quarterly Review documentation, was continuously updated, and was maintained for all individuals' prescribed psychotropic medication. The Facility's overall success in eliminating unnecessary polypharmacy is described with regard to Section J.11. Another requirement of this provision is related to the frequency with which the Psychiatrist reviews the 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 25 (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 25 (100%) individuals. The Facility's Self-Assessment noted that, despite the progress identified above, this information was not yet fully reflected in the documentation contained in the ISP through inclusion in the IRRF. This observation led to the rating of noncompliance in the Facility's Self-Assessment. This finding was consistent with the results described with regard to Monitoring Team's assessment of Sections J.8, J.9, and J.10 for this report, which also documented continued deficits in the ISP documentation and the teams' review of the psychiatric treatment plan, despite considerable improvement in some of	

#	Provision	Assessment of Status	Compliance
		the preparation that the Psychiatry Department was doing for ISP meetings. Accordingly, because the Facility had not yet met the specific requirement included in Section J.13 for the IDT to review and the ISP to reflect the review of the treatment plan, the Facility was found to be in noncompliance with this provision.	
J14	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall obtain informed consent or proper legal authorization (except in the case of an emergency) prior to administering psychotropic medications or other restrictive procedures. The terms of the consent shall include any limitations on the use of the medications or restrictive procedures and shall identify associated risks.	The review of the Rights/Consents sections of the medical records for the sample of 25 individuals indicated that 13 individuals had a Guardian of the Person. Those individuals without a Guardian relied on the Facility Director to review the material concerning risk-versus-benefit considerations related to the utilization of psychotropic medication, and then provide the necessary consent. 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 this 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 individual's 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 from the individual's residence. The QIDP 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 QIDP 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 a 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 11/5/13, a member 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 had been experiencing in understanding and reviewing the risk-versus-benefit analysis. In response to this issue, the Chief Psychiatrist attended several HRC Meetings and worked with the members of the HRC until they reached a point where they understood the process. The observation of the 11/5/13 meeting, and	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		the review of the meeting minutes, indicated that the HRC was now proficient in understanding the risk-versus-benefit process. The HRC review of psychotropic medication had previously 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 the use of each specific psychotropic medication. The Monitoring Team's current review also found signed consents for the individuals in the sample of 25 out of 25 (100%) records of individuals receiving psychotropic medication. The direct observations of the HRC 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 ABSSLC had a functioning system to obtain informed consent for the use of psychotropic medication. The HRC effectively monitored this process on an ongoing basis. As noted with regard to Section J.10, the Facility had developed a sophisticated and effective risk-versus-benefit assessment process, which was being systematically implemented. The Monitoring Team's previous reports also discussed a deficit, in that the consent documentation did not contain information concerning the dosage range of the medication, or sufficient risk-versus-benefit considerations. Providing the guardian with a copy of the Psychiatric Medication Initiation documentation, along with the side-effect information effectively addressed these issues. Accordingly, ABSSLC was found to be in substantial compliance with this provision of the Settlement Agreement.	
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. Individuals with a psychiatric disorder as well as a neurological disorder did not routinely have appointments scheduled during separate time periods from those without a psychiatric diagnosis. Given the number of individuals who were followed in the Neurology Clinic, and the relative percentage of those who met the criteria described in	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	disorder.	this provision, it appeared nearly impossible for the Psychiatrists to physically attend these Clinics, which could last in excess of three hours. These problems appeared primarily logistical in nature, because the existing Neurology Clinic was organized to bring all individuals from a specific residence, who were due to see the Neurologist, in at the same time. This was 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. However, the Psychiatrists had established a system whereby the Administrative Assistant that organized and coordinated the Neurology Clinic would call the psychiatric provider for the individual shortly before the Neurologist was due to review them, so that they could go to the Clinic to participate in that specific individual's review. During the Monitoring Team's previous 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 previous 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 there was coordination between the Psychiatry and Neurology Departments 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 to identify any reference the individual's psychotropic medication, as well as other aspects of the individual's psychiatric status. The existence of a corresponding reference to the Neurology Consultation in the Psychiatry section of the record also was assessed. Documentation that the individual had been seen in a Neurology Clinic during the past year was present in nine of the 25 individuals. Documentation that the Neurology Clinic had occurred, appeared in the Psychiatric Quarterly Review Notes for all of the nine (100%) individuals in this subsample. The Neurology Notes also referenced the psychotropic medications for all nine (100%) individuals. The identification of the individual's psychotropic medication in the Neurology note was essential to ensure that the Neurologist was aware of these medications and could account for any possible interactions with the prescribed anticonvulsant medications. Thus, the Psychiatry Department was tracking the occurrence of and results from a Neurology Consultation for all of the individuals they followed in the sample. The language of this provision of the Settlement Agreement is specific in stating that the	

#	Provision	Assessment of Status	Compliance
		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 52 individuals. However, 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. In the interval since the last Monitoring Review, the Facility had identified the individuals that met these criteria. The discussion of this initiative that appeared in the Facility Self-Assessment described the following methodology: *The Provision J.15 Tracking Log was created in May 2013 and initially tracked 16 individuals, 5 of whom did not have medications prescribed to treat both seizures and a mental health disorder but warranted closer monitoring due to neurological and mental health issues. Two of those 5 have now been removed from tracking as one is no longer followed by neurology and the other simply needed coordination between the services to address sedation, suspected to be secondary to phenobarbital and is now sleeping much less during the day. Four individuals needed further clarification as to whether seizure medications were being used for both neurologic and psychiatric purposes. All four have received clarification in their Neurology Consult Reports and only one remains in tracking due to shared indications. As of 09/29/2013, the updated tracking log consists of 7 individuals receiving medications prescribed to treat both seizures and a mental health disorder; and an additional 3 that will be monitored due to neurological and mental health issues, though they do not have medications with shared indications. All 10 have received coordination of services through one or more of the following: a psychiatric provider was present at the Neurology Consult, the psychiatric provider has discussed the results of the Neurology Consult with the IDT and documented this in the Psychiatric Quarterly Reviews, &/or clarification of coordination has occurred in the Physician's Orders.* The following table provides more specific information regarding this process: PROVISION J.15 NEUROLOGY LIST (last amended 11/5/2013) **Individual** / **Last Seen in Neurology Clinic** / **Present in Neurology Clinic** / **Discussed in Psychiatry Clinic** / **Comments**	

#	Provision	Assessment of Status					Compliance
		Individual #393	3/25/13	No	10/14/13	11/4/13 Neurology appointment has been rescheduled	
		Individual #180	8/12/13	Yes	6/5/13	Psychiatric provider discussed decrease in platelets related to Depakote	
		Individual #137**	3/11/13	Yes	10/15/13	Rescheduled due to missed appointments	
		Individual #216	6/24/13	No	8/21/13	Designated as shared by Neurology and Psychiatry in 6/13.	
		Individual #481	3/28/13	N/A		Re-emergence of seizures led to shared responsibility, as determined in 9/13.	
		Individual #526	4/8/13 11/4/13	Yes	9/26/13	11/9/13 no concerns to coordinate	
		Individual #323	3/28/13	No	9/17/13		
		Individual #525	3/14/13 9/9/13	No	6/26/13		
		Individual #405*	7/22/13	Yes	8/19/13		
		Individual #241*	6/24/13	Yes	6/26/13		
		Individual #463*	3/14/13 9/9/13	Yes	9/18/13		
		*These individuals were not prescribed medications to treat both seizures and psychiatric disorder, but Psychiatry believed there were other reasons that they should be followed closely. **This individual was not included in the narrative review of the Facility Self-Assessment, because the shared use of anticonvulsants was established after the Self-Assessment was prepared. ABSSLC was found to be in substantial compliance with this provision, because they had developed and implemented a systematic process to coordinate on those individuals who were prescribed anticonvulsant medication for both neurological and psychiatric purposes. In addition, they continued to track the occurrence of every neurological appointment for individuals prescribed psychotropic medication through their Quarterly					

#	Provision	Assessment of Status	Compliance
		Review process, even though the Settlement Agreement does not require this process for individuals being seen by the Neurologist for reasons other than the joint prescription of medications prescribed to treat both seizures and a mental health disorder.	

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, held on 11/4/13; o Section K Presentation Book; o Section K Self-Assessment, updated 10/21/13; o Department of Behavioral Services meeting minutes: 5/16/13, 5/28/13, 7/22/13, 8/22/13, and 9/19/13; o Behavior Support Committee meeting minutes: 8/7/13, 8/28/13, 9/4/13, 9/11/13, 9/18/13, 9/25/13, 10/1/13, 10/2/13, 10/9/13, 10/16/13, 10/23/13, and 10/30/13; o External Peer Review Committee meeting minutes: 7/26/13, 8/9/13, 9/13/13, and 10/4/13; o Internal Peer Review Committee meeting minutes: 9/4/13, 9/11/13, 10/10/13, and 10/25/13; o Psychology Monthly Progress Notes, 6/13 to 8/13, for: Individual #178, Individual #250, Individual #305, Individual #95, Individual #4, Individual #373, Individual #29, Individual #303, Individual #441, Individual #462, Individual #439, and Individual #177; o Psychology Monthly Progress Notes, 6/13 to 7/13, for Individual #510; o Psychology Monthly Progress Notes, 7/13 to 8/13, for Individual #455; o PBSP Targeted Behavior Data Sheets: Individual #178, Individual #250, Individual #305, Individual #95, Individual #4, Individual #373, Individual #29, Individual #303, Individual #347, Individual #455, Individual #441, Individual #462, Individual #439, Individual #510, and Individual #177; o PBSP Replacement Behavior Data Sheets: Individual #250, Individual #305, Individual #95, Individual #4, Individual #373, Individual #29, Individual #303, Individual #347, Individual #441, Individual #462, Individual #439, and Individual #177; o PBSP Targeted Behavior Data Sheets for the week of 11/4/13 to 11/8/13: Individual #299, Individual #242, Individual #76, Individual #108, Individual #42, Individual #198, Individual #17, Individual #252, and Individual #525; o Functional Assessments for: Individual #178, Individual #250, Individual #305, Individual #95, Individual #4, Individual #373, Individual #29, Individual #303, Individual #347, Individual #455, Individual #441, Individual #462, Individual #439, Individual #510, and Individual #177; o Psychological Evaluation/Update for: Individual #305, Individual #303, Individual #347, Individual #455, and Individual #177; o Master list of individuals who have a psychological assessment/update; o Behavior Support Plans for: Individual #178, Individual #250, Individual #440, Individual #305, Individual #95, Individual #4, Individual #242, Individual #373, Individual #99, Individual #303, Individual #81 (draft), Individual #347, Individual #455, Individual #441, Individual #337, Individual #425, Individual #462, Individual #486 (draft),

	Individual #354, Individual #444, Individual #94, Individual #439, Individual #139, Individual #165, Individual #9, Individual #510, and Individual #177; o Behavior Protocol for Individual #299; o Monthly Monitoring and Tracking the Guardian Consent Forms for Behavior Support Plans; o Behavior Support Plan Competency Checklists for: Individual #178, Individual #250, Individual #305, Individual #95, Individual #4, Individual #29, Individual #303, Individual #347, Individual #455, Individual #425, Individual #354, Individual #139, Individual #510, and Individual #177; o Detailed Instructions for PBSP Integrity and Reliability (I/R) Monitoring; and o Psychology Procedure, revised 4/1/13. ▪ **Interviews with**: o Ron Manns, BCBA, Director of Behavioral Services, and Kathy Theiss, BCBA, Clinical Supervisor, on 11/4/13; o Ron Manns, BCBA, Director of Behavioral Services, on 11/7/13; o Kristin Wyrick, QIDP Coordinator; Jeff Branch, Director of Active Treatment; and Jolene Willis, Assistant Director of Programs, on 11/5/13; o Direct Support Professionals, on 11/6/13; o Active Treatment Staff, QIDP Staff, and Program Compliance Monitors, on 11/7/13; and o Candia Hallford, Director of Vocational Services, on 11/7/13. ▪ **Observations of**: o Residence 5961, Residence 5962, Residence 5971, Residence 5972, Residence 6330, Residence 6350, Residence 6370, Residence 6380, 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 Clara Campbell Center; o 5th Street Diner; o Incident Management Review Team, held on 11/4/13; o Behavior Support Committee, held on 11/6/13; o Internal Peer Review Committee, held on 11/7/13; o Restraint Reduction Committee, held on 11/7/13; and o Psychiatry Clinic for Residence 6350, held on 11/6/13.
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section K, dated 10/21/13. In its Self-Assessment, for each subsection, 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. Only those subsections the Monitoring Team reviewed during this visit are discussed below: ▪ For Section K.3, the Director of Behavioral Services reviewed the minutes from the meetings of the

	Behavior Support Committee, the External Peer Review Committee, and the Interdisciplinary Peer Review Committee. Only the meeting dates of the Behavior Support Committee were identified in the self-assessment (4/1/13 through 9/25/13). A review was also conducted of the Facility's policy regarding peer review. ▪ For Section K.4, the Director of Behavioral Services sampled 10% of the monthly progress notes between 4/13 and 8/13. This resulted in a review of 111 progress notes, representing 237 individuals who had a Behavior Support Plan. An analysis of eight indicators was completed with average compliance data provided for each. ▪ For Section K.5, the Director of Behavioral Services, as part of the Facility's Behavior Support Committee, had reviewed all of the functional behavior assessments completed between 4/1/13 and 8/30/13. The exact number of assessments reviewed was not reported. To determine the degree to which assessments met expected requirements and were of adequate quality, the department director and the behavior specialist responsible for the assessment employed a standard rubric. Although eight indicators were identified within the rubric, compliance data for each indicator was not presented. ▪ Also for Section K.5, the Director of Behavioral Services reviewed the Facility's policy related to psychological assessments. ▪ For Section K.9, the Director of Behavioral Services tracked the timeliness of consent and plan implementation for each Behavior Support Plan from 4/1/13 to 8/30/13. Based upon a graph provided, it appeared that a total of 73 plans were reviewed. ▪ Also for Section K.9, the Director of Behavioral Services reviewed each Behavior Support Plan presented at the Facility's Behavior Support Committee. As reported in the text of the Self-Assessment, a total of 59 plans were reviewed between 4/1/13 and 8/30/13. A standard rubric was employed to assess 19 indicators. Data were presented on overall compliance for the standards, but data was not presented regarding individual indicators. ▪ For Sections K.10 through K.12, the Director of Behavioral Services reviewed integrity and reliability scores collected between 4/1/13 and 8/30/13. The in-service database also was reviewed for Section K.12. Data presented included: average integrity and reliability scores; average correct staff responses to 10 interview questions; average measures of PBS Integrity and Reliability (I/R) Monitoring Data broken down by setting; and monthly frequency of staff training, overall form of staff training, and monthly averages of staff competency as demonstrated through role play, interview, or observation. ▪ There was no evidence of the assessment of inter-rater reliability with staff from the Quality Assurance Department or Program Compliance Monitors. ▪ The Facility rated itself as in noncompliance with all subsections reviewed during this visit. Justification for these findings was provided. This was consistent with the Monitoring Team's findings.
	Summary of Monitor's Assessment: Although not addressed during this modified review, it should be noted that the Facility had made marked gains in increasing the number of staff who were BCBAs. The Facility also had expanded its peer review system to include weekly meetings of a committee whose primary purpose was to review individuals who were displaying limited progress on their behavior

	support plans or who presented as especially challenging cases. This was a very positive addition to the already existing BSC and EPRC functions. Behavioral Services Department staff had increased their review of staff members' understanding of PBSPs and their implementation of these plans to determine if it was with a high degree of integrity. As treatment integrity was largely assessed through videotaped recordings of behavioral events, staff are encouraged to schedule daily visits to the homes and day habilitation programs of the individuals they serve. The focus should be to train staff to competently implement individuals' behavior support plans. The provision of feedback, in the moment, will enhance staff members' skills when working with the individuals served. Behavior coaches continued to provided support and training to the direct support professionals working with individuals residing at the Facility. These department staff were available during the two daytime shifts, seven days a week. The plan was to expand the schedule of behavior coaches to the overnight shift ensuring around the clock support, which would be a positive addition. Functional Behavior Assessments continued to reflect greater emphasis on direct observation of identified problem behavior. Additionally, several assessments included reports in which identified preferences were tested to evaluate their effectiveness as reinforcers. Similarly, there were several PBSPs that reflected improved focus on dense schedules of reinforcement for appropriate behavior. Concerns remained regarding the accuracy of data collection. Problems reported in the past remained evident. Likewise, restricted ideas for addressing identified problem behaviors reduced the effectiveness of behavior support plans and the quality of life experienced by the individuals served. A focus for the future should be on improved preventative strategies, including but not limited to more comprehensive habilitation programming.

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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	The parties agreed the Monitoring Team would not monitor this provision, because the Facility had made limited to no progress. The noncompliance finding from the last review stands. Although this section was not included in the reduced monitoring outlined for this visit, a brief comment is appropriate. At the time of the Monitoring Team's visit, 10 staff members in the Department of Behavioral Services had obtained the credential of a Board Certified Behavior Analyst. This comprised 50% of the Master's level staff in the department. Commendations are extended to the Facility, the department, and the individual staff members for this accomplishment.	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.		
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.	The parties agreed the Monitoring Team would not monitor this provision, because the Facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	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 initiated some changes in the peer review process. This is described below: ▪ The Behavior Support Committee continued to serve as one mechanism for internal peer review. The committee continued to meet weekly to review behavioral assessments, behavior support plans, and crisis intervention plans. ▪ The Interdisciplinary Peer Review Committee had been discontinued due to reported difficulties of scheduling all members of the committee. ▪ In lieu of the above, the Behavioral Services Department had introduced an Internal Peer Review Committee (IPRC). Similar to the BSC, this committee was scheduled to meet weekly. However, unlike the BSC, this committee was not restricted to annual review of plans or more timely review of revised plans. The primary purpose of this committee was to provide review of individual programs with low treatment efficacy or for individuals who presented with high risk. The goal was to review three to four cases each week. ▪ The EPRC continued to meet monthly via conference call. Membership was composed of behavioral services staff from four facilities: Abilene, Austin, Corpus Christi, and Lubbock. As evidenced at the BSC meeting held during the week of the Monitoring Team's onsite review, the responsible behavior specialist presented the FBA or BSP. Minutes for 36 individuals reflected the staff members in attendance, discussion, and feedback. The author presented the plan and reviewed the individual's progress from the previous year. When revisions were recommended, these were noted in the minutes. With the exception of four individuals whose plans were reviewed and for whom a tracking sheet was provided, the dates of the ISP, the FBA, or BSP were not identified in the minutes. One promising practice was the review of counseling plans developed for two individuals.	Noncompliance

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		Minutes from the newly formed IPRC were reviewed for four meetings. (Two additional meeting minutes reviewing information for Individual #231 and Individual #196 were excluded, because these were dated 5/1/13 and 12/18/13 respectively.) Similar to the BSC, minutes from these meetings identified the material presented, feedback to the author, and future action plans, with an identified expected completion date. This was an appropriate addition to the peer review process as ongoing review of particularly difficult cases could now take place. Some concerns were raised when reviewing the minutes: ▪ The minutes recorded for four of the five individuals reviewed at the IPRC meeting held on 10/25/13 were incomplete. There was no summary of the materials reviewed, commendations, or concerns. ▪ Further concerns were raised when expected completion dates from the cases reviewed on 10/25/13 were between 12/5/13 and 1/23/13. For example, although a follow-up plan was to implement replacement behavior training for Individual #95 as soon as possible, completion was not expected until 13 weeks later. Similarly, staff working with Individual #3 were to identify preferred clothing, put signs in his I-Book, and obtain a switch for him to activate music. Here too, the expected completion date was 13 weeks after the IPRC review. Lastly, a review was completed of the minutes from four EPRC meetings held between 7/26/13 and 10/4/13. The following summarizes the findings. ▪ In all of the meetings (100%), staff from all four facilities participated. The Behavioral Services Coordinator also participated in the meeting held in July. ▪ In all of the meetings (100%) one case was presented for an individual residing at ABSSLC. ▪ Information about the individual whose case was reviewed was included in the minutes from each meeting. However, only the minutes from the last three meetings reflected the discussion and recommendations. The most comprehensive review was provided for Individual #37 at the 10/4/13 meeting. ▪ While individual staff members were identified as the person responsible for follow-up to recommendations, no expected completion dates were included. In the minutes from 8/9/13, it was noted that the behavior specialist would present the recommendations to the individual's team, and then would report back to the ERPC at the next meeting. A follow-up report was not included in the minutes from the 9/13/13 meeting. As noted in the past, the Facility is commended for conducting regular meetings of the Behavior Support Committee and the External Peer Review Committee. The introduction of an Internal Peer Review Committee to review programs in which the individual is not making progress or to review particularly difficult cases is a very promising practice. It remains important for the Facility to develop and document a mechanism for timely	

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		dissemination and implementation of recommendations made by peer review committees. When recommendations are not followed, there should be a written justification for this decision. Finally, although not a requirement for substantial compliance, the Facility is encouraged to invite direct support professionals and other department members to these meetings, because they serve as an excellent resource for training and mentoring staff. 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.	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., a smaller sample) for this subsection, because the Facility had made limited progress. The noncompliance finding from the last review stands. A total of 40 Psychology Monthly Progress Notes were reviewed, representing 14 individuals. For 12 individuals, reports were provided for the time period 6/13 through 8/13. For one individual, reports were provided for 6/13 and 7/13, and for another individual, reports were provided for 7/13 and 8/13. The format for these progress reports was consistent across individuals and remained similar to what has been described in past reports. A summary of the Monitoring Team's findings is provided below: ▪ Graphs of an individual's target problem behaviors were presented in every progress report (100%). Data were reviewed and trends were identified. ▪ In the progress reports for 13 of the 14 individuals (93%), monthly rates of target behaviors were presented graphically. For Individual #455, graphs depicted the weekly rates of his targeted problem behaviors. General labels (i.e., frequency, month) were applied to the vertical and horizontal axes, respectively. ▪ Data on replacement behavior was consistently displayed graphically in each of the reports for 11 of the 14 individuals (79%). Only the progress note from 8/13 for Individual #373 included graphic depiction of replacement behavior. There were no replacement behavior graphs for Individual #95, and a replacement behavior had not yet been identified for Individual #455. ▪ Thirty-five of the 40 monthly progress notes included information regarding monitoring of BSP implementation. This was reported in the text, in a 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. These last three indicators were measured through a review of videotapes as outlined in department policies and procedures. ▪ As defined by Cooper, Heron, and Heward (2007), IOA "…refers to the degree to which two or more observers report the same observed values after measuring the same events (p.113)." IOA was determined by viewing videotaped	Noncompliance

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		occurrences of targeted problem behavior. Three concerns were raised, including: o First, in several reports, calculations of IOA and treatment integrity were identical. While this is certainly a possibility, the manner in which these scores were presented or the actual numbers reported suggested some confusion about these measures. For example, in the 8/13 report for Individual #305, data were reported as "the total IOA and treatment integrity score was 33%." This issue was also raised at the BSC meeting held the week of the Monitoring Team's onsite review. o Second, in the monthly reports for nine of 14 individuals (64%), the method of calculating IOA was noted to be exact count per interval. This represents the most stringent method for calculating agreement between observers who are using an event recording system. It typically involves comparing the number of events tallied within smaller intervals of time. As the intervals employed by the Facility were typically half hour blocks of time, an argument could be made that it was misleading to describe the method of determining IOA as exact count per interval. At the very least, staff should identify the length of the interval within which IOA is calculated. o Lastly, in only 22 of the 35 reports in which IOA was reported, was the observation conducted in the current month. For example, although IOA was reported in three consecutive monthly reports for Individual #177, this was calculated based upon an event that occurred in May. ▪ Planned Activity Checks or PLACHECKS were described as a measure of "…engagement for the individual and those immediately around him." As noted in the last report, it remained unclear why group engagement would be reported in an individual's progress report. When this was discussed with the Director of Behavioral Services, he suggested that this measure revealed whether purposeful activities were planned and ongoing. Again, this did not reflect the degree to which the individual was purposefully engaged in an activity that was meaningful to him/her. As the PLACHECK form includes the names of the individuals in the group, the individual's engagement could be discerned from this measure. ▪ Each progress note (100%) ended with a section regarding recommendations/interventions/plans. While some included specific recommendations with identified due dates, other progress notes reflected the same recommendations across three consecutive months. For example, for three months it was noted that the BSP for Individual #178 was being revised. In the progress notes for Individual #177, a repeated recommendation was for the behavior analyst to "…reevaluate stripping as a target behavior." All recommendations should be addressed in a timely manner.	

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		Data sheets for targeted problem behaviors identified in the PBSP for 15 individuals were reviewed. For 14 of these individuals, data was provided between 6/1/13 and 8/31/13. Individual #455 had been admitted during the summer, therefore, his data sheets covered the period from 7/17/13 through 9/15/13. A summary of the findings is presented below: ▪ For eight of the individuals in the sample (53%), the method of data collection was consistent for all identified target behaviors. For the remaining seven individuals (47%), two different methods of data collection were utilized. ▪ Eleven of the 15 individuals in the sample (73%) had at least one problem behavior tracked using an ABC data sheet. This recording method allows staff to note the date and time of the behavior, the location, the activity, the immediate antecedent, and the immediate consequence. As only behavioral occurrences are recorded, one cannot determine with confidence whether there was an absence of the behavior(s) on specific days or whether staff simply did not record the occurrence. On at least one of the ABC data sheets for Individual #441 and Individual #177, lines were drawn across the entire page, suggesting that there had been no occurrences of the targeted behavior(s) for the identified week. Recording the occurrence or nonoccurrence of behavior over a seven-day period is prone to inaccuracy. When the Director of Behavioral Services was asked to describe the guidelines used to determine which type of data sheet to employ, he explained that it was the decision of the individual's behavior specialist. A suggestion would be to use ABC data sheets when first assessing baseline measures. This will provide potentially useful information regarding the antecedents and consequences that are maintaining the problem behavior. However, once baseline measures are established, staff should switch to scatterplot data sheets as these provide a more streamlined way to collect measures of targeted problem behaviors. ▪ Data sheets for five individuals allowed staff to tally the frequency of the targeted behavior within half hour intervals. In every case, data was missing. Of particular concern was the data sheet for Individual #303. The instructions on the data sheet for hyperactivity/disruption, leaving without proper escort, and aggression indicated that staff should record no more than two occurrences of these behaviors within each half hour interval. There was no explanation provided for this method of recording, which could result in significant underreporting of the targeted behaviors. Further concerns were raised as a check of his progress notes reflected graphs on which the vertical axis was labeled "frequency." There was no indication that the data reflected in the graph were restricted to no more than two occurrences per 30-minute interval. ▪ Data sheets for four individuals tracked the occurrence or nonoccurrence of the behavior within specified intervals of time. For three of these individuals, staff	

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		were to record whether the person was awake or asleep. However, there were no definitions regarding the duration of the behavior. It was unclear whether measures of awake/asleep behaviors reflected a partial interval or whole interval time sampling method. In every case, there were time slots where data were not recorded. Staff were to use a partial interval recording method when collecting data on the disruptive behavior displayed by Individual #29. However, from 10:00 pm to 6:00 am, they were to use an ABC recording sheet. As the first results in a percentage of intervals during which the behavior occurred (even momentarily), the latter results in a measure of behavioral frequency. It is not possible to combine these two measures in any meaningful way. In the graphs for Individual #250 (sleep) and Individual #29 (disruption) the vertical axis was incorrectly labeled frequency. The vertical axis in the graph depicting sleep behavior exhibited by Individual #455 was labeled hours. These graphs should be re-labeled to accurately reflect the data collection methods used to track their behaviors. ▪ For two individuals, staff were to record both the frequency and severity of the targeted behavior, self-injury, within half hour intervals. In both cases, data were missing, lines were drawn through multiple intervals of time, and in spite of missing data, a tally of the behavioral occurrences was noted. ▪ Replacement behavior data sheets were provided for 12 individuals. In all but one case, staff were to note whether the individual had the opportunity to learn or practice the replacement behavior. The exception was Individual #303 for whom a scatterplot data sheet was used to record the occurrence or nonoccurrence of his replacement behavior within 30-minute intervals. For six of the individuals in this sample, there was evidence of at least one opportunity to engage in the replacement behavior during the specified week of data collection. Data sheets for Individual #305 indicated multiple opportunities throughout the recording period. For the other six individuals, replacement behavior was not recorded for at least one week. Individual #462 had very limited opportunities to practice her replacement behaviors. Between the dates of 6/22/13 and 8/31/13, there was evidence of only one opportunity to ask for a break and no evidence of asking to transition to a quieter environment. During the week of the onsite review, the Monitoring Team occasionally observed concerning behavior. Data sheets were provided for nine individuals. A summary of findings is provided below: ▪ Individual #299 was observed on 11/4/13 eloping from his home at 4:45 p.m. Although the Behavioral Health Services Provider indicated that this behavior would be added to his data sheet, it was not being recorded at the time of the visit. ▪ Individual #252 was observed displaying loud vocalizations in his home on	

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		11/5/13 before 8:00 a.m. This behavior was not included in his behavior support plan, and therefore, was not recorded. ▪ Data sheets for the remaining seven individuals in the sample indicated that the observed behaviors were identified in their behavior support plans and should have been recorded as they occurred. In none of the incidents observed (0%) was there a record of the targeted behavior. These are described below: o Individual #242 was observed slapping his head four times on 11/5/13 at 2:14 p.m. This behavior was included in the definition of self-injury. o Individual #76 was observed sucking on her shirt on 11/7/13 at 1:45 p.m. This behavior was included in the definition of chewing inedible items. o Individual #108 was observed screaming at 7:55 a.m. on 11/5/13. This behavior was included in the definition of screaming/cursing. o Individual #42 was observed hitting her head four times on 11/6/13 at 12:49 p.m. This behavior was included in the definition of self-injury. o Individual #198 was observed reaching out to hit/scratch a staff member at 9:15 a.m. on 11/7/13. This behavior was included in the definition of aggression. o Individual #17 was observed screaming at 1:45 p.m. on 11/5/13. This behavior was included in the definition of disruptive behavior. o Individual #525 was observed screaming, throwing his body against the back of his wheelchair, and hitting his hand against his wheelchair. While screaming was not identified on the data sheet (although it is suggested that it should be), the other behaviors did have the potential to cause harm to the individual. Clearly, targeted problem behaviors were evident without a record of their occurrence. Further problems with timely recording of behavioral data were identified during the Monitoring Team's observations at the Facility. In 23 I-Books reviewed on site, none (0%) included data recorded to the most current half-hour interval of time. This was found when visiting homes during the first and second shifts. In one home, staff were observed at 1:10 p.m. completing data sheets for several hours earlier or for the entire shift. It should be noted that this included marking the data sheets through the end of the shift at 2:00 p.m. In another home visited at 1:17 p.m. on 11/4/13, there were no data sheets included in the I-Books for the current week. The accuracy of this data recorded at the end of an eight-hour shift is highly suspect. Comments provided in past reports remain relevant. 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 was very likely inaccurate and unreliable. Behavioral services staff should work closely with direct	

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		support professionals to ensure that data collection systems are manageable and completed with 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 assessment procedures that allow for the identification of medical, psychiatric, environmental, or other reasons for target behaviors, and of other psychological needs that may require intervention.	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., a smaller sample) for this subsection, because the Facility had made limited progress. The noncompliance finding from the last review stands. Functional Assessments for 15 individuals were reviewed. The Functional Assessment is completed to determine the variables that contribute to the occurrence of problem behavior, to determine the hypothetical function of the problem behavior, and to help guide the development of the behavior support plan. A summary of the review findings is provided below: ▪ All of the assessments (100%) identified both indirect and descriptive methods of determining behavioral function. ▪ Specific instruments used for indirect assessment were the Functional Analysis Screening Tool (FAST), the Questions About Behavioral Functioning (QABF), and/or the Functional Assessment Interview Form (FAIF). Every assessment (100%) identified specific indirect methods of determining behavioral function, but only 10 of these (67%) referenced current information. The results of the FAST completed in 2011 for Individual #462 were reviewed, however, it was suggested that these did not "… appear to reflect the true function." As the screening tools and questionnaires can be administered quickly, staff should update these annually. The Director of Behavioral Services also suggested that staff interview be conducted annually, even if the FAIF is not completed in full. ▪ All of the assessments (100%) indicated that structured observations of the individual had been conducted. In some cases, targeted problem behavior was not observed. One promising practice was the scheduling of observations during times when problem behavior was likely to occur based upon staff interview or a review of data or observation notes. ▪ All of the assessments (100%) included an analysis of conditional probability in which situations are determined that will likely result in problem behavior. These were completed through direct observation and/or a review of observation notes. It was noteworthy that the behavior specialist for Individual #455 completed a thorough observation, but due to the absence of targeted problem behavior, she then reviewed observation notes to develop her hypothesis. Video records were reviewed for Individual #177. ▪ All of the assessments (100%) identified setting events, antecedent stimuli, and consequences to the targeted problem behaviors. Summaries of variables likely maintaining the problem behavior were also provided. Where appropriate,	Noncompliance

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		biological variables were identified. The following comments are provided: o Concerns were raised regarding Individual #250. A hypothesized function of her targeted problem behavior was escape from catheterization. Although this might have been addressed, there was no documentation indicating that the interdisciplinary team was working together to make this a less aversive event for this woman. o In the report for Individual #95, notes were included suggesting a "…strong pattern of aggressive behavior on days prior to home visits." Appropriately, further comments noted that the most recent analysis did not support this correlation. As anecdotal reports continued, it will be important to work with staff to ensure that misconceptions about the impact of family visits are not maintained. o Individual #4 was noted to become upset if she was prompted repeatedly to engage in an activity after an appropriate refusal. It is suggested that she should be offered choices whenever possible. o Similarly, Individual #462 was observed to display noncompliance following repeated prompts to engage in a scrapbooking activity. Offering a choice of activities whenever possible might help reduce her active refusal. o The same suggestion could be made for Individual #510. Escape was identified as the primary function of her targeted problem behaviors. She had demonstrated improved responding when given a choice of reinforcers. This same strategy should be applied when presenting tasks or activities. o Individual #462 was also reported to display targeted problem behavior early in the day when first awakening. It would be advisable for staff to examine her morning routine to determine whether changes could be implemented that would make this more tolerable. o Individual #177 was noted to display his problem behavior when he had soiled his brief. It would be advisable to identify a regular schedule for checking the cleanliness of his clothing or for changing his brief so that this matter could be addressed. ▪ All of the assessments (100%) included the identification of replacement behavior. Thirteen of the 15 assessments (87%) reflected replacement behaviors that were functionally equivalent or would potentially limit the occurrence of the targeted problem behavior. o Several individuals were to learn to ask for attention, to request items, to negotiate a delay in beginning an activity, or to ask for a break or change in environment. These were all appropriate alternative behaviors. o Individual #177 was to learn to use an adaptive switch to request a	

#	Provision	Assessment of Status	Compliance
		transition outside. o Individual #373 was to learn to choose between two pictures in order to obtain attention or access to a preferred item. While this addressed the identified function, it was unclear whether she would be able to choose between two pictures, because she was visually impaired. o The disruptive behavior displayed by Individual #29 was hypothesized to function as a means to escape from demands or access tangible items. Her identified replacement behavior was described as waiting. It was unclear how this was functionally equivalent to her targeted problem behavior. o Similarly, Individual #439 was to learn to speak quietly. However, she already displayed this behavior. It was when she was not acknowledged that she would become agitated. ▪ Preference assessments were reported in all of the assessments. Where noted, methods of determining preferences were identified as interview with the individual and/or staff, or in seven cases, formal assessment through stimulus presentation. Two of these were described in great detail and involved further testing of the reinforcing value of the identified items. o The report for Individual #455 reviewed a formal assessment completed with food items. The behavioral specialist then took these identified preferences and tested the reinforcing value of these items during discrete trial training. o Similarly, a formal assessment was completed with Individual #510. When two foods were identified as most preferred, these were tested as reinforcers during discrete trial training. ▪ For nine of the 15 individuals (60%), the functional assessment had been completed before the annual ISP meeting. The Director of Behavioral Services indicated that his expectation was for draft assessments to be completed 10 days before the ISP meeting. This would allow the team to review the findings and make appropriate recommendations for the behavior support plan. ▪ Although all of the assessments were signed (100%), the accompanying date indicated that signatures were obtained between several weeks to several months after the completion of the assessment. The Director of Behavioral Services suggested that this was most likely a result of a long approval process. It is suggested that these assessments should be reviewed and approved in a timely manner to ensure that the behavior support plan is based on the most current information regarding behavioral function. ▪ As noted in the past, staff should carefully proof their reports for accuracy. The assessment for Individual #373 referenced interviews, rating scales, and observations that had occurred after the date of the report. Recommendations for Individual #441 included continuation of his psychotropic medication	

#	Provision	Assessment of Status	Compliance
		regimen, but he was reportedly not taking any medication. Facility policy also required annual updates to the individual's psychological assessment. Although the most current psychological assessment was requested for the 15 individuals in the sample, documents were provided for only five of the 15 individuals (33%). Only the report for Individual #455 indicated that a standardized psychological evaluation had been completed within the past five years. A master list provided by the Facility suggested that an additional five individuals (i.e., Individual #178, Individual #250, Individual #4, Individual #373, and Individual #510) had a current assessment. Copies of these were not provided to the Monitoring Team. Although the Facility had clearly made improvements to the functional assessment process, these were not consistently updated or completed within expected timeframes. Further, the quality of these assessments varied across individuals. Continued emphasis should be placed on observation of the individual in his/her home, work, and leisure environments, with thoughtful suggestions for prevention strategies and functionally equivalent replacement behaviors. Annual psychological assessments will need to be completed for each individual by his/her ISP meeting. For these reasons, the Facility remained out of compliance with this provision of the Settlement Agreement.	
K6	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.	The parties agreed the Monitoring Team would not monitor this provision, because the Facility had made limited to no progress. The noncompliance finding from the last review stands.	Noncompliance
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.	The parties agreed the Monitoring Team would not monitor this provision, because the Facility had made limited to no progress. The noncompliance finding from the last review stands.	Noncompliance
K8	By six weeks of the assessment	The parties agreed the Monitoring Team would not monitor this provision, because the	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	Facility had made limited to no progress. The noncompliance finding from the last review stands.	
K9	By six weeks from the date of the individual's assessment, the Facility shall develop an individual PBSP, and obtain necessary approvals and consents, for each individual who is exhibiting behaviors that constitute a risk to the health or safety of the individual or others, or that serve as a barrier to learning and independence, and that have been resistant to less formal interventions. By fourteen days from obtaining necessary approvals and consents, the Facility shall implement the PBSP. Notwithstanding the foregoing timeframes, the Facility Superintendent may grant a written extension based on extraordinary circumstances.	A request was made for the Behavior Support Plans for 30 individuals. A Behavior Protocol was provided for Individual #299, the BSP for Individual #136 was not included in the documents, and according to a note provided to the Monitoring Team, the plan for Individual #215 had not been implemented at the time of the document request (i.e., the week of the onsite visit). This was most concerning, because Individual #215 had been back at the Facility for almost three months following a failed community placement, and the failure was related to behavioral concerns exhibited in the community. A summary of the review of the 27 BSPs is provided below. ▪ Twenty-two of the 27 BSPs (81%) identified the date of the ISP. In only 16 of these cases (73%), the date matched that of the most current ISP. Two of these were identified as drafts. The draft BSP for Individual #486 identified an ISP meeting from June 2012. This suggested that although over 12 months had passed, the plan had still not been approved. ▪ Nineteen of the 27 BSPs (70%) included an implementation date. ▪ Fourteen of the BSPs (52%) included both an ISP date and an implementation date. In only two of these 14 BSPs (14%) was the implementation date within one month of the ISP date. The BSP for Individual #510 noted the "date of the actual implementation of the plan (was) at the person's home." As the expectation is for each BSP to be developed, revised, or updated at the annual ISP meeting, it will be important to have these implemented in a timely manner. This is particularly true as the FBA also should be updated in preparation for and at the annual ISP meeting, and might yield information that will result in an improved BSP. ▪ All of the plans (100%) included a rationale for the BSP. Each provided a brief review of the hypothesized function(s) of identified target behaviors, with 15 BSPs (56%) noting the date of the most recent functional behavior assessment. ▪ All of the BSPs (100%) included an adequate operational definition of the targeted problem behavior(s). BSPs for several individuals (e.g., Individual #440, Individual #81, Individual #455, Individual #354, Individual #444, Individual #94, Individual #165, Individual #9, and Individual #177) included exclusions to the targeted problem behavior, helping to further clarify the operational definition. Concerns were raised for two plans: o The plan for Individual #305 identified only one targeted problem	Noncompliance

#	Provision	Assessment of Status	Compliance
		behavior, tearing his shirt. However, it was noted in his ISP that he engaged in a variety of self-injurious behaviors. These were reportedly addressed in his Psychiatric Support Plan. This behavior should be addressed in his BSP so that staff can follow guidelines to prevent the behavior and methods to apply when the behavior occurs. o The plan for Individual #337 identified self-injury as the only targeted problem behavior. However, both stripping and placing his hands in his pants were referenced throughout the plan. In fact he was described as sitting "…with his hands in his pants for a large portion of the day." It would appear that both of these behaviors should be addressed in his BSP. ▪ While all of the plans (100%) identified replacement behavior(s), only 11 of these (41%) included adequate operational definitions of the identified behavior(s). Comments regarding other concerns about individual specific replacement behaviors are provided below: o The hypothesized function of the agitation displayed by Individual #439 was to gain attention when her appropriate requests were not acknowledged. She reportedly increased her voice volume and when still not acknowledged, she would become agitated. Her replacement behavior was to speak quietly. As the report indicated that she already displayed appropriate voice volume, it was unclear how this would change staff behavior. It would seem that a more appropriate replacement behavior would be to teach her to pair her initial request with some other behavior, such as raising her hand or ringing a bell, that would result in attention from staff. o Individual #242 was to learn to use an object mat to communicate what he wanted. During the Monitoring Team's visit, a staff member working with this individual was interviewed. He explained that the individual did not like to use this mat. He then took the mat from a backpack to demonstrate the individual's response. When it was presented, Individual #242 pushed it away. This aversion to using the mat was also noted in his QIDP progress report from 8/13. His plan should be revised to ensure communicative strategies that the individual will readily learn or use. o Individual #425 was to earn tokens for learning to wait and improve his conversation skills. It was concerning that teaching was to occur when he was displaying challenging behavior. This might inadvertently strengthen a chain of responding that begins with problem behavior. o Individual #139 was reported to engage in his targeted problem behavior when over-stimulated, uncomfortable, or when in noisy and crowded areas. His replacement behaviors were to learn to request	

#	Provision	Assessment of Status	Compliance
		something to do and learn to wait. It is unclear how either of these responses will serve the same function as his identified problem behavior. ▪ Specific schedules for training replacement behaviors were included in 23 of the 27 BSPs (85%). These schedules varied markedly. Individual #95 was to learn social skills three times each week. Individual #177 was to learn to operate an adaptive switch once per shift. Individual #250 was to learn to ask for what she needed four times per shift. Individual #354 was scheduled to expand his vocabulary twice each shift. Each training session was to consist of 30 trials. It is suggested that for some individuals, limited training opportunities will greatly impede the acquisition of new skills. While individual learning rate is dependent upon a number of variables, it might be helpful if the Facility were to develop guidelines that would include an expected minimum schedule of training. This should not only indicate the number of days during which training would occur, but also the number of trials to be conducted within each training session. ▪ While all of the plans included sections addressing preventative strategies that addressed motivating operations, setting events, and/or antecedent conditions, the quality and breadth of preventative strategies varied across plans. o Plans that included thoughtful guidelines for prevention included the following: • Offering a choice of tasks or activities was included in the BSPs for Individual #81, Individual #354, Individual #9, and Individual #510. This is a fairly simple strategy that has been documented to be effective in reducing problem behavior. • Similarly, for Individual #81 and Individual #354, for whom attention was an identified behavioral function, staff were advised to provide attention every 10 to 15 minutes and spend 10 to 15 minutes engaging with the individual every hour. • Individual #455 disliked loud and crowded environments. Staff were to offer him headphones or ask him if he would like to go to another area if the environment became noisy or crowded, respectively. o Plans that did not adequately address these antecedent conditions included the following. • Individual #178 frequently scratched old wounds. As healing wounds can be very itchy, there should be steps taken to relieve this uncomfortable condition. • It was noted that Individual #242 enjoyed spinning. Staff were advised to ensure that he had plenty of open area to engage in this behavior. It would appear that this individual would be	

#	Provision	Assessment of Status	Compliance
		better served if he could learn to discriminate between areas where spinning was acceptable (e.g., the privacy of his room) and those where it should be avoided (e.g., the kitchen area of his home). • Similarly, Individual #486 was noted to suffer from allergies. Although staff were to alert a nurse if they noticed discomfort, there was no apparent plan to administer medication during allergy season. • Other individual-specific suggestions for prevention strategies can be found in Section K.5 of this report. ▪ Reinforcement of appropriate behavior was clearly identified in 13 of the 27 BSPs (48%). Ten of these (77%) utilized token systems. The breadth of the systems and the frequency of token exchange varied across individuals. For example, Individual #81 was to earn a token (i.e., hole punch) for beginning and completing tasks, for independently asking for a break, and for participating in anger management role-play. He could exchange his tokens whenever he chose. A more restricted system with limited opportunity for exchange was identified in the plan for Individual #462. She could earn a token whenever she asked to move to another area. Token exchange occurred at lunchtime on Thursday. Staff should carefully track the integrity and efficacy of all token programs to ensure that these are resulting in positive behavior change. Adjustments to the program, including expanded delivery of tokens, more frequent token exchange, or greater variety in back-up reinforcers, should be considered when progress is not observed. ▪ All of the plans (100%) outlined strategies to follow when the targeted problem behavior(s) occurred. Eighteen of these (67%) indicated that staff were to tell the individual to stop engaging in the behavior. Individual specific concerns are addressed below: o Staff were to remind Individual #178 that they were watching him. Although this was suggested to reduce the likelihood of his engaging in self-injurious behavior, it might also result in a heightened state of anxiety. o A member of the Monitoring Team observed one incident that raised concern regarding the understanding and implementation of the BSP for Individual #242. The individual's one-to-one staff member was providing him small bits of a cookie for attending. Three times, this individual was observed hitting his head with his hand. After each display of self-injurious behavior, he was given a piece of cookie. Behavioral services staff are encouraged to make frequent visits to the individuals' homes, work sites, and activity centers to ensure that problems such as this are detected and addressed. This matter was	

#	Provision	Assessment of Status	Compliance
		discussed with the Director of Behavioral Services. ▪ All of the BSPs (100%) included baseline or comparison data and goals for reduced rates of targeted problem behavior(s). Concerns were noted in six BSPs: o For Individual #486 and Individual #94, rates of targeted problem behaviors were reported as number of intervals. Staff should specify the length of the interval and the total number of intervals per day. It might be better to describe this data as a "percentage of 48, 30-minute intervals during which the behavior occurred," or something similar. o Similarly, the behavioral goals for Individual #250 noted that she would exhibit her targeted problem behaviors a specified number of times (or less) per month. The plan noted that data collection was switched from a frequency count to a partial interval measure. Therefore, the goal should identify a percentage of intervals, with the interval length and number of daily intervals indicated. o The goals for Individual #510 and Individual #177 noted that the targeted problem behaviors would occur a specified number of times over a six- or 12-month period, respectively. It was unclear if these numbers reflected monthly averages or total occurrences of the targeted behaviors. o Comparison data for Individual #165 described his rate of disruptive/aggressive behavior. The behavioral objective specified the behavior, grabbing peers. It may be necessary to collect baseline data on this latter behavior. ▪ Instructions regarding data collection were included in all of the BSPs (100%). ▪ Twenty-five of the 27 BSPs (93%) were signed. Of concern was the plan for Individual #250, because her BSP had been signed 21 months after the implementation date. ▪ The data provided by the Facility regarding consent was very difficult to interpret. Individuals' names were repeated, without explanation, and guardian consent was noted for only four of 37 individuals (11%). This tracking data did not include the ISP date, therefore, it was not possible to determine the timeliness of the BSP implementation in relation to the individual's annual planning meeting. Based upon the review of Behavior Support Plans, the Facility remained out of compliance with this provision of the Settlement Agreement. A focus for the future should be the development of plans with clearly defined replacement behaviors, adequate schedules of teaching these replacement behaviors, enriched and specific schedules of reinforcement for appropriate and alternative behaviors, and expanded prevention strategies.	

#	Provision	Assessment of Status	Compliance
K10	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, documentation regarding the PBSP's implementation shall be gathered and maintained in such a way that progress can be measured to determine the efficacy of treatment. Documentation shall be maintained to permit clinical review of medical conditions, psychiatric treatment, and use and impact of psychotropic medications.	A total of 40 Psychology Monthly Progress Notes were reviewed and are discussed with regard to Section K.4 of this report. Included in 35 of these 40 reports were measures regarding treatment implementation. In the 22 reports (55%) in which current observations of behavioral events were reviewed to determine treatment integrity, measures ranged between 0% and 100%. For the individuals in the sample, this calculated to a mean of 80.36%. The document entitled: "Detailed Instructions for PBS Integrity and Reliability (I/R) Monitoring" provided guidelines for staff assessing treatment integrity via videotaped recording of behavioral events. Segments of tapes were identified during which behavioral events had been recorded. Behavioral services staff were to note whether or not the staff member responded according to the BSP. Similarly, behavioral services staff noted whether or not staff responded to and reinforced replacement behavior according to the BSP. Both of these measures resulted in a simple yes or no recording. It remained unclear how this process allowed staff to assess the efficacy of BSP implementation when plans involve multiple components. Utilization of competency-based checklists described in subsection K.12 should better address this issue. As noted in the previous report, the use of videotaped records is a creative way for behavioral services staff to evaluate events that they might not be present to observe. However, this does not allow for the provision of immediate feedback to staff regarding their accuracy in implementing the BSP. 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. Both positive feedback and immediate retraining can occur. Therefore, the behavioral services staff are encouraged to increase their time on site to provide direct training and supervision to direct support professionals. A second component of plan monitoring was staff interview. Individual staff members were asked 10 questions regarding an individual's BSP. These assessed the staff member's ability to: name and describe target behaviors; list reinforcers and necessary materials; describe how to respond to target behaviors; name, describe, and indicate how to prompt and reinforce replacement behavior; and indicate how to document both target and replacement behaviors. Scores of correct responding ranged from 0% to 100%, with a mean of 80%. As noted in the progress reports, scores of less than 90% resulted in retraining. As noted above with regard to Section K.4, for 13 of 14 individuals, graphs included in their psychology progress notes depicted the 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 new or	Noncompliance

#	Provision	Assessment of Status	Compliance
		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 changed related to health issues. Staff should provide graphic display of targeted behaviors in a manner that will allow analysis of the effects of planned and unplanned changes. Although there was evidence of ongoing assessment of treatment integrity and monthly review of progress, the Facility remained out of compliance with this provision of the Settlement Agreement. Data collection remained compromised, monthly assessment of inter-observer agreement and treatment integrity was not yet fully implemented, 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.	When interviewing direct support professionals, the general consensus was that BSPs were written clearly. Staff reported that although their thoughts and suggestions regarding a plan might be solicited, they did not always see a resulting change made to the plan, or explanation of why not. Finally, staff reported that they rarely were provided positive feedback regarding their work performance. While this was not specific to behavioral services staff, it was mentioned when discussing video recordings of events in the homes. Staff reported that videotapes are utilized to identify things they are doing incorrectly, but are not often used to provide necessary assistance or positive feedback. The Director of Behavioral Services explained that his department staff did not apply a grade level test to their plans. However, in the review of 27 BSPs outlined in Section K.9 of this report, the Monitoring Team found the plans to be clearly written. One suggestion would be to describe all strategies (e.g., pivot) in observable terms. The Facility remained in substantial compliance with this provision of the Settlement Agreement.	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.	At the time of the visit, BSP Competency Checklists had been developed for 14 of the 30 individuals in the sample (47%). In 12 of the checklists reviewed, a summary was provided of the following components of the individual's BSP: prevention strategies, guidelines for teaching replacement behavior, steps to take when problem behavior occurs, and methods of documenting target and replacement behaviors. The staff member conducting the training was to note whether the competency was demonstrated through role-play or on-the-job, was performed correctly or incorrectly, and whether retraining was necessary. The checklists for Individual #95 and Individual #4 appeared to be incomplete, because the only information provided were the "responding" and "documentation" pages respectively. The checklists for Individual #455, Individual #354, and Individual #510 were the most comprehensive. These checklists should prove helpful in providing competency-based training to all staff who work with the individuals served. In the future it will be helpful to review completed checklists to ensure that staff are provided with clear feedback regarding their implementation of the individual's BSP.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Behavior Coaches continued to be employed to provide training and support to the direct support professionals. At the time of the visit, coaches were on site seven days a week between the hours of 6:00 a.m. and 10:00 p.m. The goal was to hire additional staff to ensure that coaches were available 24 hours a day. While the extra support offered on site is a positive development, every effort should be made to ensure that this does not result in less involvement of the lead behavioral specialist in supervising and training direct support professionals and day habilitation staff on individuals' BSPs. The Psychology Procedure, revised on 4/1/13, outlined expectations regarding training on BSPs. The procedure indicated that the behavioral services staff member along with the home manager would identify the staff who required training. The Behavior Coach would then "provide discussion, role play, and observed competence for each step in the checklist for those identified staff." It was unclear whether all staff working with all individuals would receive this level of training. The policy should clearly delineate which staff will be expected to demonstrate competency while working with the individual versus those who can demonstrate competency through interview and/or role-play. As noted in the last report, the Facility is commended for the steps taken to address competency-based training of all staff. With continued focus on developing individual-based competency-checklists to train staff, there should be a corresponding improvement in treatment integrity and possibly efficacy. Until this process is consistently applied, the Facility remains out of compliance with this provision of the Settlement Agreement.	
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.	The parties agreed the Monitoring Team would not monitor this provision, because the Facility had made limited to no progress. The noncompliance finding from the last review stands.	Noncompliance

SECTION L: Medical Care	
	Steps Taken to Assess Compliance: The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o List of all staff who work in the Medical Department, including names and titles; o Name and Curricula Vitae 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 last Monitoring Team visit; 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 last six months; o Since the last onsite review, copy of Continuing Medical Education (CME) for each Primary Care Provider; list of CME credits according to topics reviewed; list per PCP of total CME credits during this time period; o Copy of any clinical guidelines developed and implemented since last Monitoring Team visit; o Minutes of Infection Control (IC) 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 (QI) program, including identification of trends and descriptions of improvement actions taken, including date of audit from which information retrieved; o Two most recently completed quarterly medical reviews from each residence; o For any medical staff meetings (i.e., morning medical meetings, etc.) copy of all minutes, handouts, logs from Infirmary, hospitalizations, and 24-hour reports discussed, for the week prior to the Monitoring Team's visit; o Most recent results/report of the Facility-wide medical review system, including copy of any non-facility physician review reports or data since the Monitoring Team's last visit, with separate reports/data of external medical peer review audits from internal medical peer review audits (both general medical and medical management audits), including information concerning number of corrective action plans, and Quality Assurance Department follow-up of these corrective action plans; 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. Submitted requested information included location at time of death, whether Do Not Resuscitate, whether receiving hospice services, ambulatory status, and whether supplemental oxygen prescribed as part of routine care. Date of any ethics committee meeting that reviewed the individual's terminal course, if applicable;

	o Mortality Reviews (i.e., clinical, administrative, and nursing reports) since Monitoring Team's last visit; o Corrective actions related to Mortality Reviews (including status reports on previous recommendations made prior to last Monitoring Team visit which had follow-up closure or action steps completed); o Notes and orders for any 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 following individuals: Individual #349, Individual #409, Individual #142, Individual #431, Individual #408, Individual #395, Individual #54, Individual #467, Individual #94, Individual #210, Individual #214, Individual #139, Individual #9, Individual #117, Individual #83, Individual #414, Individual #55, Individual #530, Individual #426, and Individual #21; 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 pending; 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 and all IPN commenting on consultant reports (agreeing or reason not agreeing by PCP), any documentation of notification of IDT concerning consult report and PCP response, and any ISP addendum related to the consultant report; o List of individuals: a) with tracheostomies; b) with fractures, including date of fracture, type of fracture (i.e., compound, simple, stress, etc.), and bone fractured (location); c) with injuries requiring visit to Emergency Room (ER) or hospitalization since the last onsite review; and d) with pica or ingesting inedible object, date of ingestion, object/liquid ingested, whether taken to ER or hospitalized, since the Monitoring Team's last onsite 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 (i.e., 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 (specific medications, etc.) of osteopenia/osteoporosis; o For women with diagnosis of osteopenia/osteoporosis, and premenopausal, copy of any lab work testing secondary causes (from current active record), other information indicating cause (specific medications, etc.) of osteopenia/osteoporosis; o For each individual with osteopenia/osteoporosis, any active record document for calculation of daily calcium and Vitamin D intake (i.e., 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 IPN from start of signs/symptoms to transfer to ER, ER report, discharge orders from ER and copy of Facility record orders, IPN/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 for completion of recommendations); documents from the active records for the following individuals were submitted: Individual #70, Individual #15, Individual #515, Individual #124, Individual #493, Individual #366, Individual #325, Individual #537, Individual #196, and Individual #520; o For those admitted to hospital, copy of IPN 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, IPN/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 for completion of recommendations) for the following individuals: Individual #304, Individual #406, Individual #124, Individual #325, Individual #230, Individual #515, Individual #185, Individual #167, Individual #382, and Individual #541; 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, if applicable; o Infectious disease data per quarter by category of infection for the last two quarters; o Summary report or trend analysis of infectious disease/communicable disease for the last

	two quarters; o Avatar pneumonia tracking forms/pneumonia data from Avatar database for past six months; o For those with diagnosis of pneumonia in last six months and taking food/liquid by mouth: the type of liquid (amount of thickening), and type of texture of solid food ordered, and last swallow study; o Absolute numbers of new cases (i.e., prior year, by month) for the following: a) pneumonia; b) decubitus ulcers; c) urinary tract infections (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 (i.e., type of seizure), medication regimen; o For past six months, for five individuals, documentation of seizure management (e.g., neurologist's notes): o List of individuals seen by neurologist with dates on which appointments were completed and reason, since the Monitoring Team's last visit, date of prior visit to the neurologist for these same individuals; 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 seizures since last Monitoring Team 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 with diagnosis of seizure disorder on zero, one, two, three, four, and five antiepileptic drugs (AEDs); o Numbers and percentages of persons on older AEDs (e.g., Phenobarbital, Dilantin, Mysoline, or Felbamate); o Since the Monitoring Team's last visit, any ethics committee meeting minutes, with attendance rosters, concerning DNR decisions/changes, or other concerns addressed by this committee; 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/IPN completed for all individuals; o For specialty clinic appointments (on campus and offsite), list of appointments that were completed and ones not completed (with reasons);

	o For hospitalizations in prior six months, copies of follow-up ISPA; 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 (i.e., 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, Human Rights Committee approval, relevant assessments, Individual Support Plan entries, any general discussion record, action plan, and IPN entries; o Ten most recent Physical and Nutritional Management Team recommendations for which physician orders were written based on those recommendations; o ISPA addressing missed appointments or refusals for the past three months (for mammograms, colonoscopies and offsite and onsite consultation appointments); o List of missed medical appointments with reasons past six months; o Presentation Book for Section L; o DADS Preventive Health Care Guidelines, SSLCs, dated August 30, 2011; o For women age 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), if pelvic not done, the reason/indication, and if pap smear not done, the reason/indication; o For those with a history of hysterectomy, list the reasons for the hysterectomy; o For the self-assessment process: list of monitoring/audit tools used; for each tool, identification of the total number of the eligible population to be sampled, the number of the sample, clarification of how the sample was chosen, how often the data was collected, the staff that completed the audit/monitor survey/review, 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/chart/table with date range of each database. For data collected periodically rather than continuously, the frequency of the data collection; o For each of the following individuals, copies from the active record: most current annual medical assessment and physical exam, preventive care flow sheet, most current nursing assessment, past one year of IPN, 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 past one year, most recent Individual Support Plan and subsequent addendums, most recent Behavior Support Plan, and past three medical quarterly reviews: Individual #27, Individual #162, Individual #212, Individual #140, Individual #382, Individual #297, Individual #378, Individual #385, Individual $515, Individual #452, Individual #435, and Individual #236; o Minutes of the following medical morning meeting with handouts during the Monitoring Team's visit: 11/5/13, 11/6/13, and 11/7/13;

	○ QA Corrective Action Tracking External Medical Audit April 25 to 26, 2013, and Internal Audit July 13 to 20, 2013 (additional revision 8/28/13); ○ QA/QI Council Handouts 11/4/13; ○ QA/QI Council meeting notes 10/7/13; ○ Operating Policies and Procedures Manual, Medical Services; and ○ List of those with Barrett's esophagus, including date of last EGD and copy of most recent GI consult. ▪ **Interviews with**: ○ Richard Chengson, MD, Medical Director; ○ Edward Craig, MD, Settlement Agreement Compliance Physician; ○ Eric Williams, DO, Staff Physician; ○ Mary Pat Arth, RN, NP-C, Nurse Practitioner; ○ Osagieoduwa Osawaye, RN, NP-C, Nurse Practitioner; ○ Susanne Yeagley, MD, Staff Physician; ○ Dolores Erfe, MD, Staff Physician; ○ Elizabeth Greer, RN, Medical Program Compliance Nurse; and ○ Geverna Gloyd, RN, QA Nurse. ▪ **Observations of**: ○ 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, Individual #468, and Individual #409; ○ Morning Medical Meetings, on 11/5/13, 11/6/13, and 11/7/13; ○ Lunch and Learn Meeting, on 11/6/13; and ○ QA/QI Council meeting, on 11/4/13.
	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: ○ The monitoring/audit tools the Facility used to conduct its self-assessment included: external peer review general medical audit, external peer review medical management audit, internal peer review general medical audit, internal peer review medical management audit, quality of medical care indicators for aspiration pneumonia, quality of medical care indicators for diabetes mellitus, and quality of medical care indicators for Down syndrome. ○ These monitoring/audit tools included adequate indicators to allow the Facility to determine compliance with the Settlement Agreement in those areas of clinical care, but did not include the breadth of topics needed to provide oversight for medical services. The Facility is encouraged to review the Monitoring Team's report to identify indicators that are relevant to making compliance determinations.

	○ The monitoring tools included adequate methodologies, such as record reviews. ○ The Self-Assessment identified the sample(s) sizes, including 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). This sample size(s) were adequate to consider them representative samples. ○ The following staff/positions were responsible for completing the audit tools: physicians. ○ 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 to show whether or not the intended outcomes of the Settlement Agreement were being reached. However, the quality of the data maintained in the databases was noted to be incomplete and inaccurate**.** It was noted that different databases measuring the same parameter had different numbers. An example of a database/data source that was not considered accurate included the pneumonia database. ▪ The Facility presented data in a meaningful/useful way. Specifically, the Facility's Self-Assessment: ○ Presented findings consistently based on specific, measurable indicators. ○ Measured the quality as well as presence of items. ▪ The Facility rated itself as being in noncompliance with Section L. This was consistent with the Monitoring Team's findings. ▪ The Facility's data identified some areas in need of improvement. For those areas of need, the Facility Self-Assessment provided some analysis of the information, identifying, for example, the lack of timely completion of quarterly medical reviews, the follow-up of consultant reports, and quality care concerns involving diabetes mellitus and aspiration pneumonia.
	Summary of Monitor's Assessment: The Medical Department had made considerable progress in many areas, including: ▪ The morning medical meeting was well attended by several disciplines, and the QIDP representative took concerns back to the IDT for ISPA development, when needed. Hospitalizations, ER visits, and Infirmary admissions were reviewed. The PCPs provided some clinical and critical information when reviewing cases. Consultations were reviewed. Other departments provided periodic updates. ▪ There had been considerable progress concerning obtaining quality family histories, which were then added to the annual medical assessments. ▪ There was an internal QA system, which was expanding. Currently, there were three quality of care monitoring tools recently initiated, and there were seven additional tools being developed. ▪ An extensive medical services manual was created to reflect the processes of the Medical Department. There were several areas needing guidance or improvement, including: ▪ Post-hospital ISPAs required review at the morning medical meeting. For the post-hospital ISPA to be of value, the pre-hospital review (i.e., open record review) and the hospital reviews needed to be completed prior to the IDT meeting for the ISPA. ▪ During the morning medical meetings, there remained the need for peers to challenge one another

	in critical clinical areas, such as whether the evaluation of Gastroesophageal Reflux Disease was completed and in a timely manner in those with episodes of reactive airways disease. ▪ Tracking was needed of the annual medical assessments, because timeliness remained a concern. ▪ Review of the content of the quarterly medical reviews was needed to decrease the length of the document, with a focus on information a covering PCP would need. Most quarterly medical reviews were not done timely. ▪ Some of the databases had conflicting information. ▪ The external peer review process needed to expand to a 10 percent sample size (i.e., 20 percent per year). ▪ Some of the administrative death review recommendations were completed, but some remained incomplete and tracking to closure appeared to need further review. The Facility remained in noncompliance with all subsections of Section L. However, the Facility had advanced rapidly with regard to Section L in a short period of time.

#	Provision	Assessment of Status	Compliance
L1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall ensure that the individuals it serves receive routine, preventive, and emergency medical care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be	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 384 as of 10/1/13, there were four PCPs responsible for this population. The Medical Director also had a caseload of 44. Other PCPs had caseloads ranging from 78 to 94. At the time of the Monitoring Team's visit, an additional PCP was providing care. The census also had dropped to 380. The size of the caseload for each PCP was not further reviewed during the onsite visit. However, the average caseload per PCP would be expected to approximate 380-44 (the Medical Director's caseload) = 336/5 PCPs = 67 individuals per PCP. Given the complexity of the individuals at ABSSLC, this was an appropriate caseload. A list was submitted indicating those members of the Medical Department that remained current in CPR certification. For the Medical Department, documentation indicated the Facility had a Medical Director, five PCPs, and one Settlement Agreement Compliance Physician. The submitted information verified five out of seven (71%) were current in CPR. For two PCPs, no information was provided concerning current CPR certification status. Of the six physicians and physician extenders in the Medical Department providing primary care, a list of CME credits was submitted for three of these medical professionals. For the prior six months, these medical professionals completed from one to 14.5 hours of continuing medical education. Topics included updates	Noncompliance

#	Provision	Assessment of Status	Compliance
	used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	in general internal medicine, bisphosphonate treatment, treatment of Alzheimer's dementia, geriatric medicine, cancer and diabetes, advances in trauma care, acute ocular trauma, concussion management, suicidal behavior, medical ethics, spirituality and medicine, and acute coronary syndrome. 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 covered included areas of importance to primary care and the individuals residing at ABSSLC. There were no specific topics (according to titles) focusing on the Intellectual/ Developmental Disability (IDD) population. Three medical professionals did not submit documentation of CME for this time period. <u>Physician Participation In Team Process</u> For the three morning medical meetings observed, there was a signed attendance roster in three of three meetings. Departments/positions represented at the morning medical meeting on a daily basis included: Medical Director, PCPs, Settlement Agreement Compliance Physician, Medical Program Compliance Nurse, Nursing Department administration, Dental Department, Pharmacy Department, Unit Director, PNMT/Habilitation Therapy Services, Infirmary nursing, and Hospital Liaison nursing. Departments represented at the morning medical meeting on a weekly or periodic basis included: QIDP, Direct Support Professionals supervisor, Infection Control Nurse, Respiratory Therapy, QA Department, and Dietary Department. For the three morning medical meetings observed, there were three hospitalizations and 11 admissions to the Infirmary. Based on the Monitoring Team's observations and review of documentation: ▪ **IDT follow-up with ISPA:** For one of the three hospitalized individuals, the IDT already was assigned to review and develop an ISPA. ▪ **IDT follow-up with ISPA:** For two of 11 Infirmary admissions, the IDT already had been requested to review the case for preventive measures, and develop an ISPA. ▪ **Assignment of follow-up to meeting participant:** From the minutes of the three morning medical meetings, there were no cases with critical clinical questions raised/identified followed by assignment of the concern for further review by one or more morning medical meeting attendees to identify steps to prevent a recurrence, along with a due date for review at the committee. ▪ **Additional preventive steps discussed or prior ones reviewed:** Three of three morning medical meetings included discussions during the morning medical meeting of additional steps to be taken to treat the individual early in the illness to prevent an ER visit, hospitalization, or Infirmary admission, or additional steps were determined not to be clinically indicated at the time of the discussion. ▪ **Formal record review:** For one of three hospitalized individuals, there was a prior request for a formal record review to determine preceding events, monitoring intensity, etc., before the onset of acute illness. For two hospitalized individuals, neither had a request for a formal record review. ▪ **Formal record review presentation:** During one of three morning medical meetings, there was a formal record review. ▪ **Closure discussions**: From the morning medical minutes, no prior concerns with assignments for follow-up were presented. No tracking system was presented concerning closure of concerns,	

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		ISPA, open record reviews, etc. There was no monthly review of assignments made and closures documented. ▪ **Follow-up review of requested ISPAs:** During the three morning medical meetings, four summaries were presented of ISPAs that had been assigned to IDTs through the medical morning meeting to respond to concerns. These were discussed, and four of four were accepted as resolving/answering the concern. ▪ **Infection Control updates:** During the three medical morning meetings, there was one Infection Control update presented, covering three topics. ▪ **Summaries of completed consultations:** During the three medical morning meetings, there were three summaries presented of completed consultations that had been received. ▪ **Dental Department updates**: The Dental Department provided brief updates/information during one of three medical morning meetings. ▪ **Physical Therapy/Occupational Therapy/Speech Therapy (PT/OT/ST) and PNMT updates:** The PT, OT, ST and PNMT presented updates during one of three medical morning meetings. An update by the PNMT and an update by speech therapy were presented at the same meeting. ▪ **Skin Integrity updates:** Skin Integrity reports/updates were provided at one of three medical morning meetings. ▪ **Discussion of significant weight change:** There was a discussion of individuals with significant weight loss or gain at none of three medical morning meetings. ▪ **Hospital Liaison Nurse updates:** The Hospital Liaison Nurse reported an update for three of three hospitalizations during the meetings the Monitoring Team observed. ▪ **On-call PCP participation:** For three of three morning medical meetings observed, the on-call PCP (from the prior evening) participated in presenting the cases. ▪ **Attending PCP participation:** The attending PCP for the individual (when not the on-call PCP) participated in the discussions of health status changes/on-call concerns in three of three meetings. ▪ Additionally, other business was conducted during the morning medical meetings observed, including: four updates (i.e., three nursing, and one pharmacy). The strengths noted at the medical morning meeting included attendance and participation. There were critical clinical discussions among the clinical departments concerning health status changes of individuals. The Settlement Agreement Compliance Physician along with several PCPs asked critical questions in the discussion. Some of the PCPs' answers indicated timely and appropriate response to clinical decision-making. The PCPs provided quality updates concerning current health status and background information concerning individuals on their caseloads with an acute change in health status. Summarizing important consult reports had been added to the morning medical meeting discussions. Weaknesses and concerns included follow-up and the importance of further development and clarity of next steps. Although a number of important questions were asked, some of the responses did not reflect clear next steps related to preventive care, or diagnostic evaluations that would determine the diagnosis. At times, there were assumptions as to the cause of a clinical problem, but there was no test result discussed that would confirm the assumptions. The clinical thinking, at times, was based on assumptions	

#	Provision	Assessment of Status	Compliance
		rather than evidence of causation. At times, thorough evaluations that might have identified the major cause or significant secondary causes were not pursued. As a result, the problem had potential to recur with repeated changes in health status, because the etiology of the clinical decline had not been identified or treated. By the end of each month, it is recommended a tally of the concerns assigned, ISPAs assigned, open record reviews assigned, etc., and the number of each that had closure, be calculated. Those items carrying over to the next month need additional focus until closure. Given the size of the Facility and the number of concerns that occur, it might be difficult to provide clinical teaching during this meeting. It is recommended that adequate time be given to ISPA follow-ups, with focus on prevention, assignment and closure of other concerns, and discussion of open record reviews. It was noted that some of the assignments were overdue, and this needed to be resolved. To coordinate the need for the IDT to address the individual returning from the hospital, on 7/26/13, a QIDP meeting occurred. During the meeting, QIDPs were provided guidance regarding the creation of post-hospital ISPAs. The QIDP Settlement Agreement Liaison was to obtain information at the morning medical meeting concerning possible causes of the hospitalization, interventions needed, and preventive steps to be considered, and request that the IDT meet to resolve specific questions based on the morning medical meeting discussions. An IDT meeting was to be scheduled to ensure the PCP would be able to attend, and the meeting was to be completed within 48 hours. A template was created for "ISPA – Hospital Admission." This process was new and sustainability will be determined over time. Based on ISPAs the QIDP reviewed at the morning medical meeting during the Monitoring Team's onsite visit, the structure for this system appeared to be in place. The post-hospital ISPA will need the PCP's participation to provide the clinical guidance to the IDT, and the system created appeared to be designed to ensure the PCP attendance or participation. This process also will require the open record review/Hospital Admission Medical Record Review to be completed prior to the IDT meeting, in order for any findings that are applicable to be included in the ISPA. This would also require the form "Hospital Admission Medical Chart Review" to be completed in a timely manner in order for the IDT to incorporate findings related to the hospitalization into the ISPA, if indicated. An in-service for this form had occurred on 6/4/13 to three PCPs, and on 8/5/13 to one PCP. A separate form entitled "Client Report Template" (revised 6/10/13), appeared to provide an outline of needed clinical information in preparation for a clinical presentation by the PCP at the morning medical meeting. <u>Routine Care</u> A list of dates of the last two annual medical assessments and physical exams were submitted for 389 individuals. Thirteen individuals newly admitted within the prior year were omitted, leaving 376 individuals listed. Of these, 289 out of 376 (77%) of the recent annual medical assessments were completed within 365 days of the prior assessment. For 20 individuals, a copy of the most recent annual medical summary and physical examination evaluation, as well as the prior annual medical summary and physical examination evaluation were submitted for	

#	Provision	Assessment of Status	Compliance
		review. Timeliness was determined based on whether or not the most recent annual medical summary and physical examination evaluation was completed within 365 days of the prior annual evaluation. ▪ For the 20 individuals, compliance was 14 of 20 (70%). ▪ For the 20 most recent annual medical assessments, there was an interval history included as part of the document in 20 of 20 (100%) reviews. ▪ For the 20 most recent annual medical assessments, the major active problems listed had plans of care addressing each of the significant problems in 20 of 20 (100%) assessments. ▪ For the 20 most recent annual medical assessments, 20 (100%) addressed smoking history. ▪ Family history was adequate/helpful or attempts at obtaining the family history were recorded in 20 of 20 (100%). ▪ A discussion of appropriateness/requirements for transition to the community was included in 20 of 20 (100%). As part of the monitoring review process, the Monitoring Team selected the medical records of 12 individuals to determine compliance with several requirements of Section L.1. These individuals are listed in the documents reviewed section. These were selected based on high-risk categorization for various diagnoses/health care issues (e.g., aspiration, GERD, skin breakdown, cardiac issues, etc.). Documents reviewed included preventive care flow sheet, physician orders for the prior one year, IPN for the prior one year, the three most recent quarterly medical reviews, most recent BSP, last annual ISP and subsequent addendums, labs, x-rays/CT scans, MRI scans, ultrasound scans, other radiographic test results for the prior one 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 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 12 medical records reviewed: ▪ For a cut off date of 10/15/13, 12 of 12 (100%) annual medical assessments had been completed in the prior 365 days. ▪ Active problem lists appeared to be thorough in 10 of 12 (83%). ▪ Eleven of 12 (92%) annual medical assessments included a review of smoking history and/or substance abuse history. ▪ A family history was documented in seven of 12, was noted to include limited information in three of 12, and attempts (unsuccessful in obtaining information) in two of 12. For one, the attempts at communicating with the family member were listed. For one, there was no date of the attempt or attempts. o The Medical Department had created a "Family Medical History Form ABSSLC" which was distributed to the responsible family contact for completion and return prior to the annual medical assessment. On 6/11/13, the PCPs completed an in-service on this form, and five PCPs attended.	

#	Provision	Assessment of Status	Compliance
		▪ Twelve of 12 (100%) had information discussing requirements for transition. ▪ These 12 medical records also were reviewed to determine whether the physician IPN note used the SOAP format for acute illness visits. In 12 of 12 (100%), the SOAP format was used, and included date and time on the IPN. For the 376 individuals that had been residing at ABSSLC at least a year, routine documentation over the year (four quarters) required one annual medical exam and three quarterly medical reviews (the annual substituted for a quarterly medical review). Because of this calculation, for any one quarter of the year, 75 percent of the individuals would have a quarterly medical review (376 x .75=282 quarterly medical reviews). A document was submitted entitled: "Dates of last two completed quarterly medical reviews/IPN completed for all individuals." The number of quarterly medical reviews completed per quarter was listed. For the first calendar quarter (January through March) 2013, 118 of 282 (42%) were completed. For the second quarter (April through June) 38 of 282 (13%) were completed. For the third quarter (July through September), there were zero of 282 (0%) completed. For the three quarters combined, compliance was 18 percent (156/846). For the 12 medical records reviewed, there were nine quarterly medical reviews completed in 2013 as well as six annual medical reviews completed in 2013, for a total of 15 timely documents. As three calendar quarters were completed prior to the Monitoring Team visit, there was a potential of 36 (12 x 3) quarterly medical reviews and annual medical reviews for the three quarters. This was a compliance rate of 42 percent (15 of 36). The Facility submitted two most recently completed quarterly medical reviews from each residence. These were reviewed for content and completeness. All PCPs used a template format, and the Facility submitted 38 quarterly medical reviews. ▪ A template was utilized/completed in 38 of 38 quarterly medical reviews. ▪ Thirty-eight of 38 (100%) included the date of the quarterly review completion. ▪ Thirty-eight of 38 (100%) included the signature of the PCP. ▪ Major diagnoses were listed in 38 of 38 (100%) medical quarterly reviews. ▪ Diagnoses were listed with changes noted either in specific statement or recent entries in the active problem list in 20 of 38 (53%). Diagnoses were listed with no changes specifically stated in eight of 38 (21%). For 10 of 38 (26%), there was no information to indicate a change had been made to the active problem lists, or if none were needed. ▪ The last three monthly weights, change in weight over past three months, or equivalent information were recorded in 37 of 38 (97%) medical quarterly reviews. ▪ There were brief comments/entries listing numbers of seizures (if applicable) in 23 of 23 medical quarterly reviews. o When there was a history of a seizure disorder, the date of the most recent seizure was documented in 23 of 23 medical quarterly reviews. o For 15 individuals, there was no history of a seizure disorder. ▪ There was documentation of changes in medication in 19 of 38 medical quarterly reviews.	

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- Important/abnormal labs and drug levels/radiographic test results were documented in 29 of 38 medical quarterly reviews.
- For individuals that were hospitalized or had an ER visit, there was documentation of ER visits, and hospitalizations with dates and discharge diagnoses/treatments in nine of nine medical quarterly reviews.
- There was documentation of important consultation (date and consult specialty) in 32 of 38 medical quarterly reviews.

Overall, the content appeared to include much of the information any PCP would need if called to evaluate the individual. However, the length of all quarterly medical reviews exceeded one page. It is recommended that the Medical Department meet to discuss information important when covering for other PCPs in caring for an acute or emergent illness. The quarterly medical review should focus on health status changes and important medical findings/test results (important normal values such as drug levels as well) to allow the PCP to quickly gain knowledge of the current health status of the individual. Providing lists of stable conditions detracted from this goal. Considerable space was taken up by pasting the active problem list into the document. It is recommended that stable conditions not be listed. Diagnoses with change (either improved or worsened) would provide valuable information quickly to the covering PCP. It is recommended that important consult results from the prior quarter be included briefly in the document. Some lab and diagnostic tests were listed, but there might have been a number of important test results not described or not listed. It was also noted that the copies were extremely light and difficult to read.

Access to Specialists

The following chart indicates the offsite appointments scheduled, the offsite appointments completed, follow-up appointments scheduled, follow-up appointments completed, and pending appointments based on submitted the Facility data. The information was for the period 4/1/13 to 9/30/13.

Specialty	Initial Appointment Scheduled	Initial Appointment Completed	Number of Appointments Rescheduled	Follow-up Initial Appointment Completed	Pending	Percent Completion or Order Discontinued*
Audiology	7	0	0	0	0	0%
Cardiology	69	62	6	6	0	100%
Dermatology	2	2	0	0	0	100%
Endocrinology	38	33	5	4	1	97%
Gastroenterology	73	60	5	4	1	99%
Hematology	42	38	4 refusals for one initial	2	1	98%
Infectious Disease	3	3	0	0	0	100%
Internal Medicine	11	11	0	0	0	100%

#	Provision	Assessment of Status							Compliance
		Iron Infusion	5	5	0	0	0	100%	
		Nephrology	6	6	0	0	0	100%	
		Neurology	2	2	0	0	0	100%	
		Neurosurgery	11	11	0	0	0	100%	
		Ophthalmology	21	21	0	0	0	100%	
		Orthotic	1	1	0	0	0	100%	
		Orthopedic	34	33	3 refusals for one initial	1	0	100%	
		Otolaryngology	38	35	0	0	2	92%	
		Pain Management	10	10	0	0	0	100%	
		Plastic surgery	1	1	0	0	0	100%	
		Podiatry	3	3	0	0	0	100%	
		Pulmonology	3	3	0	0	0	100%	
		Rheumatology	16	16	0	0	0	100%	
		Sleep Study	3	3	0	0	0	100%	
		Surgery	30	29	1	1	0	100%	
		Urology	2	2	0	0	0	100%	
		Vein Clinic	1	1	0	0	0	100%	
		Wound Clinic	39	35	4	4	9	100%	
		Total	471	426	28	22	5		

*Cancelled by PCP or specialist, moved to community, not rescheduled (No further information provided)

Total completed at initial appointment: 426/471 = 90%

Onsite specialty clinics were held to meet the needs of the individuals from April through September 2013. The following table provides information concerning the dates of the specialty clinics, the appointments scheduled, and the initial appointments completed.

Specialty	Date of Clinic	Appointments Scheduled	Number of Appointments Completed	Percent Appointments Completed
Dermatology	4/17/13	6	6	100%
Dermatology	7/31/13	8	7	88%
Dermatology	8/28/13	3	2	67%
ENT/Allergy	9/16/13	11	11	100%
Gynecology	4/18/13	4	4	100%
Gynecology	5/30/13	3	2	67%
Gynecology	7/24/13	2	2	100%
Optometry	4/10/13	39	33	85%

#	Provision	Assessment of Status	Compliance

Optometry	5/8/13	35	27	77%
Optometry	6/12/13	24	18	75%
Optometry	7/10/13	21	17	81%
Optometry	8/14/13	21	17	81%
Optometry	9/11/13	37	29	78%
Pap & Pelvic Clinic	5/22/13	6	3	50%
Pap & Pelvic Clinic	7/30/13	7	1	14%*
Podiatry	4/16/13	42	28	67%
Podiatry	5/21/13	44	31	70%
Podiatry	6/18/13	46	35	76%
Podiatry	7/16/13	31	28	90%
Podiatry	8/20/13	39	31	79%
Podiatry	9/17/13	33	27	82%
Neurology/VNS	4/8/13	31	25	81%
Neurology	4/22/13	24	20**	83%
Neurology	4/25/13	17	13	76%
Neurology/VNS	5/13/13	30	4	13%***
Neurology	5/23/13	22	17	77%
Neurology/VNS	6/10/13	28	23	82%
Neurology/VNS	6/24/13	30	23	77%
Neurology/VNS	6/27/13	19	17	89%
Neurology/VNS	7/8/13	28	24	86%
Neurology/VNS	7/22/13	30	26	87%
Neurology/VNS	8/12/13	34	29	85%
Neurology/VNS	8/26/13	27	23	85%
Neurology/VNS	9/9/13	36	26	72%
Neurology/VNS	9/23/13	38	27	71%
Urology	4/5/13	8	7	88%
Urology	5/3/13	5	5	100%
Urology	7/5/13	7	7	100%
Urology	9/6/13	6	6	100%
Total		**882**	**730**	**83%**

*Appointment kept, procedure attempted, but refused/unable to complete for five out of seven.
** Includes one record audit (individual came and left unseen).
***Non-completion of appointments not due to refused/missed appointments by individuals.

From a separate document: "Individuals seen by Neurologist since last monitoring visit April 2013 through September 2013," eight individuals were also listed as having had a neurology consult on 4/11/13. If this occurred, then the above, submitted data needed further review for completeness and accuracy.

#	Provision	Assessment of Status	Compliance
		To improve the quality of information provided to the consultants, the Medical Department expanded the consultation report to provide more room for important clinical information, and listed core areas that should be completed where clinically appropriate to the concern (i.e., history of present illness, past medical history, etc.). On 5/21/13, an in-service was provided with six PCPs attending. The quality of the consultation referrals was 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 12 out of 12 (100%) records reviewed. ▪ Preventive care flow sheets were up-to-date in 10 out of 12 (83%) records reviewed. ▪ Current vision screening was documented within the prior 12 months (with cut off date of 10/15/13) in one out of 12 (8%) of the records reviewed, and in 12 of 12 (100%) within the prior 24 months. ▪ Audiological screening occurred in two out of 12 (17%) records reviewed in the prior year, in eight of 12 (67%) records reviewed in the prior two years, and in 11 of 12 (92%) records reviewed in the prior three years. ▪ The influenza vaccination had been documented in the active record as given to 12 of 12 (100%) individuals in a timely manner during 2013. ▪ Whether the individual needed to receive varicella vaccine (i.e., or reason provided for not giving the vaccine was provided such as age or immunity status), and whether it was given if indicated, was recorded in seven of the 12 (58%) 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 being tracked for completion), was recorded in 12 of the 12 (100%) active records reviewed. ▪ A Tdap vaccine had been given to 12 of 12 (100%) individuals. This statistic would need verification by the PCP, and Infection Control nurse. Although tetanus vaccine was documented to have been administered, it was not always clear which tetanus vaccine had been administered. o On 7/29/13, the Infection Control Nurse met with nursing administration and the Settlement Agreement Compliance Physician to discuss documentation/verification of prior Tdap administration. Subsequently, 131 individuals were identified that had not received a Tdap. This was a continuing project of the Infection Control nurse. ▪ A pneumococcal vaccination had been given to 11 of 12 (92%) applicable individuals. o For two records, information concerning some of the vaccinations could not be located on the annual medical assessment, nursing assessment, or preventive care flow sheet. Information was obtained from the original immunization record. However, vaccinations should be part of several documents in the active record.	

#	Provision	Assessment of Status	Compliance
		A list was submitted indicating women residing at ABSSLC who were over the age of 40, along with the date of last mammogram, and the reason, if it was not done or outdated. A total of 158 women were identified as being over the age of 40. Of these, there were 29 women aged 70 or greater. The DADS SSLCs policy "Preventive Health Care Guidelines," dated 8/30/11 was to be followed. Of the remaining 129 women, eight had reasons not to have a mammogram (i.e., guardian refusal, inability to physically provide proper positioning for the test, etc.). Of the remaining 121 women, two were less than 40 years of age or were at the 40th year. ▪ Of the remaining 119 women, 53 (45%) had mammograms within the prior year (October 2012 through October 2013). ▪ Of the 119 remaining women, 37 (31%) had a mammogram completed during October 2011 through October 2012. ▪ Of the 119 remaining women, 29 (24%) had the most recent mammogram earlier than October 2011. From the sample of 12 medical records reviews, there were four females between the ages of 40 and 70. Of these, two females were eligible for a yearly mammogram (i.e., no contraindication or reason for not completing a mammogram). Zero of two (0%) were up-to-date on mammogram testing. A list of all females age 21 and older was submitted for those that had a prior hysterectomy. The list also included those having completed pelvic exams, along with the dates of the exam. The list included 23 individuals that had a hysterectomy. For 13, the reason for the procedure was benign pathology. For two, the hysterectomy was due to a diagnosis of possible malignancy. For eight individuals, the surgery occurred prior to admission to ABSSLC, and no reason was listed. Individuals attending the Gynecologic, pap, and pelvic clinic since 10/31/12 were listed, along with whether the exam was completed. Fifty-two appointments were scheduled from 10/31/12 through 7/30/13. Thirty-four women completed a gynecologic exam. No list was submitted for all women age 21 and older, and the date of the last pap smear. It could not be determined the number of women that should have had a pap smear and pelvic exam in the prior three to five years, and the number that completed a pap smear and pelvic exam during the same time period. From the sample of 12 active records reviewed, there were seven females between the ages of 21 and 65 that were age appropriate for a pap and pelvic examination. Four of seven females had risk factors that outweighed benefit of the procedure. There were three females remaining eligible for pap smear. One of three (33%) females had a pap smear completed within the prior three years. The Medical Department submitted a list of those individuals over the age of 50 with the date of the last colonoscopy, with the reason for the colonoscopy. A total of 212 names were submitted. Of these, 29 had reasons for deferring the procedure (i.e., guardian declined permission, high risk of aspiration, age greater than 75, gastroenterologist recommended against the procedure as risks outweighed benefits, prior total colectomy, skeletal abnormalities/osteoporosis, anatomic abnormalities, etc.). Forty had a colonoscopy	

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		completed for an active problem. Therefore, the eligible population for screening colonoscopy was 143 individuals. ▪ Of these, 130 of 143 (91%) completed a colonoscopy within the prior 10 years, and/or had alternate testing considered acceptable as clinical equivalents. Of the 12 active records reviewed, there were three individuals from the age of 50 to 75. None were over the age of 75. Of the three, two had a clinical reason for not pursuing a colonoscopy. For the remaining individual for whom colonoscopy screening was indicated, one of one (100%) had a colonoscopy completed in the past 10 years. A list of individuals with a diagnosis of osteopenia or osteoporosis was submitted. Identification of the medications and dosages of the medications treating these diagnoses also was requested. Additionally, for all those over 50, a list of the last DEXA scan date and copies of the most recent DEXA scan report were requested. This information was requested, because for those with a diagnosis of osteopenia or osteoporosis, a T score usually would be an important aspect of the work-up provided through a DEXA scan. Additionally, based on the T score, treatment would be ordered to optimally treat the individual. Follow-up DEXAs to determine T scores are indicated at intervals (every two to three years) to determine effectiveness of treatment. A total of 201 individuals with a diagnosis of osteopenia or osteoporosis were reviewed. Thirty-nine had osteopenia and 154 had osteoporosis. Eight individuals had both a diagnosis of osteopenia and osteoporosis listed. T scores from the DEXA scans were included in the actual copies of the DEXA scan reports, but were not included in the chart of data. ▪ One hundred ninety-one of the 201 (95%) DEXA scans were considered current (completed within the prior three years). ▪ One hundred fifty-one of 201 (75%) were treated with a bisphosphonate or alternative medication to treat or prevent osteoporosis. o One hundred one were treated with a bisphosphonate. o Forty-three were treated with Prolia. o Seven were treated with alternative options. ▪ Ninety-six of 201 (48%) were treated with calcium supplementation. ▪ Eighty of 201 (40%) were treated with Vitamin D supplementation. The Facility indicated there was no system in place for calculation of daily calcium and Vitamin D intake for each individual. The annual nutritional assessment was able to provide calculations of calcium intake based on the prescribed diet. It is recommended that a system/document be created, that a PCP can access, that provides the amount of daily calcium and Vitamin D in the diet/formula/dietary supplements, and amount of calcium and Vitamin D in supplements (e.g., multivitamins, etc.). For individuals at risk in this area, IDT's should consider including in individuals' IHCPs the need for the residence to maintain a log of the percentage of meals taken, in order for the PCP to calculate the calcium and Vitamin D ingested per day. A Vitamin D level might be helpful in determining needs exceeding daily maintenance requirements.	

#	Provision	Assessment of Status	Compliance
		The Facility was asked to submit documentation of any work-up for secondary causes of osteoporosis/osteopenia in men, which might include a Complete Blood Count (CBC), renal and hepatic function, calcium and phosphorus level, thyroid function, testosterone level (in men), and Vitamin D level. Other tests might be indicated based on clinical findings and history. The Facility submitted a list of 78 men and 123 women with a diagnosis of osteoporosis or osteopenia. Only two tests were listed with these individuals, a thyroid function test and a Vitamin D level. The list combined men and women for a total of 201 individuals. Of these, 186 (93%) had a thyroid test completed and 189 (94%) included a Vitamin D level. No other test results were submitted. It is recommended that a policy be created and implemented that provides guidance concerning tests that should be completed in an evaluation of secondary causes and the population for which additional specific tests would be appropriately ordered. It was noted that the copies supplied were difficult to interpret due to faint print and some areas of pages could not be read. From the sample of 12 medical records reviewed, eight had a diagnosis of osteopenia or osteoporosis. Eight had completed a DEXA scan, and eight of these DEXA scans were completed in the prior three years. ▪ Of these, eight (100%) had a DEXA scan/T score recorded. ▪ Of these, eight (100%) had a T score consistent with the diagnosis of osteoporosis or osteopenia. ▪ Of these, eight (100%) had been prescribed supplemental calcium and Vitamin D. ▪ Of these, five had a bisphosphonate ordered. ▪ Of these, three had Prolia ordered. ▪ Of these, zero had Miacalcin prescribed. The Medical Department initiated an internal monitoring audit of the quality of care for osteoporosis (evaluation and treatment). A monitoring form entitled: "Quality of Medical care indicators for osteoporosis" (revised 7/25/13) included important clinical indicators, such as timely serial completion of DEXA scans, annual Vitamin D levels, whether the individual was receiving the daily recommended dose of Vitamin D and calcium, whether medications were prescribed to treat the osteoporosis, and whether a dental evaluation had been completed prior to initiation of this medication. Additionally, from minutes of a meeting entitled: "ABSSLC Interdisciplinary Performance Improvement Meeting" of 7/19/13, the Settlement Agreement Compliance Physician met with Nutrition Services to discuss revision of the annual nutrition assessment template. This was to include the calculation of daily calcium and Vitamin D in the offered diet, with comparison to daily requirements, and a recommendation to the PCP. A new template was dated 9/17/13, and appeared to be consistent with the new State Office template. This was reviewed at the morning medical meeting of 9/26/13. An example of the new nutritional services comprehensive assessment was submitted. The daily calcium intake for the offered diet was clearly noted. The daily Vitamin D intake for the offered diet/formula was not listed. This would be a helpful addition in determining the amount of Vitamin D the individual receives through an offered diet. Additionally, the PCP will need to have the Pharmacy provide the amount of calcium and Vitamin D prescribed through multivitamins, and supplements. The PCP will also need to determine how much of the offered diet is ingested in determining how much calcium and Vitamin D the individual is actually receiving. Based on this information, along with Vitamin D levels, the PCP would be able to calculate the amount of needed	

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		supplementation for calcium and Vitamin D. A list of those with Down syndrome was submitted, along with the date of the last thyroid test. A total of 13 individuals were identified with a diagnosis of Down syndrome. As of the Monitoring Team's visit date of 11/4/13, 12 of 13 (92%) had a thyroid test completed within the prior 12 months. <u>Acute and Emergency Care</u> The active record was reviewed for 10 individuals who had most recently gone to the ER and returned. There were 11 ER visits for these 10 individuals. These individuals are listed in the documents reviewed section. Nine of the 10 individuals had gone to the ER from their residence. One had gone from the Infirmary to the ER. The following summarizes the results of this review: ▪ Information was submitted indicating that the ER was notified prior to the arrival of the individual with appropriate medical background information provided for eight of 11 (73%) ER visits. ▪ Prior to the transfer to the ER, a PCP was onsite for four of these transfers. In four of four (100%) records, the PCP had written an IPN that included the date and time. ▪ For four of four (100%) PCP transfer IPNs, vital signs were recorded. ▪ For four of four (100%) PCP transfer IPNs, reason for the transfer was documented. ▪ In four of the four (100%) PCP transfer IPNs, the SOAP format was utilized. ▪ A copy of the ER report was available in 11 of 11 (100%). ▪ For the 10 ER visits, diagnostic categories included: Gastrointestinal (two), Neurological (two), Trauma (four), Cardiovascular (two), and Respiratory (one). ▪ When the individual returned to the Facility after evaluation at the ER, 10 of 10 (100%) applicable events had documentation in the active record of a PCP IPN. For one return visit, there was insufficient time for a PCP IPN, because the individual was returned to the ER after arrival back at ABSSLC. For nine of 10 (90%), there was an IPN based on a PCP assessment after the return of the individual. For one of 10, there was a PCP IPN entry in which the PCP recorded communication with the hospitalist, but no further PCP IPN was submitted after return of the individual. ▪ For the nine PCP IPNs written based on evaluation after the individual's return to ABSSLC: o Nine of nine (100%) post ER visit PCP IPN included date and time. o Seven of nine (78%) post-ER visit PCP IPN included recording of vital signs. o Eight of nine (89%) post-ER visit PCP IPN utilized a SOAP format. o A summary of ER information and findings was included in nine of nine (100%) PCP IPN. ▪ When returning to the Facility, for 10 of 11 ER visits, the individual returned to the Infirmary. For one of 11 ER visits, the individual returned to the residence. ▪ For 11 of 11 (100%) ER visits, treatment was considered timely. 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. Zero individuals died while in the hospital. Ten of 10 (100%) had PCP IPN post-hospitalization.	

#	Provision	Assessment of Status	Compliance
		▪ Of the 10 post-hospital PCP IPN submitted, 10 of 10 (100%) included vital signs or documentation at an attempt at vital signs. ▪ Ten of 10 (100%) post-hospital PCP IPNs included date and time. ▪ Ten of 10 (100%) post-hospital PCP IPNs had an adequate summary of hospital events and findings. ▪ Ten of 10 (100%) post-hospital PCP IPNs used the SOAP format. ▪ Eight of 10 active records of the hospitalized individuals included a copy of the hospital admission history and physical. ▪ Ten of 10 (100%) active records included a copy of the hospital discharge summary. ▪ There were Hospital Liaison Nurse notes for 10 of these 10 (100%) hospital admissions. ▪ For 10 of the 10 individuals that returned to the Facility, additional PCP IPNs were included as part of the follow-up. ▪ For the 10 hospitalizations, major organ system categories included the following: Respiratory (three), Gastrointestinal (three), Cardiovascular (one), Renal (one), Sepsis (one), and Chest/abdominal pain (one). To determine whether there were any early warning signs or symptoms of impending illness which would eventually lead to hospitalization, the Medical Department developed a form entitled: "Hospital Admission Medical Chart Review" (dated September 2013), which included such information as the hospital diagnosis, the time-frame reviewed (at least seven to 14 days), discharge diagnoses for hospitalizations within the past six months, and summary of events prior to the hospitalization, along with any recommendations to prevent another hospitalization. On 10/1/13, five PCPs attended an in-service. As part of the QA monitoring of completion of this form, on 8/28/13, the internal medical QA monitoring tool entitled: "Quality of Medical Care Indicators for ER/Hospital visits" was revised to include the clinical indicator: "Is there a completed Hospital Admission Medical Chart Review form in the IPN?" This new form and process had been initiated recently before the Monitoring Team's visit. Whether it is utilized and completion of the form sustained, as well as impact of information gained from reviewing the pre-hospitalization time period will be reviewed as part of the Monitoring Team's next review. However, if a quality review is completed, this system has potential for significant impact on reducing repeated hospitalizations. *Infirmary Length of Stay* ABSSLC had an Infirmary. The admission of individuals to the Infirmary over the prior six months varied from one day or less to 77 days. In the following table, the number of admissions per month was broken down by length of stay: **Length of Stay** / **April 2013** / **May 2013** / **June 2013** / **July 2013** / **August 2013** <1 day / 4 / 5 / 6 / 5 / 8 1 day / 32 / 36 / 4 / 25 / 32 2 days / 11 / 16 / 12 / 9 / 8 3 days / 7 / 1 / 3 / 3 / 3	

#	Provision	Assessment of Status	Compliance

4 days	5	6	1	2	3
5 days	2	4	4	0	0
6 to 10 days	7	3	2	5	1
11 to 20 days	1	4	4	3	1
21 to 30 days	0	0	2	0	1
31 to 60 days	0	0	2	0	0
>60 days	1	1	0	0	0
Not available	0	0	0	0	3
Total	70	76	40	52	60

Pneumonia
Data was submitted that had been entered into the Avatar database. Information concerning pneumonias was submitted for the time period from March 31, 2013 through September 9, 2013 (report dates of data sheets included: 4/12/13, 6/5/13, 6/6/13, and 9/19/13). The following information was derived from this database:

Month	Number of Pneumonia Cases	Number of Aspiration Pneumonia	Number of Bacterial Pneumonia	Number of Pneumonia NOS	Number of Viral Pneumonia
Mar 2013	1	0	1	0	0
April 2013	1	0	1	0	0
May 2013	4	3	1	0	0
June 2013	3	0	3	0	0
July 2013	1	1	0	0	0
Aug 2013	2	2	0	0	0
Sept 2013	2	1	1	0	0
Total	**14**	**7**	**7**	**0**	**0**

Offsite physicians diagnosed six of these 14 pneumonias, and onsite ABSSLC physicians diagnosed eight of the 14. Documentation indicated that 11 of the 14 had chest x-ray findings consistent with the diagnosis. For five of the 14, data submitted indicated blood cultures were obtained. Blood cultures were positive in one of five. Seven of the 14 were individuals that had feeding tubes. Seven of seven feeding tubes were gastrostomy tubes. None were jejunostomy or gastro-jejunostomy tubes (J/G-tube). Seven of the 14 ate by mouth. Of these, seven of seven had a therapeutic textured diet of chopped or pureed consistency. Two of the seven had an order for thickened liquids. For those with gastrostomy tubes, seven of seven utilized an intermittent flow rate, zero utilized bolus feedings, and zero utilized continuous feeding. For those that took nutrition orally, the date of the most recent "Modified Barium Swallow Study" was recorded in three of seven. Dates of completion ranged from 1996 to 2012. Of the 14 with pneumonia, the most recent EGD was recorded in three of 14. Dates of completion ranged from 1996 to 2012. Two individuals had a tracheostomy. One individual had a fundoplication.

#	Provision	Assessment of Status	Compliance
		For those determined to have a bacterial pneumonia, five of seven had a feeding tube. For those determined to have aspiration pneumonia, two of seven had a feeding tube. For those determined to have an aspiration pneumonia, two of seven had an EGD recorded. From the Pharmacy and Therapeutics (P&T) Committee of August 21, 2013, the Infection Control data from April 2013 indicated there was one bacterial pneumonia and one aspiration pneumonia. From the same minutes, the May 2013 data indicated there was one bacterial pneumonia and one aspiration pneumonia. At the P&T Committee of November 6, 2013, the Infection Control data from August 2013 indicated that there were three pneumonias (differentiation of type was not included). For September 2013, the data indicated four pneumonias (differentiation of type was not included). The total of 11 pneumonias from this monthly information did not agree with the Avatar information provided, which indicated the total for this time period was 14. From a third submitted document entitled: "Infectious Disease Status 2nd Qtr 2013," the graph and chart indicated that there were two pneumonia cases in April 2013 (neither were categorized as aspiration pneumonia). For May 2013, there were three aspiration pneumonia cases reported, and one non-aspiration pneumonia. *Sepsis* Thirty individuals were diagnosed with sepsis in the past 12 months. The following is a breakdown of occurrence per month: **Month** / **Number of Individuals with Sepsis Diagnosis** / **Month** / **Number of Individuals with Sepsis Diagnosis** September 2012 — 2 — March 2013 — 3 October 2012 — 2 — April 2013 — 4 November 2012 — 1 — May 2013 — 1 December 2012 — 1 — June 2013 — 1 January 2013 — 3 — July 2013 — 3 February 2013 — 6 — August 2013 — 3 It was noted that six individuals had sepsis diagnosed twice during this time period. For one entry, the information appeared to be duplicated and was removed in listing the number of sepsis cases per month. *Trauma* During the time period from June 2013 through September 2013, there were six fractures. There were three events in which more than one bone was fractured. The fracture sites included the following: one was an upper extremity fracture and five were lower extremity fractures. These occurred during the following	

#	Provision	Assessment of Status	Compliance
		months: June (one), July (one), August (two), and September (two). During the time period from April 2013 through September 2013, 18 individuals went to the ER or were hospitalized for injuries. These occurred during the following months:	

Month	Number of Injuries with ER Visit/Hospitalization	Month	Number of Injuries with ER Visit/Hospitalization
April 2013	1	July 2013	3
May 2013	5	August 2013	3
June 2013	4	September 2013	2

It was noted that the submitted document entitled: "List of individuals with injuries requiring visit to ER or hospitalization" included 26 incidents. However, the Monitoring Team removed eight duplicated entries to determine an accurate list. This suggested the Medical Department or other Facility Department had conducted no analysis of this information.

Chronic Conditions and Specific Diagnostic Categories

At-Risk Individuals

Based on a review of the 12 individuals in the sample, the following are examples of clinical questions and concerns related to the quality of the assessments completed, and outstanding concerns for which there was no information available in the submitted documents:

- Individual #162 had a long history of gastroesophageal reflux disease, diagnosed by pH probe in 2002. This individual underwent a fundoplication at that time and gastrostomy-tube placement. In 2004, an esophagogastroduodenoscopy was done for vomiting, but showed no Barrett's esophagus. Due to an upper gastrointestinal bleed in 2008, an EGD was done and revealed erosive esophagitis. In November 2011, the individual was found to have a large gastric residual and was started on Reglan. In February 2012, the individual had an upper gastrointestinal bleed. An EGD of 1/9/13 continued to show esophagitis without Barrett's esophagus. It also showed a partial unraveling of the fundoplication and a hiatal hernia. In April and May 2013, the Reglan was tapered. The individual remained on a proton pump inhibitor. The documents reviewed did not indicate how the gastric residual was followed to ensure this had resolved or whether or not there were plans for further evaluation and treatment, given the Reglan had been discontinued. There was no further information or plan documented for follow-up of the unraveling of the fundoplication and hiatal hernia. An EGD in 2013 continued to indicate GERD, at times associated with bleeding. The history of increased gastric residual, GERD, and partially unraveled fundoplication are identified risks for reflux aspiration and aspiration pneumonia/pneumonitis, but there was no aggressive evaluation and treatment of these concerns in the documents reviewed.
- Individual #212 was prescribed Zantac to reduce stomach acid production, as well as Reglan, and medications for bronchospasm. The individual was noted to have aspiration on an upper

#	Provision	Assessment of Status	Compliance
		gastrointestinal radiologic study in the past, as well as severe GERD, and a hiatal hernia. In 1982, a G-tube was placed, and in 1986, a fundoplication was completed. The individual had had numerous aspiration pneumonias (11 from 1989 to 2011), and additional recorded acute respiratory distress without further definitive diagnosis. In February 2012, the individual underwent an EGD, and esophagitis, gastritis, and H. pylori were found and treated. A jejunostomy was recommended/suggested, but the guardian did not agree to this option. Since that time the individual had numerous hospital admissions or ER visits due to respiratory distress (i.e., 3/23/12, 10/18/12, 1/6/13, 3/17/13, 3/23/13, and 9/9/13). The history noted in the ISPA of 9/18/13 in which it was described that the individual: "shows signs of respiratory issues very quickly and they disappear just as fast" is consistent with bronchospasm from acute reflux of gastric acid. A chest x-ray of 9/13/13 did not indicate pneumonia, and the diagnosis of acute bronchitis was made with no further evaluation of the history of multiple episodes of respiratory distress. There was documentation of environmental allergens, as well as gynecologic discomfort as etiology of the respiratory distress. However, the documentation did not indicate an aggressive evaluation as to cause of the frequent respiratory distress. There was no further evaluation of the functional status of the fundoplication to determine if it had become unraveled, nor a determination by consultants whether the individual would benefit from repair of the hiatal hernia. There was no information concerning a plan to determine the possible contribution of GERD to the many episodes of respiratory distress. There was also one acute illness on 11/30/12, associated with unusually warm, red skin, tachycardia, and wheezing, findings which might indicate an additional diagnosis is present, but there was no discussion in the record as to the cause of these cluster of findings, a differential diagnosis, or a planned evaluation or work-up. Until there is an aggressive evaluation for the GERD and other conditions, which might require a number of consultations and diagnostic tests, the recurrence of respiratory distress likely will continue. The record review identified a number of clinical concerns that remained unresolved. ▪ Individual #382 developed respiratory distress requiring either hospitalization and/or Infirmary admission on 10/30/12 (Infirmary), 11/3/12 (Infirmary), 2/25/13 (Infirmary), 3/10/13 (hospital), and 8/19/13 (hospital). Pneumonia was diagnosed on the latter three admissions to the Infirmary or hospital. On 3/20/13, a Modified Barium Swallow Study was completed, and demonstrated aspiration on thin liquids, but not thickened liquids. On 8/20/13, a bedside swallow study completed in the hospital indicated the individual safely swallowed nectar thick liquids and pureed food. The individual was placed on nectar thick liquids and foods thinned to applesauce consistency. On 4/17/13, four non-restorable teeth were extracted. The individual used vacuum tooth brushing. Due to the pneumonia of 8/19/13, and continued infiltrate on chest x-ray of 9/3/13, another MBSS was ordered. The head of bed had been elevated at all times from 20 degrees to 30 degrees. There was no documentation concerning whether GERD was a contributing factor in the recurrences of pulmonary illness until a gastroenterology consult was requested on 10/3/13, specifically requesting consideration of an EGD and need for fundoplication. The individual was prescribed a proton pump inhibitor. It was noted that the individual had five episodes of respiratory distress before consideration of a GERD evaluation. Until the most recent hospitalization, the evaluation and treatment of this individual did not appear to be aggressive in	

#	Provision	Assessment of Status	Compliance
		meeting the needs of the individual's health. ▪ Individual #297 had numerous hospitalizations and Infirmary admissions for respiratory distress/hypoxia [i.e., 2/12/12, 2/24/12, 4/14/12, 5/1/12, 5/8/12, 8/19/12, 8/26/12, 9/13/12, 10/10/12, 10/15/12, 11/21/12, 1/8/13, 1/16/13 (coded during this hospital admission with successful resuscitation), 2/9/13, 3/15/13, 4/7/13, 7/17/13, and 9/23/13]. The individual was prescribed a proton pump inhibitor, underwent G-tube placement in 2001, and a fundoplication in the past. On 6/28/12, Gastroenterology was consulted, and recommended a J-tube, but the PCP did not agree with the recommendation, because the individual was considered stable at that time. On 8/17/12, the individual was seen by pulmonology. On 12/12/12, the individual underwent an EGD with findings of an incompetent lower esophageal sphincter, and chronic gastritis. On 3/15/13, an allergy consultant indicated there were no significant environmental allergens found on testing. On 4/15/13, the individual underwent a revision of the fundoplication with lysis of adhesions. There were no complications. Given the number of respiratory events, including, at one point coding, there appeared to be a significant delay in evaluation. Although there was concern about allergies causing respiratory distress and increased secretions, this had been ruled out in the past (1998). Although this was again part of the differential diagnosis, the reason for not completing a GERD evaluation at the same time was not clear. *GERD* As part of the review of 12 records, GERD was reviewed. ▪ Of the 12, nine were diagnosed with GERD. Not each case would have had the listed test or procedure, but the following provides evidence of the spectrum of treatment at the Facility: o Of these nine, six had results of an EGD report available or discussed in the IPN/ISP. o Of these nine, three had a fundoplication. o Of these nine, eight had a feeding-tube. o Of these nine, nine had appropriate medication prescribed. o Of these nine, one had a tracheostomy. The Medical Department's management of GERD is further discussed with regard to Section I.2. *Barrett's esophagus* Fifteen individuals were diagnosed with Barrett's esophagus. Date of the last EGD and copies of the most recent gastroenterology consult were submitted. Fourteen of 15 (93%) were up-to-date with follow-up consultation and monitoring procedures. *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. No individuals were newly diagnosed with diabetes mellitus type II. Seven individuals were newly	

#	Provision	Assessment of Status	Compliance
		diagnosed with cardiovascular disease. No cases of a newly diagnosed cancer were reported in the past year. *Pica* A list of pica events or ingestion of inedible objects was submitted for the six months prior to the Monitoring Team's visit. Entry dates of events included the time period of 4/13/13 through 9/10/13. This included 49 events involving 13 individuals. Zero of 49 pica incidents required an ER visit or hospitalization. *Chronic constipation* Three hundred fifty-nine individuals were treated with routine medication for chronic constipation. According to data submitted, from March through August 2013, there were seven incidents of bowel obstruction. These occurred in the following months: March (one), April (two), May (four), June (zero), July (zero), and August (zero). From a separate submitted database, entitled "Newly Diagnosed with bowel obstruction or bowel perforation," the number of occurrences per month was: March (one), April (two), May (three), June (zero), July (zero), and August (one). *Enteral feeding-tubes* The Facility submitted information that six individuals were identified as having jejunostomy tubes or gastro-jejunostomy tubes. A review of the medication profiles was completed to determine whether medications not recommended for administration through these specific tubes or dosage/blood level was affected by administration through a J-tube were ordered through these enteral tubes (i.e., Quinolones, Sucralfate, Antacids, Bismuth, Beta blockers, Nitrates, Opioids, and Tricyclic anti-depressants). The review indicated that for six of six individuals with gastro-jejunostomy tubes or jejunostomy tubes, these medications were not prescribed. The Drug Regimen Review Profile was reviewed. As part of the safety process, two of six Drug Regimen Review Profiles included notations "has J-tube. Do not give quinolones, sucralfate, antacids, or bismuth by J-tube." One additionally had the statement "do not give ketoconazole by J-tube." The other four had no notation. It is recommended that the drug regimen review profiles have standardized notations to ensure the reader is aware of medications that should not be given by J-tube, or that other warnings of effect on drug level be added. *Skin Integrity* On 5/28/13, 6/27/13, and 9/5/13, a Skin Integrity Committee met. Minutes were submitted for these three meetings. The minutes of the 5/28/13 meeting provided trends for ongoing and continuing cases of pressure ulcers, new cases of pressure ulcers, and the number of individuals with pressure ulcers. In April 2013, there were six ongoing and continuing decubiti (improved from 17 in December 2012), one new case (improved from a peak of seven new cases in November 2012), and five individuals with decubiti (indicating a downward trend peaking in November to December 2012 with 15 individuals). There were four stage II pressure ulcers and one stage IV pressure ulcer. At that meeting, it was agreed that the Skin Integrity Committee policy needed revision. Areas of focus would be determining core membership and the process of reporting pressure ulcers. The committee was to develop guidelines on utilizing the "Wound	

#	Provision	Assessment of Status	Compliance
		Assessment Worksheet." Preventive measures were to be defined in protocols for medical, habilitation, and nursing services. The 6/27/13 Skin Integrity Committee minutes provided data for May 2013, in which there was continued improvement in trends related to skin integrity, with three ongoing pressure ulcers (i.e., the stage of one wound could not be identified, one Stage II, and one Stage IV), two individuals with pressure ulcers, and no new cases. The Committee planned to expand to include other wound related concerns, and agreed to focus on the three individuals at ABSSLC with the highest number of injuries in the quarter. The IHCP was to be reviewed for each at the next Committee meeting with focus on preventive interventions and monitoring indicators. Habilitation Services presented 17 preventive interventions, recorded in the minutes. The 9/5/13 minutes of the Skin Integrity Committee documented that the ongoing cases of pressure ulcers had increased to five in August 2013, new cases had increased to two in August 2013, and five individuals had pressure ulcers. There was a detailed summary for two individuals with recurrent pressure ulcers. No further progress was made on other endeavors of the committee. The consideration of reviewing IHCPs for those with highest injury rates was tabled. At the 11/6/13 morning medical meeting, an update of Skin Integrity data was presented by the Nursing Operations Officer (NOO). For the month of September 2013, the total number of pressure ulcers was three (down from six new and ongoing pressure ulcers in August 2013). It was noted that according to the Facility's data, there was an 83 percent decrease in the number of pressure ulcers over the prior 12 months. The Facility indicated that the prior high numbers of decubiti were in part due to lack of standardization in documentation and reporting. With a standardized system for reporting in place, the actual numbers of decubiti could be tracked. This change in documentation and reporting was reflected in the percentage decrease in the monthly prevalence of decubiti, as well as incidence of new cases. There were no new cases of pressure ulcers in September 2013. Two individuals had pressure ulcers in September 2013. It is recommended that information be tracked as to the geographic location associated with the initial pressure ulcer (i.e., ABSSLC, hospital, etc.). The Medical Department submitted a draft entitled: "ABSSLC Clinical Pathway/Guideline for Pressure Ulcer Prevention as well as Pressure Ulcer Care." It included guidance for nursing, medical, and habilitation services in assessing, preventing, treating, documenting, and reporting pressure ulcers. This was one of the Skin Integrity Committee recommendations. There appeared to be continued progress in this area. *Seizure management* The Facility submitted information concerning antiepileptic medication usage. As of 9/30/13, 188 individuals were prescribed antiepileptic medication. ▪ Of these, 95 (51%) were prescribed one antiepileptic medication, 58 (31%) were prescribed two antiepileptic medications, 31 (16%) were prescribed three antiepileptic medications, four (2%) were prescribed four antiepileptic medications, and no individual was prescribed five antiepileptic	

#	Provision	Assessment of Status	Compliance
		medications. ▪ Additionally, 60 individuals with a diagnosis of seizures were on no antiepileptic medications. ▪ Twenty-nine individuals were considered to have a refractory seizure disorder. Twenty-nine of 29 (100%) of these had a VNS implant. There was no individual with a refractory seizure disorder who was currently being evaluated for a VNS. The Facility indicated that it had begun to develop a database to track individuals with seizure activity. The document entitled "Refractory Seizure Disorder" indicated that there was no standardized definition of "intractable seizure disorder." The Facility had defined this condition to determine when an individual might need other therapeutic options. The Facility's definition of "refractory seizure disorder" was based on three criteria: two anti-epileptic medication failures, at least one seizure per month for 18 months, and no seizure-free period lasting over three months during those 18 months. ▪ In the prior six months, eight individuals were sent to the ER for an uncontrolled/prolonged/new onset seizure. This occurred during the following months: May (one), June (zero), July (three), August (two), and September (two). ▪ In the six months prior to the Monitoring Team's visit, two individuals were diagnosed with status epilepticus. A list was submitted indicating the percentage of individuals prescribed older antiepileptic medications. A total of 34/188 (18%) of individuals taking anti-epileptic medication were prescribed Dilantin, 8/188 (4%) were prescribed Primidone, 61/188 (32%) were prescribed Phenobarbital, and 4/188 (2%) were prescribed Felbamate. It was noted that the document providing this information ("Number and percentage of persons on older AEDs") calculated that 98 individuals were prescribed these four medications. However, the correct number was 107. Additionally, 29 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: ▪ Three of the five individuals had been seen more than once over the past six months. ▪ 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 two of the five (40%) individuals, notes included 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 the presence or not of side effects. ▪ For five of the five (100%) individuals, reference was made to wellness or adequate/good control	

#	Provision	Assessment of Status	Compliance
		of seizures. Do Not Resuscitate Orders A total of 16 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, zero individuals in 2012, for three individuals in 2011, for zero individuals in 2010, for two individuals in 2009, and for 10 individuals in years prior to 2009. For 12 of 16 (75%), adequate clinical justification was provided for the DNR. Clinical justification included the following: zero individuals had dementia, one had compromised respiratory function, three had cardiac diagnosis, zero had cancer, six had severe osteoporosis, one had a neurodegenerative disorder, and one had a syndrome associated with obesity precluding effective Cardiopulmonary Resuscitation (CPR). For four individuals, the document stated: "No medical justification." These were based on family/LAR request. For two of these four, an ethics committee meeting with the family occurred in 2013 to clarify the ongoing existence of DNR. For such cases in which the documentation for the DNR includes "no medical justification", a representative (legal and/or medical) from the State Office should be included in the meeting (via conference call, etc.), to assure consistency/compatibility with the State Office guidelines. Two DNRs were rescinded in the prior six months. For one individual, a PCP IPN of 6/28/13 indicated that the ethics committee communicated with the family member/correspondent to discharge the individual from Hospice services and begin a PNMT evaluation to address feeding and hydration [i.e., Modified Barium Swallow Study (MBS), positioning evaluation, etc.]. It was noted the individual did not have an identifiable terminal condition. The individual did have severe osteoporosis. There was agreement to rescind the DNR, but to forego chest compressions during a code due to the severe osteoporosis, and to offer all other modalities of resuscitation. For a second individual, a PCP IPN of 8/5/13 documented discussion with the guardian concerning a DNR placed in 2007. As there was no known terminal condition, a DNR order was not appropriate for the individual. This was rescinded. Because of severe deformities of the chest, an order was placed not to provide chest compressions during a code, which would allow for other rescue support measures without the potential of pain/trauma from the chest compressions. The Facility Ethics Committee met on the following dates to discuss specific individuals to review DNR status: 5/2/13, 5/3/13, and 6/28/13. For meetings in which more than one individual was discussed, meetings were conducted so that each individual had a separate ethics meeting without discussion of other individuals. Minutes reflected a discussion of one individual per meeting. Because of this, several sets of meeting minutes could occur in one day, for privacy protection. There were seven individuals discussed at these three dates of meetings. Seven sets of minutes were submitted for the Facility Ethics Committee on these three dates. The meetings/minutes included the following components: ▪ Seven of seven (100%) meeting minutes documented date and time. ▪ Seven of seven (100%) meeting minutes included the name(s) of individuals for discussion of DNR/hospice. ▪ Seven of seven (100%) meeting minutes listed names of attendees. ▪ Seven of seven (100%) meeting minutes included a signature sheet.	

#	Provision	Assessment of Status	Compliance
		▪ Seven of seven (100%) meeting minutes included a synopsis of the proceedings and critical review of information. ▪ Seven of seven (100%) meeting minutes included a summary of critical discussion with family/guardian. ▪ Seven of seven (100%) meeting minutes included discussion by the PCP. ▪ Seven of seven (100%) meeting minutes included a recap with recommended action steps outlined. ▪ Seven of seven (100%) meeting minutes included documentation of any orders (i.e., order for hospice, order to rescind DNR, etc.) based on the decision of the ethics committee. <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 (external) audit review (Round #7). The following represents a synopsis of the information: ▪ For the one external peer review dated April 25 to 26, 2013, PCP compliance in essential areas ranged from 93 percent to 100 percent. It was noted that five of six PCPs had 100 percent compliance. The one PCP with less than 100 percent compliance was a locum tenens position. For areas considered nonessential, compliance ranged from 99 percent to 100 percent. The PCPs were compliant with the non-essential areas monitored. ▪ The external audit review process information indicated the number of records chosen for review. ▪ The external audit review process information indicated how the sample was obtained. ▪ Areas that appeared to need improvement from the external peer review were identified by the Medical Department. These included answers to the following audit probe questions: (#1) Essential: Is the active problem list in the correct location according to the Active Record Order Guideline Index? (#4) Essential: Is the annual physical exam and summary current? and (#13) Non-essential: Are the current 180-day orders present in the record? ▪ From the external peer review audit, there were five corrective action plans generated. ▪ An external medical management audit for Round #7 was also completed on April 25 to 26, 2013. The three areas of clinical focus were: aspiration pneumonia, diabetes mellitus, and osteoporosis. ▪ Areas that appeared to need improvement from the external medical management peer review audit included answers to the following audit probe questions: (#3) Is there evidence that the individual has had a modified barium swallow completed since a diagnosis of aspiration pneumonia? There was 100 percent compliance with the clinical indicators for diabetes mellitus and osteoporosis. ▪ From the external medical management audit for Round #7, there was one corrective action plan generated. ▪ A Medical Provider Exit Interview was conducted. According to the external reviewer, strengths included following up on consultant recommendations and record organization. No information was provided as to whether or not areas needing improvement were specifically addressed by the	Noncompliance

#	Provision	Assessment of Status	Compliance
		external peer review auditor. ▪ Compliance rates were also calculated as an average of all PCP scores. ▪ There was analysis for compliance per question across the PCP clinical practices. There was review of audit results to determine the most common areas of non-compliance, which might need additional focus. ▪ Additionally, each PCP was tracked for compliance. Each PCP was provided percentage compliance for the general medical audit for both the essential and nonessential indicators. The external audit review process for Round #7 reviewed 23 active records for the general medical audit and nine active records for the medical management audit. This was 8 percent (32/380) of the records at the Facility. A second external medical peer review is anticipated to occur approximately six months from the April audit. A 20 percent sample of records per year is considered compliance for the external medical peer review process and the Facility needed to adjust the size of the sample completed by the external peer review auditor to ensure that the two visits equal or exceeds this percentage review of the population residing at ABSSLC. 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. The date of the final report discussing closure was 9/30/13. ▪ The QA Department determined that 100 percent of providers corrected all deficiencies. There were six Corrective Action Plan identified from the general medical audit and medical management audit. All six CAPs were corrected. A comparative analysis was made of the current compliance for the external medical peer review audit and the prior external medical peer review audit of October 2012. It was noted that the October 2012 external peer review audit required a CAP for only one of the essential indicators, versus two essential indicators not meeting compliance for the April 2013 audit. In October 2012, for the combined results of the general medical and medical management audits, there were 30 CAPs generated. For the April 2013 audits, there were only six CAPs. Improvement plans also included an in-service to PCPs on all responses to questions that fell below the compliance threshold, and continued educational opportunities were offered during discussions at the morning medical meeting and lunchtime teaching in the Medical Department. Additionally, the Settlement Agreement Compliance Physician was to review the findings of indicator #1 (Is the active problem list in the correct location according to the active record order guideline index?) and #4 (Is the annual physical exam and summary current?). Additional steps planned or completed are discussed with regard to Section L3, which discusses the internal peer review audit process and other initiatives of the Medical Department. As a continuing challenge, there have only been six diagnoses used in the medical management reviews.	

#	Provision	Assessment of Status	Compliance
		Expansion of this to other common conditions/clinical needs is necessary to ensure the breadth needed of a quality review. <u>Mortality Reviews</u> At the time of the review, the Facility had one outstanding clinical death review for deaths that occurred more than 30 days from the Monitoring Team's visit. Since the start of the Monitoring Team's last visit, four deaths had occurred: ▪ The average age was 69 (varied from 55 to 83). ▪ One died under the age of 65, and three died at age 65 or greater. ▪ Of the deaths, one was female, and three were males. ▪ The death certificate had been received in three of four. ▪ The causes of death were: colon cancer with metastases, acute aspiration, acute renal failure and Congestive Heart Failure (CHF)/end stage Chronic Obstructive Pulmonary Disease (COPD). ▪ An autopsy was performed in three of the four. ▪ DNR status was ordered while residing at ABSSLC for one of the four, and ordered for none while in the hospital. ▪ Two died in a hospital setting. ▪ Two died at the Facility. ▪ None had multiple or prolonged hospitalizations within six months prior to death ▪ One had a feeding-tube. ▪ Two were enrolled in hospice. ▪ None were considered ambulatory (either independently or with assistance). ▪ One of four required supplemental oxygen. Since the Monitoring Team's last visit, three clinical death review investigations were completed and three 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 for two of three. The Clinical Death Review also had two clinical recommendations for one individual, but these additional recommendations were not listed among the administrative death review recommendations. It was noted that a representative of PNMT was a member of the clinical death review committee. ▪ Of these death reviews, two administrative death reviews had follow-up recommendations. ▪ Administrative death reviews included from 12 to 23 recommendations per review, for a total of 35 recommendations. ▪ The clinical death review had two additional recommendations, for a total of 37 recommendations. ▪ Systemic issues related to potential improvements in medical care were eight of the 37 recommendations from the administrative death reviews. ▪ Systemic issues related to potential improvements in nursing care were 24 of the 37 recommendations from the administrative death reviews. ▪ Systemic issues related to potential improvements in Pharmacy Services were three of the 37	

#	Provision	Assessment of Status	Compliance
		recommendations from the administrative death reviews. ▪ Systemic issued related to potential improvements in dental services were zero of the 37 recommendations from the administrative death reviews. ▪ Systemic issues related to potential improvements in habilitation therapies were one of the 37 recommendations from the administrative death reviews. ▪ Systemic issues related to potential improvements in medical records were one of the 37 recommendations. The Facility submitted adequate follow-up documentation for 26 recommendations. No evidence was provided for six, although there was the statement that the recommendations had been completed. Evidence was partial for two. There was no information that three additional recommendations had been completed. Documentation of closure of recommendations was followed through the QA/QI Council. The minutes of the 10/7/13 QA/QI Council indicated that the QA Nurse provided a list of recommendations from the death reviews. Based on this review, concerns were identified, including a lack of timely follow-up to numerous recommendations. For example, for one individual, responses/closures were due by 8/1/13, but according to the 10/7/13 minutes, all death review recommendations for this individual needed closure. For one individual, all recommendations reportedly had been addressed, but no evidence was included in the minutes to show adequate action had been taken. For two other individuals, a list of 23 recommendations was part of the minutes, and based on questions from the Assistant Director of Programs and responses from staff present at the meeting, it appeared that numerous recommendations that should have been completed had not been. This was of significant concern. At the QA/QI meeting the Monitoring Team observed, no update was provided regarding the status of these recommendations. Meeting minutes of a QA Tracking Systems meeting on 7/25/13 indicated that a tracking system was created to ensure closure of recommendations from the death reviews. However, at the Monitoring Team's meeting with the QA nurse, it was noted that closure had occurred with the Medical Department recommendations, but the QA nurse had not received any information for other department recommendations. Facility staff subsequently produced considerable documentation that was not previously forwarded to the QA Department for review in a timely manner. Review of these documents indicated a number of recommendations had been closed (noted above), but some stated there was closure without training rosters or other evidence, some appeared in process, and some had no information indicating closure. At the time of the Monitoring Team's visit, there did not appear to be a working system in place for the QA Department to track all recommendations to closure.	
L3	Commencing within six months of the Effective Date hereof and with full	<u>Medical Department Internal QA System</u> The data from two internal medical peer reviews was provided. One peer review occurred within seven days of the April 2013 external medical peer review audit. The other occurred July 13 to 20, 2013. The audit questions were identical to those used in the external medical peer review audit for each of the internal medical peer reviews.	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	For the April 25-26, 2013 general medical audit: Five of the essential indicators fell below 100 percent compliance. Five of the non-essential indicators fell below 80 percent compliance. Compliance among PCPs ranged from 82 percent to 100 percent for essential components, and 85 percent to 100 percent for nonessential components. Areas that appeared to need improvement included answers to the following audit probe questions: (#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 exam and summary current? (#5) Annual Physical summary complete including past medical history, family history and plan of care? (#7) Drug and/or food allergies, intolerances or adverse drug reactions are appropriately documented? (#10) Are the appropriate preventive screening services provided? (#15) Did the provider document rationale for not following recommendations made by the pharmacist? (#17) Medically appropriate diagnostic tests and/or therapeutic procedures ordered? (#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? and (#20) Are abnormal diagnostic tests that needed interventions addressed by the provider with appropriate follow-up documentation in the integrated progress note? For the internal medical peer review audit, there were 43 corrective action plans identified. There was information submitted concerning tracking these corrective action plans to closure. As of September 30, 2013, the QA Department report indicated 100 percent of the 43 corrective action plans had been completed. An internal medical management audit was completed during the time period of approximately April 25 to 26, 2013, utilizing the same audit questions from the external medical management peer review for the following clinical concerns: aspiration pneumonia, diabetes mellitus, and osteoporosis. Areas that appeared to need improvement included answers to the following audit probe questions: ▪ For aspiration pneumonia: (#3) Is there evidence that the individual has had a modified barium swallow completed since a diagnosis of aspiration pneumonia? (#4) Did the provider order appropriate interventions after the MBS? (#7) Did the provider refer the individual to the QIDP or the PNMT nurse after the last diagnosis of aspiration pneumonia? (#8) If the individual has a diagnosis of GERD, is it on the active problem list? (#11) Did the PCP review the risks and interventions for the individual for aspiration pneumonia and recommendations made? and (#12) Did the provider review the medications to see if any changes or additions were needed to reduce the risk of aspiration pneumonia? ▪ For Diabetes mellitus (#2) Did the provider prescribe the appropriate follow-up lab? (#3) Did the provider order appropriate diagnostics and consults if warranted? and (#6) Did the provider evaluate and assess the individual for other risk factors such as smoking, hypertension and obesity? ▪ For osteoporosis (#4) Did the provider order or document findings of a dental exam before initiating a bisphosphonate?	

#	Provision	Assessment of Status	Compliance
		Compliance for the internal medical management audit per PCP was not submitted. For the April 2013 internal medical management peer review audit, there were 14 corrective action plans identified. There was information submitted concerning tracking these corrective action plans to closure. As of a September 30, 2013 QA Department report, 100 percent of the 14 corrective action plans had been completed. The QA Department tracked the internal general medical and medical management closure of action plans. Thirty-five of the action plans were completed within 30 days. An additional 18 action plans had been completed within 60 days, and the remainder were completed by the 91st day. The QA Department provided a comparison of results to the prior internal general medical and medical management peer review audits. The Medical Department initiated systemic changes to address some of the concerns identified. Along with those discussed in relation to Section L.2, a family history questionnaire was developed and implemented, which was mailed to listed family members prior to the annual evaluation. If received in a timely manner, this information was to be included in the annual medical assessment. The Medical/QA Department planned to randomly sample completed annual medical assessments with focus on completeness of the family medical history, as well as preventive screening services that had been completed at ABSSLC or elsewhere. For questions #18 and #20 of the general medical audit, the PCPs were to be provided ongoing in-services on topics for improvement in this area, as discussed later in this subsection. The Medical/QA Departments were to develop an audit process to evaluate those with confirmed aspiration pneumonia prior to discharge from the Infirmary using the medical management, monitoring tool for aspiration pneumonia. The Facility had developed a monitoring tool to address quality care of diabetes mellitus. The Facility also had plans to develop and provide training on a policy for dental exams prior to starting bisphosphonate treatment. An additional internal medical peer review audit was completed July 13 to 20, 2013. The Settlement Agreement Compliance Physician was the auditor. Two essential indicators for the general medical audit fell below compliance and five non-essential indicators fell below compliance. Areas identified as needing improvement were: (#5) Is the annual physical summary complete including past medical history, family history, and a plan of care? (#17) Are medically appropriate diagnostic tests and/or therapeutic procedures ordered? (#18) Are responses to lab values that needed interventions documented in the integrated progress note by the provider? (#20) Are abnormal diagnostic tests that needed interventions addressed by the provider with appropriate follow-up documented in the integrated progress note? (#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 (#28) Is there a clear explanation on the integrated progress notes as to why the provider has chosen to not implement the recommendations?	

#	Provision	Assessment of Status	Compliance
		In July 2013, an additional medical management medical peer review audit was also completed. Topics were aspiration pneumonia, diabetes mellitus, and osteoporosis. The questions indicating a need for improvement were the following: ▪ For aspiration pneumonia: (#2) Did the provider prescribe a HOBE? (#7) Did the provider refer the individual to the QIDP or the PNMT nurse after the last diagnosis of aspiration pneumonia? (#11) Did the PCP review the risks and interventions for the individual for aspiration pneumonia and recommendations made? and (12) Did the provider review the medications to see if any changes or addition needed to reduce the risk of aspiration pneumonia? ▪ For diabetes mellitus: (3) Did the provider order appropriate diagnostics and consults if warranted? (#6) Did the provider evaluate and assess the individual for other risk factors such as smoking, hypertension and obesity? ▪ For osteoporosis, all indicators were at 100 percent compliance. There were a total of 44 corrective action plans generated from the internal medical peer review audit of July 2013. There were 35 action plans from the general medical audit and nine action plans from the medical management audit. The QA Department tracked all action plans until closure. As of 9/30/13, there were no outstanding medical management action plans. As of October 8, 2013, there were no outstanding general medical action plans. For the internal medical peer review in July 2013, information was provided for compliance per PCP. PCP compliance with essential indicators ranged from 79 percent to 95 percent. PCP compliance with non-essential indicators ranged from 86 percent to 98 percent. It was noted that there was a 23 percent reduction in the number of action plans from the April 2013 internal audit to the July 2013 audit. The results were reviewed for systemic actions to be taken. The Facility tracked the frequency of inadequate response to each clinical indicator. The Facility was able to determine those clinical probes with the most negative responses. Due to PCP shortage and turnover, and changes in assigned caseloads, continuity of care was a concern that might have potentially contributed to areas needing improvement. Some of the plans to resolve findings of prior medical audits had advanced. For example, a monitoring tool to measure the quality of the annual medical assessment had been developed and approved. A monitoring tool to measure quality of medical care for aspiration pneumonia had been developed and approved. A monitoring tool for quality care of diabetes mellitus had been developed and approved. <u>Inter-rater reliability</u> The QA Department provided inter-rater reliability for the past six months. The QA representative tracked test scores from the external peer reviewer, test scores from one member of the QA Department, and test scores from all PCPs involved in the internal medical peer review process. Results indicated the following: ▪ For the external peer review audit, inter-rater reliability for the 30 question general medical audit was 85 percent. ▪ For the external peer review audit, inter-rater reliability for the three diagnoses of the medical management audit was 78 percent.	

#	Provision	Assessment of Status	Compliance
		▪ Discrepancies in answers were listed for the medical management audit, and were an opportunity to review the differences to determine strategies for improved agreement in audit review. These same percentages for inter-rater reliability were given for the results of the internal medical peer review audits of April 2013. According to submitted data, these numbers remained consistent between the April external and internal medical peer review audits. Continued tracking of the inter-rater reliability will determine whether the agreements remain stable or improve or not. <u>Medical Department Internal Reviews/Initiatives and Improvement Projects</u> The Medical Department had implemented the following additional processes for internal peer reviews: ▪ The morning medical meeting had become a forum for medical peer interaction. There were a number of critical questions asked from peer to peer, following case presentations. Additionally, significant consult reports were reviewed at the morning medical meeting, with additional questions and comments by the PCP as well as peers. All new consult referrals were discussed at the "Lunch and Learn" meeting, which included focus on documenting critical clinical information needed by the consultant. ▪ Quality indicators were identified for 10 clinical areas, independent of the audit tools utilized in the external and internal medical peer review and medical management peer review process. Topics included: aspiration, osteoporosis, constipation, Down syndrome, diabetes mellitus, consultations, medication orders, hospital visits, annual medical summaries, and preventive care. Four of these were in response to corrective action plans developed in response to the external/internal medical peer review audits. To prepare the PCPs, on 9/4/13, an in-service was held entitled: "Quality of Medical Care Indicators Monitoring Procedure." Three of these monitoring tools were implemented. ▪ On 7/11/13, an in-service to the PCPs for "Quality of Medical Care Indicators for Down Syndrome" was completed. The audit was completed 9/4/13 to 9/5/13, and inter-rater reliability was reportedly 100 percent. Findings documented compliance with four of six indicators. A follow-up meeting with the PCPs was completed on 9/17/13, and results were reviewed. Action plans were documented with assigned staff. ▪ A "Quality of Medical Care Indicators for Diabetes" monitoring tool was implemented. On 9/11/13, PCPs were trained. For the auditors, a document providing guidance for location of the needed information in the active record was created, entitled: "Guidelines for Completion of the Monitoring Tool Quality of Medical Care Indicators for Diabetes." The audit was completed from 9/16/13 to 9/17/13. Inter-rater reliability was reported to be 94 percent. Based on the Facility's review, eight of 16 clinical indicators were in compliance. The results were reviewed with the PCPs at a meeting held on 9/24/13. Action steps were assigned to participants. As part of the quality care initiative for diabetes, the annual physician order form was revised to include lab and consultations specific to those with diabetes mellitus. On 9/24/13, in-service training was provided to the PCPs. ▪ A "Quality of Medical Care Indicators for Aspiration Pneumonia" monitoring tool was implemented. On 7/9/13 and 10/1/13, PCP training occurred. The audit was completed 9/23/13 to 9/24/13. Inter-rater reliability was reported to be 92 percent. Three of 13 clinical indicators attained compliance. On 10/1/13, an in-service was held to discuss findings and assign action plans to	

#	Provision	Assessment of Status	Compliance
		correct the deficiencies. ▪ Additionally, there was an in-service reviewing the results of the monthly database report for incomplete medication orders, held on 10/10/13. On 9/11/13, there was an in-service for "State Office Guidelines: Screening for Diabetes." <u>Additional Medical Department Training</u> The internal and external peer review audits identified the following clinical indicators as areas needing improvement, for which the PCPs were provided an in-service on the date noted: ▪ (#29) Does the integrated progress record include a clinical assessment and a SOAP note from a provider within 24 hours of the readmission to the SSLC from a hospital /ER or long-term acute care facility? In-service training completed on 8/28/13. ▪ (#ASP2) Did the provider prescribe a HOBE? (#ASP7) Did the provider refer the individual to the QIDP or the PNMT nurse after the last diagnosis of aspiration pneumonia? (#ASP11) Did the PCP review the risks and interventions for the individual for aspiration pneumonia and recommendations made? (#ASP12) Did the provider review the medications to see if any changes or additions needed to reduce the risk of aspiration pneumonia? In-service training completed on 8/26/13. ▪ (#28) Is there a clear explanation on the integrated progress notes as to why the provider has chosen to not implement the recommendations? In-service training completed on 8/26/13. ▪ (#18) Are responses to lab values that needed interventions documented in the integrated progress note by the provider? In-service training completed on 8/26/13. ▪ (#DM3) Did the provider order appropriate diagnostics and consults if warranted? (#DM6) Did the provider evaluate and assess the individual for other risk factors such as smoking, hypertension, and obesity? In-service training completed on 8/26/13. ▪ (#26) When a referral for consultation is requested, is pertinent current and past medical history included in communication with the consultant? (Policies and Procedures Exhibit A; Health Care Guidelines 2009: 1.C.1f) In-service training completed on 8/23/13. ▪ (#17) Medically appropriate diagnostic tests and/or therapeutic procedures ordered. In-service training completed on 8/16/13. ▪ (#27) Are medical and/or surgical consultant recommendations addressed in the integrated progress notes within five business days after the consultation? In-service training completed on 8/16/13. ▪ (#16) Do the medication orders for acute conditions include indication and duration for all medications prescribed? In-service training completed on 8/16/13. ▪ (#20) Are abnormal diagnostic tests that needed interventions addressed by the provider with appropriate follow-up documented in the IPN? In-service training completed on 8/16/13. ▪ (#5) Is the annual physical summary complete including PMH, family history, and a plan of care? In-service training completed on 8/16/13. The follow-up to findings, with in-service education and training was timely and thorough.	

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>In summary, the Facility remained in noncompliance with this provision. Three additional clinical audits had been implemented. Seven others had been created, but had not been implemented. To move in the direction of substantial compliance, it will be important to demonstrate audits of a breadth of diagnoses and conditions. It will be important to implement the seven other clinical audits, as well as conduct analysis, discuss results with the PCPs, document findings and recommendations in minutes (e.g., medical staff, QAQI Council), etc., and complete the circle of the QI process (e.g., training of PCPs in areas needing improvement, a follow-up audit to provide evidence of any impact of the findings and training, etc.), with analysis of the results and evidence of improvement. The Medical Department is encouraged to continue the current quality improvement efforts. The steps taken thus far were contributing to rapid progress in this area.</td><td></td></tr>
<tr><td>L4</td><td>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</td><td>The Facility provided the current medical services policy and procedure manual. The following provides the content of this manual, along with the dates of approval or revision to indicate whether this was a new policy, or one that was revised periodically:
<table>
<tr><th>ABSSLC Medical Department</th><th></th></tr>
<tr><th>Policy/Procedure</th><th>Date of Approval/Date of Most Recent Revision or Review</th></tr>
<tr><td>Medical Services 03-01.01</td><td>Revised 9/11/12</td></tr>
<tr><td>ABSSLC Minimum Common Elements of Clinical Care Policy</td><td>Approved 9/13/13</td></tr>
<tr><td>DADS/ABSSLC Medical Care 009.2</td><td>Revised 7/2013, Effective 9/27/13</td></tr>
<tr><td>DADS/ABSSLC Medical Peer Review 054</td><td>Effective 9/27/13</td></tr>
<tr><td>ABSSLC Medical Staffing Procedure</td><td>Approved 9/20/13</td></tr>
<tr><td>ABSSLC Participation in Morning Medical Meeting Procedure</td><td>Approved 9/20/13</td></tr>
<tr><td>ABSSLC Medical Assessments/Summary/Plan of Care Procedure</td><td>Approved 9/20/13</td></tr>
<tr><td>ABSSLC Hospital Discharge Procedure</td><td>Approved 9/20/13</td></tr>
<tr><td>ABSSLC Use of Physician Orders Sheet Procedure</td><td>Implemented 6/20/13</td></tr>
<tr><td>ABSSLC Use of Consultation Report Form Procedure</td><td>Approved 9/20/13</td></tr>
<tr><td>ABSSLC Bisphosphonate Prolia Therapy Procedure</td><td>Implemented 8/1/13</td></tr>
<tr><td>Quality of Medical Care Indicators Monitoring Procedure</td><td>Implemented 9/5/13</td></tr>
<tr><td>DADS/ABSSLC Emergency Response 044.2</td><td>Effective 9/7/11</td></tr>
<tr><td>Emergency Response Procedure P-11</td><td>Revised 12/2010</td></tr>
<tr><td>Deaths of Individuals (while on absence from the Facility) 03-01.03</td><td>Date cut off from document copy</td></tr>
<tr><td>DADS/ABSSLC: Deaths of persons served by DADS Facilities or Community 03-01.02</td><td>Revised 4/1/06</td></tr>
<tr><td>DNR policy</td><td>Revised 10/2004</td></tr>
<tr><td>ABSSLC Procedures for rescinding a “Do Not Resuscitate</td><td>6/25/10</td></tr>
</table></td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
	standards of care with regard to this provision in a separate monitoring plan.		

Order"	
Autopsies	Undated
DADS/ABSSLC Clinical Death Review Procedures 03-05.01	Revised 4/14/11

Other Clinical Departments	
Policy/Procedure	**Date of Approval/Date of Most Recent Revision or Review**
ABSSLC Dental Policy and Procedures	Approved 9/24/13
Process for Medical Restraint Plans (for medical and dental)	Approved 8/19/13
Medical Restraint Plan for medical (template)	Date cut off from copy
Medical Restraint Plan for dental (template)	8/2013
Laboratory Department 03-03.04	Revised 3/27/12
X-ray Department 03-03.05	Date cut off from copy
Podiatry Clinic 03-03.07	Revised 4/26/10
Procedures for obtaining surgery permits	Revised 4/26/10
Occupational Therapy	Revised 9/13/10
Occupational Therapy Procedure for Mealtime Monitoring	Revised 9/13/10
Thickening Food and Liquids	Revised 9/13/10
Mealtime Monitoring	Revised 9/13/10
Occupational Therapy Procedure for Adaptive Equipment Review	Revised 9/13/10
Speech Language Pathology	Revised 9/13/10
Physical Therapy	Revised 9/13/10
Wound Care	Revised 9/13/10
ABSSLC Skin Integrity Committee Policy 03-05.02	Revised 5/2013
ABSSLC PNMT Supplemental to State Policy Number 012.2 for Physical Nutritional Management	Revised 1/12/12
DADS: Pharmacy Services 011	Effective 10/10/11
Pharmacy 03-06.03	Revised 4/2010
Antiepileptic and Psychotropic Medications: Surveillance Studies and Drug Levels 03-06.04	Revised 5/28/09
ABSSLC Policy for Procurement of Medication after hours	Undated
DADS: Psychiatry Services 007.3	Effective 5/1/13
DADS/ABSSLC Psychological and Behavioral Services 008	Effective 11/13/09
DADS: Habilitation, Training, Education, and Skill Acquisition Programs 017	Effective 8/1/13
DADS/ABSSLC Quality Assurance 003.1	Effective 10/15/12
ABSSLC Recordkeeping Procedures 03-04.05	Revised 7/9/10

#	Provision	Assessment of Status	Compliance

ABSSLC Management of Protected Health Information 03-04.07	Revised 4/26/10
Policy for Routing reports/documents 03-04.09	6/15/11
Chart procedures 03-04.08	9/2009
Facility Daily Population Report 03-04.04	Undated

Guidelines Included in Medical Policy and Procedure Manual	Date of Document
Health Care Guidelines	5/2009
DADS/SSLC Preventive Health Care Guidelines	8/30/11
Urinary Tract Infection	Undated
Diabetes Prevention Guidelines (includes Screening for Diabetes, Diabetic Ketoacidosis and hyperosmolar hyperglycemic state for the PCP, hypoglycemia for the PCP)	Undated
Enteral Feeding clinical guidelines for the PCP	Undated
ABSSLC Clinical Guidelines for Barrett Esophagus Screening and Surveillance Procedure	Implemented 3/24/13
Reducing the Risks for Aspiration Pneumonia for the PCP	Undated
Seizure Management Instructions for the PCP	Undated
Osteoporosis Guidelines for the PCP	Undated
Constipation/Bowel Management	Undated
Prader-Willi syndrome	Undated

Contents of the "Medical Services" policy included basic medical staff requirements and job duties; provision of Dental Services, Infirmary, Treatment Room, and Outpatient Clinic care and treatment; Pharmacy Services; Lab Services; X-ray Services; and medical consultant programs. Also included in this policy was guidance concerning immunizations, communicable disease, quarantine guidelines, guidance when there was a death of an individual, admission and discharges to ABSSLC, admission and discharges to the Infirmary, and overnight observations at the Infirmary.

The "Minimum Common Elements of Clinical Care Policy" included guidance for a variety of QA/QI concerns, including utilization of standardized and evidence based procedures on a routine basis and as needed for acute changes in health; accuracy/evidence for diagnoses utilized by Medical Services, Psychiatric Services, Dental Services, and Nursing Services; monitoring of treatments and interventions to measure timeliness; analysis and outcomes based on such monitoring tools as the internal and external QA and medical management audit, data concerning staff practices and other clinical databases; use of clinical indicators; listing of integrated clinical teams and committees; and references for several clinical conditions for guidance in providing quality care.

The "Medical Care" policy provided ABSSLC expectations of PCP practices, documentation requirements (i.e., active problem list, acute illness documentation, chronic health concern documentation, etc.), orders,

#	Provision	Assessment of Status	Compliance
		consultation initiation and follow-up, hospital transfers and readmissions, annual assessments and other periodic documentation requirements, Pharmacist concerns, communication with the individual, PCP meeting participation, management expectations for acute illness/injury, seizure management, goal of treatment for aspiration pneumonia, management of chronic illnesses, preventive medicine, and quality medical internal and external audits. The "Medical Peer Review" policy provided guidance for completing medical peer reviews at the Facility, with focus on investigating PCP practices to resolve complaints or allegations. The "Medical Staffing Procedure" reviewed assignment of caseloads. The "Participation in Morning Medical Meeting Procedure" outlined membership at this meeting, the meeting minute template, and process steps for the meeting. The "Medical Assessments/Summary/Plan of Care Procedure" outlined several steps in completing the annual medical assessment document. The "Quality of Medical Care Indicators Monitoring Procedure" provided process steps for the internal medical peer review audit. A policy or procedure entitled "Autopsies and Medical Certification of Death" was not submitted. A training roster for this document indicated it occurred on 3/18/13. The Medical Services manual was extensive. Areas that need guidance and placement in policy/procedure format were the timing of completion with the open record review and hospitalization review in sufficient time for the IDT to use this information to create an ISPA, and guidance on process and content of the ethics committee. In addition, the Health Care Guidelines, dated 2009, should have yearly review, including updates and change to guidelines consistent with current professional standards and recommendations. In addition, policies should be reviewed and revised, as appropriate every year. The Facility remained in noncompliance with this provision.	

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 8/5/13, 10/17/13, and 10/31/13; o Morning Medical Meeting minutes dated 8/29/13, 9/25/13, and 10/2/13; o Medication Variance Committee meetings minutes, dated 5/8/13, 5/22/13, 6/26/13, and 7/24/13; o ABSSLC Medication Variance Graphs; o ABSSLC's Infection Control overall summary report list; o Nursing Meeting minutes, dated 9/7/13, and 9/18/13; o QA/QI Quarterly Section Review of Settlement Agreement Progress Medication Variance Committee, dated 10/14/13; o ABSSLC's Immunization Database examples; o Drug Utilization Discrepancy data; o Medication Administration Observations data; o Assessment Workgroup Meeting minutes dated 8/16/13, 8/28/13, and 10/28/13; o Nurse Educator Observation form for onsite medication observation; o Case Manager scheduling tool; o Spread Sheets regarding Case Manager Training; o Pharmacy and Nursing Medication Room audits; o Prescriber Medication Variances data; o Pharmacy Technician Medication Variances data;

	○ Pharmacy and Therapeutics Committee meeting minutes, dated 9/21/13; ○ Medical records for the following individuals: Individual #216, Individual #429, Individual #479, Individual #545, Individual #139, Individual #8, Individual #245, Individual #37, Individual #311, Individual #285, Individual #282, Individual #23, Individual #413, Individual #493, Individual #515, Individual #199, Individual #295, Individual #87, Individual #22, Individual #371, Individual #470, Individual #9, Individual #25, Individual #23, Individual #187, Individual #138, Individual #212, Individual #157, Individual #234, Individual #207, Individual #17, Individual #112, Individual #52, Individual #236, Individual #524, Individual #146, Individual #193, Individual #499, Individual #412, Individual #484, Individual #80, Individual #165, Individual #55, Individual #129, Individual #521, Individual #520, Individual #70, Individual #378, Individual #409, Individual #162, Individual #353, Individual #91, Individual #492, Individual #180, Individual #339, Individual #515, Individual #366, Individual #255, Individual #145, Individual #21, Individual #40, Individual #327, Individual #297, Individual #122, Individual #91, Individual #540, Individual #26, Individual #84, Individual #27, Individual #19, Individual #406, Individual #228, Individual #343, and Individual #174; ○ Emergency Code Drill Trend Report; ○ Emergency Response Monitoring Data reports; ○ Emergency Drills Incident Management Review Team Meeting report; ○ Recruitment At a Glance 2013 report; ○ Emergency Response Committee meeting minutes for March through August 2013; ○ Emergency Equipment Check Sheets; and ○ Recommendations from Mortality Review for Individual #228. ▪ **Interviews with**: ○ Mary White, RN, MSN, Chief Nurse Executive; ○ Amy Jo Bramlett, LVN, At-Risk Coordinator; ○ Elizabeth Mendoza, RN, Nurse Operations Officer (NOO); ○ Jo Gloyd, RN, Quality Assurance; ○ Stephanie Richey, RN, Case Manager Supervisor; ○ Krista Hamilton, RN, Infection Control Manager; ○ Mary Willingham, RN, Program Compliance Nurse; ○ Richard C. Martinez, Risk Manager; ○ Jeff Goza, Assistant Director of Administration (ADOA); ○ Martin Mack Byran, Camera Monitor; ○ Marla Knight, PharmD, Clinical Pharmacist; ○ Debbie Taylor, Assistant Director, Facility Competency Training/Development (CTD); and ○ Barbara J. Marrow, Director, Facility Competency Training/Development. ▪ **Observations of**: ○ Medication Administration in Residences 5972 and 6521; ○ Medication Variance Committee meeting; and ○ Use of emergency equipment in the Infirmary and Residence 6350.

	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. The Monitoring Team's review of the revised Monitoring Tools found some 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 below with regard to Section M.1.) At the time of the review, although the Facility had implemented the revised nursing monitoring tools, the methodology used to select some of the samples had resulted in little to no data being generated for some areas. In addition, the Facility reported that due to significant staffing challenges in the Nursing Department, some of the monitoring activities had not been consistently conducted. Although there was considerably more data included in the Self-Assessment for Section M than previously, 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 it was evident the Facility put forth a great deal of effort to include data that was related to the specific subsections for Section M, many of the data graphs did not include clear labels to allow the Monitoring Team to accurately interpret what the data represented. In addition, the Self-Assessment did not consistently identify the specific criteria for compliance for the different areas audited or reflect the use of nursing protocols when assessing the quality of the nursing services and documentation. As the Facility reviews 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 based on similar criteria. o In addition, there was no inter-rater reliability reported for some of the nursing monitoring tools, and the variability that was reported for other tools did not include any explanation. From the problematic issues the Monitoring Team found regarding the 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 uninterpretable. In some cases, the information did not make sense. o Did not adequately address the quality of the documentation audited. 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. For example, one of the data graphs contained in subsection M.4 indicated that the data presented was the percentage of nurses that attended a departmental nursing meeting. However, the data presented were not percentages. Since the last review, the Facility appeared to have generated some valuable data. However, the lack of a clear format for presenting these data unfortunately rendered it uninterpretable. The Facility should consider adopting a standardized format(s) for presenting data in a meaningful way that facilitates its interpretation and analysis, and provide training to the disciplines regarding how to analyze their data to identify problematic trends. ▪ The Facility rated itself as being in substantial compliance with none of the subsections of Section M. This was consistent with the Monitoring Team's findings. However, the significant efforts the Facility made to demonstrate how their data supported their self-ratings was hampered by, amongst other factors, the lack of organization of the format regarding the data presentation. The Facility's data identified some of the areas that were in need of improvement, but did not provide specific information regarding the analysis of the information, identifying some potential causes for the issues, and the 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 August 2013, the Nurse Operations Officer moved into the Chief Nurse Executive position; ▪ In September 2013, the Nurse Operations Officer position was filled; ▪ In October 2013, the Case Manager Supervisor position was filled; ▪ In September 2013, an additional Registered Nurse Educator was added to the department; and ▪ The Hospital Nurse Liaison position was vacant. In addition, at the time of the review, the Nursing Department had a total of 181.5 allotted positions, including 79 for RNs and 100.5 for Licensed Vocational Nurses. The current nursing vacancies included nine RN positions and 14.5 LVN positions. From a review of the Facility's nursing staffing data and discussions with the CNE, since the last review, the Nursing Department had experienced significant staffing challenges from that warranted the use of Agency nurses. 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 was aggregating and trending data generated from the Infection Control Real Time Audits, and including much of this information in the minutes of the Infection Control Committee meetings. ▪ Although there continued to be significant problematic issues regarding the care plans addressing

	infectious illnesses, there was some noted improvement in the quality of some of the care plans that were reviewed. ▪ 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 of the infection resulting in some systematic changes in the Facility's procedures. ▪ The Facility had implemented some procedures to track the excesses and shortages of medications in an attempt to reconcile these numbers and identify the issues related to medications that were being returned to the Pharmacy without explanation. ▪ On a very positive note, some of the minutes of the Morning Medical Meetings indicated that data regarding unreconciled medication variances was beginning to be clinically reviewed in relation to individuals who were experiencing changes in status. Although the Facility had made some positive steps forward in the areas noted above, there continued to be an 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.

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M1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, nurses shall document nursing assessments, identify health care problems, notify physicians of health care problems, monitor, intervene, and keep appropriate records of the individuals' health care status sufficient to readily identify changes in status.	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., a smaller sample) for this subsection, because the Facility had made limited progress, due to turnover in leadership. The noncompliance finding from the last review stands. 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 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: ▪ The Facility's Self-Assessment indicated that a review of a sample of 22 annual	Noncompliance

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		nursing assessments for a six-month time period (March through August 2013) from a total of 205 (11% sample size) was conducted to ensure inter-rater reliability for the Annual Nursing Assessment monitoring tool. Although the data presented listed the inter-rater reliability percentage by item and looked very promising, there was extreme variability noted for most of the items listed (from 0% to 100%) without explanation. In addition, the Self-Assessment contained inter-rater reliability data for "Integrated Progress Notes regarding hospitalizations, urgent care & emergency room visits." It was unclear to the Monitoring Team what the data represented (i.e., a specific item on one of the monitoring tools or the inter-rater reliability for an entire tool by month). ▪ In addition, the Monitoring Team could not accurately interpret the data presented regarding pressure ulcers. For example, the data for March 2013 indicated that 21 pressure ulcer reports were reviewed, there was one new case of a pressure ulcer, and there was a total number of six pressure ulcers. Clearly the numbers presented did not add up possibly due to how the data was organized and presented in the current format. Although the Facility indicated at the entrance meeting that there had been an 89% decrease in pressure ulcers at the Facility, the data regarding pressure ulcers in its present format did not support the Facility's finding. <u>Self Rating</u> The Facility's Self-Assessment indicated that: "Based on the results of the self-assessment, the ABSSLC facility is not in compliance with provision M.1. The facility has experienced change in department lead for Section M. Many new processes have been put in place and are in their infancy stage. With the new changes, the facility anticipates efforts for more progression and ultimately compliance." Discussions with the CNE indicated that since the last review, the Facility had had major staffing challenges, as well as staff turnover in many of the key leadership positions. In addition, interviews with the Risk Manager and Quality Assurance Nurse indicated that during the past six months, some of the monitoring activities had been stopped and restarted at various times, which was indicated in some of the data graphs contained in the Self-Assessment for Section M. Although there were problems noted in the data contained in the Self-Assessment for Section M, making the interpretation of the data difficult, if not impossible at times, it was clearly evident that significant concentrated efforts had been put forth to add data and data graphs to the Self-Assessment for each of the subsections of Section M. Unfortunately, problematic issues such as the format, organizing the data in a meaningful way, providing crucial information in the labeling of the data graphs, and the overall presentation of the data hindered its accurate interpretation. It was not clear how the	

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		Facility itself was able to accurately interpret and analyze its data in order to identify areas of strength and weakness. As noted in previous reports, the Facility in conjunction with the State, 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 the Facility begins to generate more consistent monitoring data, it is the Monitoring Team's ultimate hope that the ongoing analysis of data would then result in the development and implementation of plans of action specifically addressing the areas that reflect problematic trends. <u>Staffing</u> At the time of the review, ABSSLC had a census of 378 individuals. Since the last review, ABSSLC had experienced a number of changes regarding the Nursing Department and nursing positions, which included: ▪ In August 2013, the Nurse Operations Officer moved into the Chief Nurse Executive position; ▪ In September 2013, the Nurse Operations Officer position was filled; ▪ In October 2013, the Case Manager Supervisor position was filled; ▪ In September 2013, an additional Registered Nurse Educator was added to the department; and ▪ The Hospital Nurse Liaison position was vacant. In addition, at the time of the review, the Nursing Department had a total of 181.5 allotted positions, including 79 for RNs and 100.5 for Licensed Vocational Nurses. The current nursing vacancies included nine RN positions and 14.5 LVN positions. From a review of the Facility's nursing staffing data and discussions with the CNE, since the last review, the Nursing Department had experienced significant staffing challenges that warranted the use of Agency nurses. Although the Facility had participated in a number of recruitment activities, such as providing a Job Fair in March 2013 and advertising on the radio and television, staffing issues had remained challenging for the Nursing Department. 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> At the time of the review, the QA Nurse indicated that the following Nursing Health Monitoring Tools were being utilized: ▪ Annual Nursing Assessment Monitoring Tool; ▪ Care Plan Monitoring Tool; ▪ Real Time Infection Control Monitoring Tool; ▪ Urgent Care/ER/Hospitalizations Monitoring Tool;	

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		▪ Medication Administration Observation Tool; and ▪ Nursing Protocols for the following: Aspiration/Respiratory, Constipation, Seizures, Vomiting, and Abdominal Distention/Pain. The Facility had added instructions to the tools addressing nursing documentation. However, the Monitoring Team's review of these instructions found that when determining compliance, they did not include the use of nursing protocols as the standard for assessing the quality of the nursing care provided or related documentation. This affected the validity and reliability of the data generated. In addition, there was no mention in the instructions that the nursing assessments/interventions found in the nursing care plans should be in alignment with the assessments contained in the nursing protocols for specific health issues. Without this key element by which to measure the clinical quality of the nursing services and documentation, the monitoring findings will not represent an adequate and accurate review of the quality of the clinical care and treatment individuals receive. In addition, the Quality Assurance Nurse indicated that sample selection regarding the monitoring of the Nursing Protocols included selecting a random sample of individuals with high and medium risks from the Facility's At-Risk list. However, she reported that quite frequently, the individuals selected had not experienced the specific health issue being audited. Consequently, at times, little to no data were generated addressing the nursing protocol for a specific health issue. <u>Assessment and Documentation of Individuals with Acute Changes in Status</u> There had been a slight increase in the use of the Nursing Protocols in some of the care plans reviewed. However, little to no evidence was found in the nursing documentation reviewed that the nursing protocols were actually being implemented and used to drive the identification and implementation of the specific nursing assessments, 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, regarding individuals with acute changes in health status. A review of six individuals' IPNs (i.e., Individual #282, Individual #23, Individual #413, Individual #493, Individual #515, and Individual #199) who had been transferred to a 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 indicated that the licensed nursing staff timely and	

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		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 six individuals found essentially the same significant problematic clinical issues regarding nursing assessments and documentation that the Monitoring Team identified during the past reviews. The overall problematic issues that were found in all six 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; ▪ 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;	

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		▪ 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 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 (reactively) 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; ▪ 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	

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		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. 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 Facility should develop and implement 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 limited review of records while on site, it was noted that very few documents were missing from the active records. However, 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 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. ▪ In June 2013, the Facility began to track Acute Infections with Avatar instead of with the Facility Communicable Disease Tracking Database; ▪ The Facility had implemented the use of the Infection Control Note form to be used when Isolation Precautions were ordered and filed in the IPNs; ▪ The Facility's data indicated that 100% of isolation cases were audited from March through September 2013, using the Real Time IC monitoring tool. The Facility's data indicated some gradual improvements were made in the areas addressing the care plans, including the inclusion of a goal and interventions addressing the spread of the infection. The Monitoring Team noted the same; ▪ 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,	

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		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: 13, 15, 12, 26, 11, 13, and 18, from March through September 2013, respectively. ▪ The Facility developed an Infection Control Tracking/Trending Report that presented a number of IC data sets, such as the Real Time audit data, Inter-rater Reliability percentages for QA and IC, and Hand-washing audit data, in a clear and easy-to-read format. ▪ The Facility continued to aggregate and trend data generated from the Infection Control Real Time Audits, and included this information in the Infection Control Committee meeting minutes. However, the presentation of these data included just one overall compliance score for each month, rendering it uninterpretable. Some data was provided for the specific items in the auditing tool, which 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, 97% 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 of the infection resulting in some systematic changes. ▪ The content of the minutes of the Infection Control Committee meetings continued to significantly improve regarding the increase in the analysis of IC issues and the associated data, 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 at the time of the review, the Facility had transferred 97% of the immunization data into the AVATAR system, 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. ▪ Regarding nursing care plans addressing infectious illness, the documentation the Facility provided to the Monitoring Team indicated there had been 41 individuals who had 48 incidents of an acute infection (Conjunctivitis) (i.e.,	

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		Individual #470, Individual #9, Individual #25, Individual #23, Individual #187, Individual #138, Individual #212, Individual #157, Individual #234, Individual #207, Individual #17, Individual #112, Individual #52, Individual #236, Individual #524, Individual #146, Individual #193, Individual #499, Individual #412, Individual #484, Individual #80, Individual #165, Individual #55, Individual #129, Individual #521, Individual #520, Individual #70, Individual #378, Individual #409, Individual #162, Individual #353, Individual #91, Individual #492, Individual #180, Individual #339, Individual #515, Individual #366, Individual #255, Individual #145, Individual #21, and Individual #40). Of the 48 incidents, 27 (56%) were found to have had Care Plans addressing the infectious issue. Of the 27 Nursing Care Plans reviewed, 10 were found to be clinically adequate (37%). (More details are provided below with regard to Section M.3.) ▪ In addition, since the last review, the following contagious infectious illnesses had reportedly occurred: seven episodes of MRSA (i.e., Individual #327, Individual #297, Individual #122, Individual #91, Individual #540, Individual #26, and Individual #84) and three episodes of C-diff. (i.e., Individual #27, Individual #19, and Individual #406). Of the seven episodes of MRSA, three (43%) were found to have had an acute care plan addressing the infectious issue. Of the three Nursing Care Plans reviewed, none were found to be clinically adequate (0%). Of the three episodes of C-diff, two (67%) were found to have had an acute care plan addressing the infectious issue. Of the two Nursing Care Plans reviewed, one (i.e., Individual #19) was found to be clinically adequate (50%). (More details are provided below with regard to Section M.3.) ▪ Although the Monitoring Team noted some improvement regarding the quality of the care plans that were initiated, discussions with the Infection Control Nurse a review of the Real Time IC data also indicated that the Facility found similar significant problematic issues regarding the development, implementation, and individualization of care plans addressing acute infectious illnesses. The Facility continued to make a number of positive steps forward in the area of Infection Control. However, a significant amount of work was 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 From interviews conducted on site with CTD staff, since the last review, the following steps were initiated 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 different scenarios when conducting the monthly drills. ▪ A number of valuable reports were generated from the Facility's database for the Emergency Drills that were implemented since January 2013, such as the level of compliance by question, Mock Code pass/fail rates by area, and reasons for failed Mock Code by staff member. As a result, the Facility was able to aggregate the data to identify problematic trends resulting in failed drills across a number of areas. ▪ In addition, the Facility had initiated reviewing data regarding failed drills by new and tenured staff in order to identify problematic issues, such as the need for additional training or the need to modify the training. ▪ The information contained in the Emergency Drills Incident Management Review Team Meeting report was extremely detailed regarding the location, time, issue or concern, and the action taken regarding all the failed drills that had occurred since January 2013. A review of these data from March through September 2013 indicated that there had been no incidents of staff refusing to participate in the Mock Drills, as had occurred in the past. ▪ In addition, since the last review, the Facility had initiated conducting Emergency Mock Drills at the Senior Center, the Sunshine Inn, and the recreation building (5911). Clearly, the Facility had continued to implement additional positive steps addressing the Emergency Response System. However, some 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 and medical 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. ▪ A review of the Emergency Response Committee minutes indicated that the minutes for March and April 2013 were unable to be located; the minutes for May 2013 indicated that members from the Nursing Department had not	

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		attended the committee meetings for the last three months and essentially no other information contained in the minutes addressing the area regarding emergency response; the minutes for June 2013 contained very little content and no indication that any of the few issues that were noted were actually followed up on; the minutes for June 2013 indicated that no meeting was conducted that month; and a note regarding the minutes for August 2013 indicated that the minutes were not able to be located. Unfortunately, all the impressive data sets the Facility was able to now generate regarding Mock Drills appeared not to have been reviewed, analyzed, and discussed at a committee designated for this purpose. ▪ 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. Although the nurse observed in the Infirmary was found to be very familiar with the use of the emergency equipment, the Monitoring Team's observations of a nurse demonstrating the emergency equipment at Residence 6350 found that she was unfamiliar with how to open the Automatic External Defibrillator (AED), and where the outlet was to plus in the suction machine. In addition, she needed several prompts to complete the demonstration. In light of the fact that during the past year, the Facility had hired a number of new nurses, 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: ▪ 97 drills conducted in March 2013 – 80 passed (82%); ▪ 90 drills conducted in April 2013 – 80 passed (89%); ▪ 97 drills conducted in May 2013 – 80 passed (82%); ▪ 86 drills conducted in June 2013 – 67 passed (78%); ▪ 107 drills conducted in July 2013 – 85 passed (79%); ▪ 108 drills conducted in August 2013 – 85 passed (79%); ▪ 82 drills conducted in September 2013 – 74 passed (90%); and ▪ 89 drills conducted in October 2013 – 82 passed (92%). 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	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., a smaller sample) for this subsection, because the Facility had made limited progress, due to turnover in leadership. The noncompliance finding from the last review stands.	Noncompliance

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	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's Self-Assessment indicated that a review of a sample of 22 annual nursing assessments for a six-month time period between March through August 2013 (population of 205; sample percentage 11%) was conducted to ensure: a scheduled, documented review that assesses the individual's health status was done; completed by the RN; the Annual Nursing Assessment was completed within 10 working days (or according to Facility policy) prior to the annual ISP; there was documentation in the that the RN completing the review deliberately and systematically collected and reviewed data to identify the individual's current health status, including identification of all actual and potential health problems; each nursing problem/diagnosis was identified and included the reason for the diagnosis; that general approaches and interventions were summarized and incorporated into Section X - Nursing Summary/Analysis in the Comprehensive Nursing Review form; and that nursing interventions were problem focused, individualized, and documented in the Care Plan. Although there were issues regarding the Facility's data in that a number of items audited contained more than one element making it difficult to determine which elements were present and which were absent from one compliance score, and that the criteria for compliance were not clearly delineated for each item, the Facility's initial attempts at presenting data related to this requirement of the Settlement Agreement clearly demonstrated much promise and a significant improvement in the content of the Self-Assessment for this area. Due to the problematic issues noted, the Monitoring Team could not accurately interpret some of the data presented. However, regarding the timeliness of completion of the Annual Nursing Comprehensive Assessments prior to the ISP, the Facility's data showed a dramatic increase in compliance from 0% in March 2013 to 100% in August 2013. However, there was no information provided in the Self-Assessment addressing what actions were implemented that made such a significant positive impact regarding their timely completion. In addition, the Facility's data addressing nursing interventions being problem-focused, individualized, and documented in the Care Plans demonstrated some variability, albeit very low compliance scores throughout the review period. However, in August 2013, these three areas were noted as being at 0% compliance without any explanation. <u>Self-rating</u>: The Facility's Self-Assessment indicated that: "Based on results of self-assessment, the facility is not in compliance with provision M.2. Since the self-assessment time period,	

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		the annual nursing assessment has been modified per state office requirements for standardization with all assessments in April and August 2013. Due to the multiple changes in forms utilized for annual nursing assessments and guidelines, confusion has led to the results of lack of progress in this provision." 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 problems regarding the quality of the content of the Comprehensive Nursing Assessments, which was also demonstrated in some of the Facility's data contained in the Self-Assessment for this section. The Facility's Action Plan indicated that in September 2013, mentoring for RN Case Managers on quality and completion of nursing assessments was to begin, including an analysis of health issues and risk indicators. However, at the time of the review it had not yet been implemented. In addition, there were no specific details indicating how this step would be accomplished, such as incorporation of the nursing protocols into the mentoring process to ensure the quality of the documentation was in alignment with nursing standards of practice. During the Monitoring Team's onsite review, the CNE reported that since the last review, in addition to the changes in the nursing assessment forms, a number of challenging staffing issues had also contributed to the lack of overall progress for the Nursing Department. However, the CNE indicated that since the nursing staffing had become more stable and most of the key nursing leadership positions had been filled, the Facility would be able to increase its focus on this area in the next six months. Since the last review, according to the Provision Action Information, additional steps the Facility took to address this area included a Case Manager retreat in June 2013 that included focused attention regarding Case Manager Orientation, Infection Control Acute Care Plans, the AVATAR process, Integrated Risk Rating Forms (IRRFs), Integrated Health Care Plans (IHCPs) and Team Building Skills. Also, the Facility reported that in September 2013, the Quality Assurance Nurse conducted training with the RN Case Managers regarding the quality of nursing assessments. However, from discussions with the QA Nurse, the training curriculum used did not include the use of nursing protocols that would need to be added (more details are discussed with regard to Section M.4). In addition, in September 2013, the new Comprehensive Nursing Assessment form was received from the State Office. Also, the Facility also established an Assessment Workgroup in August 2013 to develop strategies to improve the quality and timeliness of all disciplines assessments. The Quarterly/Annual Nursing Assessments for 10 individuals who the Facility identified as being at risk for specific health indicators were reviewed, including those for: Individual #216, and Individual #429 for aspiration; Individual #479 for dental issues;	

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		Individual #545 for constipation; Individual #139, and Individual #8 for cardiac issues; Individual #245, and Individual #37 for weight issues; and Individual #311, and Individual #285 for urinary tract infections. ▪ Of the 10 individuals' nursing quarterly assessments reviewed, 10 (100%) were timely completed. ▪ 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 little to no progress had been made regarding the quality of the quarterly/annual Comprehensive Nursing Assessments since the last review. Consistent with the findings from the previous 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. Interviews with nursing leadership during the review appeared to indicate that there was an increase in understanding regarding the use of the Nursing Protocols in guiding nursing assessments and the associated nursing documentation. However, 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. It is imperative that the 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/mental health status. Appropriate competency-based training and mentoring regarding the Quarterly/Annual Comprehensive Nursing Assessments should be provided from a competent source to ensure that the nursing assessments include an adequate clinical analysis of the individuals' progress. As noted in previous reports, this area should be considered a priority for nursing. Regarding the nursing documentation for four individuals discharged/ transitioning to the community, a review of the nursing notes and Nursing Discharge Assessment Summaries for four individuals including: Individual #295, Individual #87, Individual	

#	Provision	Assessment of Status	Compliance
		#22, and Individual #371 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. 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 specific information addressing what currently was being done regarding the Action Step stating: "Review & revise current nursing discharge/transition procedures" although the Facility indicated that this step was "in process." Although the Presentation Book for Section M contained two revised Nursing Discharge Assessment forms and the CNE reported that an in-service was conducted during the QA/QI Council meeting addressing discharge assessments, additional information regarding the Facility's plan for addressing this area should be included in the Action Plan and/or Facility's Self-Assessment. 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.	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., a smaller sample) for this subsection, because the Facility had made limited progress, due to turnover in leadership. The noncompliance finding from the last review stands. 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's Self-Assessment indicated that a review was conducted of 69 Integrated Health Care Plans during six-month period from March through August 2013, including the following items: o IHCP was created during annual ISP; o IHCP identifies all medium and high risks; o IHCP has implementation date not more than 14 days after IHCP finalization for every medium and high risk action step; o IHCP has interventions for all medium and high risks;	Noncompliance

#	Provision	Assessment of Status	Compliance
		o IHCP goals are person-centered and measurable; o IHCP has clinical indicators to be monitored for all medium and high risks; o IHCP has prevention interventions for all medium and high risks; o IHCP has frequency of monitoring for all medium and high risks; o IHCP has location of documentation for every medium and high risk action steps; o IHCP is integrated into the ISP; and o There is IHCP competency evidence. With few exceptions, the Facility's data indicated 0% compliance for all items across each month of the review period. 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. Although the Monitoring Team noted some problematic issues regarding what criteria were used to determine compliance with these particular indicators, the significant work and effort put forth by the Facility in auditing and generating monitoring data was obvious, and with some additions, and the development of appropriate criteria, the indicators showed promise. ▪ The Self-Assessment indicated that the IHCP monitoring tool the At Risk Coordinator initially used was modified and implemented in September 2013. In addition, in response to the problematic issues regarding the IHCPs, the Facility was in the process of reestablishing the Care Plan Committee. Also, the Facility indicated that the Skin Integrity Committee also would be available to provide feedback for IHCPs involving individuals at risk for skin integrity issues. <u>Self-rating</u>: The Facility's Self-Assessment indicated that: "Based on results of self-assessment, the facility is not in compliance with provision M.3. The facility is in the process of modifying activities to engage [sic] to determine self-assessment [sic] with modifications to integrated health care plan monitoring tools. Anticipate more accurate results to reflect primary areas of concern that require more focused assessing [sic]. These processes were newly implemented due to facility self-assessment of Provision I.1. Facility processes are constantly changing as results of facility self-assessments provide [sic] evidence of lack of progression." The records of 10 individuals who the Facility identified as being at high risk for specific health indicators were reviewed, including: Individual #216, and Individual #429 for aspiration; Individual #479 for dental issues; Individual #545 for constipation; Individual #139, and Individual #8 for cardiac issues; Individual #245, and Individual #37 for weight issues; and Individual #311, and Individual #285 for urinary tract	

#	Provision	Assessment of Status	Compliance
		infections. Of the 10 individuals' Integrated Health Care Plans (IHCPs) reviewed: ▪ Ten (100%) were found to have a care plan addressing their high or medium risk health/mental indicators. ▪ One (10%) of the ten care plans (i.e., Individual #545 addressing constipation) contained nursing interventions that 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 other nine care plans reviewed were not in alignment with the nursing protocols addressing the specific health issues. ▪ One (10%) of the 10 care plans was found to be clinically adequate (i.e., Individual #545 addressing constipation). Regarding the other nine IHCPs, there was no indication that any type of nursing assessments were to be proactively conducted addressing the specific health issue in alignment with the nursing protocols. Also, the overall quality of the nursing interventions was poor in that they were generic, and non-specific to the individual's health care needs. ▪ One (10%) of the 10 care plans contained adequate proactive interventions addressing the health indicator (i.e., Individual #545 addressing constipation). ▪ One (10%) of the 10 care plans was adequately individualized (i.e., Individual #545 addressing constipation). ▪ Due to the nonspecific interventions contained in the remaining nine 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. Although at the time of the review, the Facility was in the process of working to improve their overall ISP process that included the development of Integrated Health Care Plans, it was very concerning to the Monitoring Team to note the overall lack of progress in this area since the last review. Specifically, some of the problematic issues identified in the Facility's previous care plans were found in the current IHCPs including: ▪ The rationale for several risk levels on the Integrated Risk Rating forms did not consistently include the needed clinical justification to support the designated level. Consequently, it was often difficult for the Monitoring Team to determine the accuracy of some of the risk levels and the need for action steps addressing the health risks. ▪ Many of the goals listed in the IHCPs did not address the etiology of the health problem as an objective clinical area of focus to assist the team in developing	

#	Provision	Assessment of Status	Compliance
		action steps that were individualized. Consequently, many 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. ▪ As noted above, only one of the sets of nursing action steps found in an IHCP reviewed was in alignment with the clinical assessments required by the nursing protocols for the specific health issues. ▪ The action steps contained in the care plans did not consistently 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. Unfortunately, many of the nursing action steps were noted to be meaningless in that they were often generic, not measurable, and non-specific to the individual's health care needs. ▪ At the time of the review, except for one, 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 many of the action steps prohibited validation that the step was actually being implemented. It is imperative that the Facility address the lack of clinically adequate care plans for the individuals under their care regardless of the system and system changes made to the Facility's overall plans of care. As previously recommended, the Facility should develop and implement appropriate care plans based on priority and risk for all the individuals at ABSSLC. Regarding nursing care plans addressing infectious illness, the documentation the Facility provided to the Monitoring Team indicated there had been 41 individuals who had 48 incidents of an acute infection (Conjunctivitis) (i.e., Individual #470, Individual #9, Individual #25, Individual #23, Individual #187, Individual #138, Individual #212, Individual #157, Individual #234, Individual #207, Individual #17, Individual #112, Individual #52, Individual #236, Individual #524, Individual #146, Individual #193, Individual #499, Individual #412, Individual #484, Individual #80, Individual #165, Individual #55, Individual #129, Individual #521, Individual #520, Individual #70, Individual #378, Individual #409, Individual #162, Individual #353, Individual #91, Individual #492, Individual #180, Individual #339, Individual #515, Individual #366, Individual #255, Individual #145, Individual #21, and Individual #40). ▪ Of the 48 incidents, 27 (56%) were found to have had Care Plans addressing the infectious issue. The individuals without a Care Plan addressing the infectious issue included: Individual #9 (three incidents), Individual #25, Individual #23, Individual #187 (two incidents), Individual #138, Individual #212, Individual	

#	Provision	Assessment of Status	Compliance
		#157, Individual #234, Individual #17, Individual #112, Individual #236, Individual #524, Individual #193, Individual #499, Individual #80, Individual #520, Individual #339, and Individual #366. ▪ Of the 27 Nursing Care Plans reviewed, 10 were found to be clinically adequate (37%) (Individual #499, Individual #409, Individual #212, Individual #162, Individual #353, Individual #91, Individual #492, Individual #52, Individual #207, and Individual #412). In addition, since the last review, the following contagious infectious illnesses had reportedly occurred: seven episodes of MRSA (i.e., Individual #327, Individual #297, Individual #122, Individual #91, Individual #540, Individual #26, and Individual #84), and three episodes of C-diff. (i.e., Individual #27, Individual #19, and Individual #406). ▪ Of the seven episodes of MRSA, three (43%) were found to have had an acute care plan addressing the infectious issue. The individuals without a Care Plan addressing the infectious issue included: Individual #122, Individual #540, Individual #26, and Individual #84. ▪ Of the three Nursing Care Plan reviewed, none were found to be clinically adequate (0%). Although some improvement was noted regarding the nursing interventions such as when specifically the IC Nurse was notified of the infection and how often vital signs were to be taken, they lacked basic interventions addressing how often the infected site was to be assessed, and where this information was to be documented in order to determine if the appropriate healing was taking place. ▪ Of the three episodes of C-diff, two (67%) were found to have had an acute care plan addressing the infectious issue. The individual without a Care Plan addressing the infectious issue was Individual #406. ▪ Of the two Nursing Care Plan reviewed, one (i.e., Individual #19) was found to be clinically adequate (50%). There was some initial positive progress noted in the clinical content contained in some of the Nursing Care Plans reviewed. Clearly, the efforts between the IC Nurses and other nurses within the Nursing Department resulted in an increase in the number of clinically appropriate Care Plans addressing infectious illnesses. However, as noted above, there continued to be a number of Care Plans that had not been initiated for incidents of acute infectious illnesses, and problematic issues persisted regarding the quality of a number of Care Plans the Monitoring Team reviewed. 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. The Facility indicated that since the last review, the Infection Control Nurses reviewed	

#	Provision	Assessment of Status	Compliance
		and critiqued all acute care plans nursing personnel generated for acute infections. However, the IC Nurse reported that nurses were not consistently incorporating individual instructions and education into the acute care plans for infections. To address this issue, Infection Control nursing personnel developed a presentation of required information regarding infection control acute care plans, and in June 2013, presented this information at the Case Manager Retreat, which had some positive impact as noted above in the findings of the Monitoring Team. Although the initial progress found during the review was promising, ABSSLC had no formal system in place to follow-up to ensure that individuals with infectious diseases were being provided care plans that included appropriate and individualized infection control measures, or if clinically appropriate interventions to prevent the spread of infections were actually being implemented. Nursing Administration, in conjunction with the Infection Control Nurses need to continue efforts to 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/Nursing 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. The Facility indicated that it was not in compliance with this requirement of the Settlement Agreement. This was consistent with the findings of the Monitoring Team.	
M4	Within twelve months of the Effective Date hereof, the Facility shall establish and implement nursing assessment and reporting protocols sufficient to address the health status of the individuals served.	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., a smaller sample) for this subsection, because the Facility had made limited progress, due to turnover in leadership. The noncompliance finding from the last review stands. 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: ▪ The Facility's Self-Assessment indicated that a review was conducted of Integrated Progress Notes from March through August 2013 to validate compliance with the Nursing Protocol Cards addressing abdominal distention,	Noncompliance

#	Provision	Assessment of Status	Compliance
		constipation, respiratory distress, seizures, and vomiting. However, it was unclear to the Monitoring Team what was meant by "a sample 207" noted in the Self-Assessment describing the Facility's data. In addition, no information was provided regarding the population (N) for each of the above areas audited or the number of individuals' IPNs that were actually audited from the population (n) to yield a percent sample size. Consequently, there was no way for the Monitoring Team to determine exactly how many cases the data contained in the Facility's Self-Assessment represented. In addition, there was no information provided as to how samples were chosen. Discussions with the Quality Assurance Nurse indicated that for some areas, a random sample was selected from the total population of the Facility. However, she reported that quite frequently, the individuals selected had not experienced the specific health issue being audited, such as a seizure or constipation. Thus, at times, little to no data addressing the specific health issue was generated. In addition, the procedure described for how the auditing was conducted regarding nursing protocols indicated that it only assessed reactive care (i.e., only after an acute health event occurred), rather than proactive care (i.e., looking at individuals who were at high or medium risk for a specific health issue and auditing to ensure that nursing protocols were initiated to prevent the occurrence of the acute health event). Only monitoring reactive care does not usually capture the entire clinical picture and can generate erroneous data regarding the quality and adequacy of the care being provided to individuals. ▪ Although no monitoring was conducted regarding the nursing protocols during the months of March and April 2013, the data presented in the Self-Assessment for this section only consisted of one compliance score for each of the specific nursing protocols areas without a break down by item by month in order to determine which items were problematic and which were not. As mentioned in previous reports, providing one compliance score for an entire monitoring tool is meaningless in that it does not identify the specific strengths and weaknesses of the area being monitored. Unfortunately, the Monitoring Team could not interpret the data presented regarding the nursing protocols. ▪ Regarding the Facility's Self-Assessment data addressing training, the Facility indicated that 100% of new nurses from March through August 2013 had completed the new employee nurse education. However, no information was provided regarding how many new nurses these data represented. In addition, the other data contained in the Self-Assessment graph addressing training did not make sense and could not be accurately interpreted by the Monitoring Team. For example, the data regarding the "Percentage of nurses retrained on Comprehensive Nursing Assessment Guidelines" indicated that in March 2013, 95% of the nurses were retrained, but in June 2013, the compliance percentage was only 86.4%. Although the difference in percentages could have possibly	

#	Provision	Assessment of Status	Compliance
		represented nursing turnover, without an explanation accompanying the data and the N/n clearly identified, the data could not be interpreted. Also, the data contained in the graph addressing "Percentage of nurses attended monthly departmental nursing meeting" and "Percentage of nurses retrained on medication variance policy" were not percentages, again rendering the data uninterpretable. Self-rating: 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 compliance. Overall documentation regarding protocols has shown some progress. Nurses are capturing more of the essential elements required within the nursing protocols; however, consistency and follow-through in documentation continues to be lacking." The Facility's Action Plan for this area indicated that they had begun confirming the clinical competency of all nurses and were in the beginning stages of developing a curriculum addressing the implementation of nursing protocols. However, there was no information provided that specifically addressed where they were in the process of implementing these actions regarding this crucial area of the Settlement Agreement. For example, the Action Plan indicated that the Facility was in process of developing a curriculum regarding Nursing Protocols. However, when the QA Nurse was asked about this step, it appeared that no action had yet been taken. Although the Monitoring Team found an increase in the use of nursing protocols in some of the IHCPs that were reviewed, a majority of the nursing assessments listed in the nursing protocols were noted to be included in the plans for implementation only after an acute health event occurred rather than proactively for individuals with known high and medium health risks in attempts to prevent the occurrence of an acute health event. In essence, using nursing protocols only reactively indicates that an individual has to become ill in order to be provided regular nursing assessments in alignment with the protocols and only for as long as the acute event persists. Consequently, only implementing nursing protocols reactively does not result in improved clinical care focused on minimizing health risks. Unfortunately, at the time of the review, the increased reactive use of nursing protocols found in some of the IHCPs did not result in an improvement in clinical care. Many of 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, although some limited progress was seen, the problematic findings found in the nursing documentation reviewed for Sections M.1 regarding nursing care for individuals admitted to a community hospital, 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	

#	Provision	Assessment of Status	Compliance
		demonstrated that the Facility was not implementing nursing protocols sufficiently 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-risk health indicators and their changes in status warranting hospital admissions were exemplified in a review of Individual #228's health care prior to his death in July 2013. Based on the documentation the Facility provided identifying risk ratings, Individual #228 was noted to be at high risk for gastro-intestinal issues, osteoporosis, urinary tract infections (UTI), and polypharmacy, and at medium risk for aspiration, choking, constipation, cardiac disease, falls, fractures, infections, seizures, and behavioral issues. The documentation indicated that the results of a Modified Barium Swallow obtained on 5/23/07 demonstrated severe dysphagia that resulted in him having to have his food and fluids thickened to a pudding consistency. The IRRF, dated 12/5/12, indicated that he had no history of aspiration pneumonia and ate independently with verbal prompts from staff. In addition, he had an ileostomy as the result of a small bowel obstruction prior to his admission to ABSSLC in 2007. From review of the IRRF, IHCP, and last two Comprehensive Nursing Assessments, he had been seen in the Emergency Room in December 2012 for a UTI. In addition, the Nursing Quarterly from 2/13 through 4/13 indicated that on 2/19/13, he was vomiting, coughing and wheezing, and was treated with Albuterol and cough medication, which resolved his symptoms. On 4/12/13, he was diagnosed and treated for another UTI, and on 4/19/13, he was displaying signs of abdominal pain and was evaluated due to his history of having gallstones. On 4/27/13, the documentation indicated that he was treated for episodes of vomiting resulting in abnormal lung sounds. However, it was unclear from the documentation if these episodes resulted in ER visits or Infirmary admissions. A review of the documentation indicated that Individual #228 experienced significant vomiting episodes, and frequently demonstrated behaviors that were believed to be indicative of pain. However, it was very unclear from the documentation reviewed as to when the vomiting episodes began and how often they were occurring. The documentation from the IRRF indicated that from January through November 2012, there had been 81 episodes of vomiting. However, the information contained in the Comprehensive Nursing Assessment, dated 2/12/13, indicated in one section that seven episodes of vomiting had occurred during the current quarter, while the information contained in the Nursing Summary section indicated that Individual #228 had 19 episodes of emesis during the quarter. On 7/9/13, the documentation indicated that Individual #228 underwent a scheduled outpatient laparoscopic cholecystectomy	

#	Provision	Assessment of Status	Compliance
		(removal of the gallbladder) that was suspected to be the cause of the symptoms of pain and vomiting, and returned to the Facility the same day. In reviewing the documentation from 4/30/13 to 7/12/13, at which point Individual #228 was admitted to the hospital where he died on 7/15/13, a number of significant problematic issues were found regarding the care of this individual. Some of these problems included: ▪ A review of the IPNs on the day Individual #228 underwent a scheduled outpatient laparoscopic cholecystectomy found that there were no notes indicating when the Individual left for the procedure, how he was transported, who accompanied him, what information/records were sent, and that a nursing assessment was conducted at the time he was transferred documenting his status as required by nursing standards of practice. In addition, there was no assessment of the surgical site found on the Post-Hospital Nursing Assessment, dated 7/9/13. ▪ The IPNs indicated that on 7/10/13, Individual #288 was given a Morphine injection for pain. Although the note included a FLACC score of 5 (The Face, Legs, Activity, Cry, Consolability scale, or FLACC, scale is a measurement used to assess pain for individuals that are unable to communicate their pain), no physical assessment was found in the documentation indicating that the cause of the pain was being assessed. In addition, no vital signs were documented in order to obtain an objective measurement of how the pain was affecting the individual (i.e., increases in pulse rates, respirations, and/or blood pressure values) that then can be used for comparison when assessing the effectiveness of the medication. ▪ A review of the IPNs for 7/10/13 found that no assessment of the effectiveness of the pain medication administered was conducted within an hour as required. ▪ The IPNs on 7/10/13 at 0156 indicated that Individual #228 had vomited twice, however, there was no indication that lung sounds were assessed for an individual who had already been identified at risk for aspiration, and who was at an increased risk of aspiration due to the sedation from the surgical procedure. In fact, no assessment of the lung sounds was found in the IPNs following the additional vomiting episodes at 0230, 0245, and 0510. ▪ The IPNs indicated that on 7/10/13 at 1445, Individual #288 was given Lortab for pain. However, no physical assessment was found in the documentation indicating that the cause of the pain was being assessed and no vital signs were documented. ▪ In addition, the IPNs indicated that on 7/10/13 at 1610, Individual #288 was given Lortab for pain. However again, no physical assessment was found in the documentation indicating that the cause of the pain was being assessed and no vital signs were documented.	

#	Provision	Assessment of Status	Compliance
		▪ The IPN note on 7/10/13 at 2244 indicted that the individual had vomited twice, and his pulse was 138 and respirations were 28, which increased to 152 and 36 at 2235. An appropriate assessment, including lung sounds was conducted at that time and the individual was given medication for nausea and pain at 2300. However, the subsequent IPNs on 7/10/13 at 2330, 7/11/13 at 0200, 7/11/13 at 0530, 7/11/13 at 0830, 7/11/13 at 0945, 7/11/13 at 1005, 7/11/13 at 1225, 7/11/13 at 1300, and 7/11/13 at 1330 did not include an assessment of the lung sounds to adequately evaluate his respiratory status in spite of the fact that the nurse's plan in the IPN stated: "assess lung and bowel sounds q [every] shift" ▪ On 7/11/13 at 2242, the IPN indicated that the individual's temperature was 103.7 temporal, his blood pressure was elevated at 168/92, and respirations were increased at 36. He was assessed at that time, and again on 7/12/13 at 0035 after being given Tylenol for his elevated temperature and Lisinopril for his elevated blood pressure. His temperature had decreased to 101.4 temporal, and his blood pressure had decreased to 124/83. However, the IPN indicated that the site he was receiving intravenous (IV) fluids had infiltrated resulting in edema to his left foot "up to his knee." A review of the subsequent IPNs on 7/12/13 at 0100, 7/12/13 at 0200, 7/12/13 at 0500, and 7/12/13 at 0530 indicated that his temperature, pulse, and respirations were again increasing. However, no nursing assessments of lung sounds, bowel sounds, the abdomen, the incision site, the edema to the left foot, the site where he was receiving IV fluids, or the individual's mental status were found documented in the IPNs. Although the nurse's note dated 7/12/13 at 0530 stated: "upper airway noise heard," indicating that something was abnormal, and an attempt to suction the individual was documented at that time, no vital signs or nursing assessment was conducted to evaluate Individual #228's obvious change in respiratory status. ▪ The subsequent IPN on 7/12/13 at 0605 indicated that the last episode of vomiting was reported to have occurred at 0500. However, no documentation of this vomiting episode was found. In addition, the IPN noted that the Individual had an "audible grunt on exhale," and his abdomen was taunt and he was "guarding on palpation to any quadrant." Although the documentation indicated that the bowel sounds were assessed as being active and the abdomen was palpated, there was no documentation indicating that the individual's lung sounds and respiratory status had been assessed. An RN Nursing Assessment dated 7/12/13 noted that Individual #228's respirations were shallow and rapid, and he had a grunt or wheeze at the end of expiration. However, there was no time noted on the form to indicate when the assessment was conducted. ▪ A review of the documentation contained in the IPNs for the above situation indicated that the physician had not been timely notified of Individual #228's changes in status.	

#	Provision	Assessment of Status	Compliance
		▪ No IPN was found that contained documentation regarding the time, mode of transportation, and the individual's status at the time he was transferred to the hospital on 7/12/13. ▪ The summary section of the Comprehensive Nursing Assessment, dated 2/12/13, did not include any type of analysis regarding the individual's chronic vomiting episodes. In addition, as noted above, there was a significant discrepancy in the clinical data contained in the Nursing Assessment regarding the number of vomiting episodes that had occurred during the quarter (seven versus 19). ▪ In addition, there was no information or analysis found in the Nursing Quarterly Assessments addressing Individual #228's frequent episodes of pain. ▪ Since there were no uniformed and consistent nursing assessments regularly conducted, changes in status were not quickly recognized and responded to. ▪ There was no indication from the nursing documentation if the individual's daily intake of fluids and urine output was adequate, especially since Individual #228 experienced significant episodes of vomiting and was at risk for UTIs. ▪ Late Entries from the physician were made seven to eight days after the individual's death on 7/15/13. ▪ Although the IHCP for Individual #228 included a number of action steps in alignment with nursing protocols, albeit reactive rather than proactive, none of the assessments required by the protocols were consistently implemented as outlined in the IHCP. ▪ A review of the IPNs found no regular nursing assessments of the individual's surgical site, the edema to his left leg from the IV infiltrating, and/or his mental status. ▪ There were no IPNs found from the PNMT a month prior to Individual's #228 death indicating that they were involved in his care related to his frequent vomiting episodes and risk of aspiration. ▪ There was no indication that either the PNMT or Dietician was notified of the vomiting episodes that had occurred after his surgery in July 2013. Also, a review of an additional six individuals that were admitted to the hospital since the last review (i.e., Individual #282, Individual #23, Individual #413, Individual #493, Individual #515, and Individual #199) found similar problematic issues throughout the nursing documentation as those found in Individual #228'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 consistently using nursing protocols as part of a structured system to guide nursing	

#	Provision	Assessment of Status	Compliance
		practice and the associated documentation to ensure that: ▪ Clinical baseline data were established to quickly recognize changes in health status; ▪ Clinically appropriate nursing assessments were conducted for significant health issues and documented at the appropriate clinical frequency; ▪ 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. The Facility indicated that it was not in substantial compliance with this requirement. This was consistent with the Monitoring Team's findings from this review.	
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.	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., a smaller sample) for this subsection, because the Facility had made limited progress, due to turnover in leadership. The noncompliance finding from the last review stands. 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, the Facility's Self-Assessment indicated that current annual assessments were to be available for IDT members review at least 10 days prior to annual ISP. At the time of the review, the Facility's process consisted of having the QIDP Coordinator check the electronic personal folder of the individual scheduled for an annual ISP 10 days prior to the annual ISP. The QIDP Coordinator then entered the assessments that had been saved into the electronic personal folders for the IDTs review into the Facility database. A review of the assessment database from March through August 2013 was conducted to determine if the nursing assessments were completed prior to the annual ISP and posted to the shared drive within 10 business days of the ISP. The Facility's findings indicated that nursing assessments were filed timely 77%, 72%, 84%, 58%, 69%, and 77%, respectively. The Facility's Self-Assessment indicated that the low numbers of compliance were related to the assessors responsible for completing the assessments not consistently saving the document in the appropriate shared location. At the time of the review, the Facility had begun a new process in which the QIDP Coordinator reported to IMRT the assessments that were not available 10 days prior to the annual ISP. <u>Self-rating:</u> The Facility's Self-Assessment indicated that: "Based on the results of the self-	Noncompliance

#	Provision	Assessment of Status	Compliance
		assessment, the AbSSLC facility is not in compliance with any of the subsections of Section M.5. The center recognizes the need to have regular risk screening, assessment and management system to identify individuals whose health or well-being is at risk. The facility identifies the need to improve." 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 10 individuals determined to be at risk (i.e., Individual #216, and Individual #429 for aspiration; Individual #479 for dental issues; Individual #545 for constipation; Individual #139, and Individual #8 for cardiac issues; Individual #245, and Individual #37 for weight issues; and Individual #311, and Individual #285 for urinary tract 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 10 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 10 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 continued to be 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, falls, injuries and/or fractures, there was a lack of individual-specific information from the current year as compared to the previous year that made it difficult to determine the accuracy of the risk rating that was assigned. Consistent with the findings from past reviews, the nursing assessments reviewed for the At-Risk individuals noted 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 10 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%).	

#	Provision	Assessment of Status	Compliance
		Although all 10 individuals (100%) were found to have a care plan addressing their high or medium health/mental risk indicator in the Active Record, only one 10%) sufficiently addressed the health risk in accordance with applicable nursing protocols (i.e., Individual #545 addressing constipation). ▪ Implemented a plan within fourteen days for each individual, as appropriate in none (0%) of the cases reviewed. The 10 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 one of these cases (10%) (i.e., Individual #545 addressing constipation). ▪ Included preventative interventions in the plan to minimize the condition of risk in one of the cases (10%) (i.e., Individual #545 addressing constipation). Although some generic interventions were found in some IHCPs addressing, for example, the need to encourage adequate fluids and exercise, 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 IHCP/Risk Action Plans into the ISPs in 10 of the 10 cases (100%). ▪ None (0%) of the plans reviewed showed adequate integration between all of the appropriate disciplines, as dictated by the individual's needs. ▪ One of the plans (10%) had appropriate, functional, and measurable objectives incorporated into the ISP to allow the team to measure the efficacy of the plan (i.e., Individual #545 addressing constipation). ▪ One of the plans (10%) included the specific clinical indicators to be monitored (i.e., Individual #545 addressing constipation). ▪ The frequency of monitoring was included in the plans for one of the individuals (10%) (i.e., Individual #545 addressing constipation). Although the other 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 was continuing to implement the revisions that had been made to the ISP and At-Risk process. However, the 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 most of the interventions contained in the IHCPs still had not been adequately addressed.	

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		The Facility indicated that they were not in substantial 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 a separate monitoring plan.	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., a smaller sample) for this subsection, because the Facility had made limited progress, due to turnover in leadership. The noncompliance finding from the last review stands. 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 starting in July 2013, the medication variance data was entered into the Avatar Electronic Medical Record System. However, at the time of the review, the Facility reported that the data could not be extracted from Avatar in order to review any trends or conduct an analysis of medication variances for July and August 2013. ▪ In August 2013, nursing began inspecting/auditing the medication rooms. However, data found in the Self-Assessment regarding the Pharmacy's auditing of the Medication Rooms was unable to be interpreted, because it was unclear to the Monitoring Team what specifically the data under the heading: "Percentage of Pharmacy Audits that meet 100% compliance" actually represented (i.e., the Self-Assessment did not describe the indicators or criteria used). In addition, the Self-Assessment noted that for August 2013, the percentage of Pharmacy Audits that met 100% compliance was 98%, and the percentage of Nursing Audits that met 100% compliance for the same month was reported as being 0%. However, there was no explanation addressing the vast difference in compliance scores between the two disciplines, or even if the items that were being audited were the same on the Pharmacy's auditing tool and nursing's auditing tool. In addition, there was no information contained in the Self-Assessment addressing the results of specific items for either tool which would have been more meaningful than only presenting percentages. Consequently, the Monitoring Team could not accurately interpret these data. ▪ In addition, the data contained in the Facility's Self-Assessment regarding the Medication Administration Observations was unclear regarding what the "population" represented in relation to the number of medication observations completed and the number of failed observations. ▪ Although the Self-Assessment included a graph of the breakdown of medication variances from March through June 2013, no additional information was	Noncompliance

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		provided in the Facility's Self-Assessment addressing what steps the Facility was taking regarding problematic issues, or referencing other documents that would illustrate any actions planned or taken. 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 requirement of the Settlement Agreement. From discussions with the Facility staff while on site, since the last review, the Facility had implemented a number of actions addressing this area that would have demonstrated how the Facility was responding to problematic issues in its attempt to move forward. 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." In addition to the information that was provided in the Facility's Self-Assessment, interviews with the CNE and the Clinical Pharmacist, and review of the Presentation Book for Section M, and the Provision Action Information indicated that since the last review, the Facility had initiated the following steps regarding the Facility's overall medication administration system: ▪ In June 2013, the CNE and NOO met with some of the LVNs that administer medications to discuss issues related to the medication administration system. Factors that were identified as needing improvement included the need for uniform organization across the campus of items such as floor stock and the MEDEX books; more focus on the Medication Administration Records (MARs) when setting up and administering medications; bagging medications for each shift each day after verifying the auto fill; and the need for improved communication. ▪ In August 2013, the Nurse Managers received training regarding the timely identification, reporting, and investigation of medication variances that included the proper determination of the severity classification of the variance. ▪ In August 2013, the Nursing audit for the medication rooms was developed and implemented. ▪ The Facility had developed a new policy that limited the number of staff that had access to the Pharmacy during off hours. ▪ In attempts to increase the Facility's capability to reconcile medications, the Pharmacy had decreased the number of floor stock medication available on the units, and had switched many of the oral liquid and solid medications to unit does medications. The Facility indicated that these changes assisted with reducing medication administration time, and facilitated compliance with the	

#	Provision	Assessment of Status	Compliance
		physicians' orders, due to the fact that each dose of medication order was now in the individual's medication bin. In addition, interviews with staff indicated that these changes made it easier to track if medications were actually given as ordered to individuals. ▪ The Facility continued to include excesses and shortages of medications, and medical and pharmacy errors in the medication variance data. ▪ The statewide Medication Administration Competency class was implemented at ABSSLC, and at the time of the review, all nurses responsible for medication administration had attended and passed the class. ▪ The Facility had replaced two medication carts since the last review that could not be locked as required. ▪ The Pharmacy and Nursing Departments had implemented new processes regarding the auto-fill procedure in the Pharmacy for medications in order to decrease interruptions, and begin to identify and reconcile excess and shortages of medications by starting with an accurate count of medication per individual. ▪ In response to past incidents, the Facility developed a new procedure regarding orders written by outside consultants in which a medication was ordered that was contraindicated for the individual. The new procedure required that the Primary Care Physician co-sign any orders from an outside consultant to ensure that any medications that were ordered were appropriate. ▪ Information regarding excess or shortages of medications was now being kept in a folder in each of the buildings so that the physicians/practitioners could review this information in the event that an individual experienced a clinical change in status, such as an increase in seizures or constipation that could be related to these types of medications variances. ▪ The Medication Variance Committee was beginning to analyze data from the Medication Administration Observations, discussing it, and integrating into the meeting minutes. ▪ On a very positive note, the minutes of the Morning Medical Meeting dated 8/29/13, 9/25/13, and 10/2/13 indicated that data regarding unreconciled medication variances was beginning to be clinically reviewed in relation to individuals who were experiencing changes in status. For example, on 10/2/13 when Individual #343 was being discussed regarding an admission to the Infirmary for seizure activity, the Clinical Pharmacist noted that two doses of Miralax (a laxative used for constipation) had been recently returned to the Pharmacy without explanation. For some individuals, constipation can precipitate seizure activity. Thus, by having this information available in the Morning Medical meeting, a decision was made to review the individual's Bowel Movement Log along with his Seizure Log to identify if any correlation was present that could have contributed to his change in status. In another case, the	

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		meeting minutes dated 8/29/13 indicated that the Clinical Pharmacist reported that Individual #174 had two containers of Keppra solution, used for seizures, returned to the Pharmacy without explanation. Although the minutes did not indicate that the individual had experienced a change in status at that time, providing this information alerted the team to the possibility that there could be a change in status. 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: ▪ A review of the minutes of the Medication Variance Committee minutes dated 5/22/13, 6/26/13, and 7/24/13 indicated that there had been some incidents where the controlled drug count was inaccurate. The minutes indicated that the Facility was trying to research the correct procedure for counting the controlled drugs to determine whether it should be two licensed nurses versus a licensed nurse and a staff member. However, no indication was included in the minutes provided as to how the Facility resolved this issue and what was being done to reconcile the inaccurate counts. ▪ Although at the time of the review, data regarding unreconciled medication variances was beginning to be clinically reviewed in relation to individuals' health status in the Morning Medical meetings, the outcomes of any follow-up actions taken were not found documented in the minutes provided. ▪ In August 2013, the Facility began entering data regarding medication variances into the Avatar system. However, the Facility reported that at the time of the review, it was unable to extract certain queries from Avatar in order to analyze the data or identify trends. This issue was evident during the Monitoring Team's observation of the Medication Variance Committee meeting while on site. Although a number of graphs were presented representing the medication variance data, there was very little analysis of the data conducted before the meeting or even during the meeting. It is the hope of the Monitoring Team that the problematic issues involving Avatar can be swiftly ameliorated. ▪ Since the last review, the Facility had implemented a system of "bagging" medications by individual by shift in all residences except for Residences 6510 and 6480, which the CNE indicated would eventually be initiated, in order to timely identify excess or shortages of medications. Although the Facility indicated that since this process was initiated, the number of excess/short medications had decreased, the minutes of the Medication Variance Committee meetings reviewed indicated that the process was very time consuming and viewed by Nurse Managers as a short-term solution. Although the Facility's data for July and August 2013 indicated there had been an overall decrease in the	

#	Provision	Assessment of Status	Compliance
		number of unexplained excess/shortage in medications, the Facility's ability to maintain the current labor-intensive procedure and expand it Facility–wide in light of the staffing challenges the Facility had experienced was a concern. At the time of the review, the Facility had no alternative plan in the event the current procedure was not sustainable. ▪ Although the Facility had been expanding its identification and tracking of medication variances over the past few reviews, the At-Risk Coordinator and Clinical Pharmacist candidly reported that there continued to be issues regarding the reliability of the Facility's medication variance data. ▪ As noted in previous reports, the Facility's data continued to indicate that the percent compliance from the Medication Administration Observations conducted remained consistently high. However, given the numbers of unreconciled medications that were returned to the Pharmacy since the last review, the high compliance scores regarding the Medication Administration Observation data continued to be highly suspect. At the time of the review, there was no indication that nursing was analyzing these obvious discrepancies between data and practice. ▪ Although the Facility was spending much time reconciling excesses and shortages of medications, the number of medication variances addressing the excesses and shortages, 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, which was also noted in the Facility's Medication Variance Committee minutes, dated 7/24/13. ▪ The Nurse Educators as well as the Facility's medication administration observation data indicated that Medication Administration Observations had not been conducted as required. The Nurse Educators indicated that the staffing challenges since the last review had prevented this process from being conducted as frequently as required. ▪ Although the Facility had implemented strategies, such as switching many stock medications to unit doses to be able to better track if medications were given as ordered, it was very concerning that the underlying problem related to the still high number of unreconciled medication excesses was likely that nursing was not administering medications as ordered, because issues such as order changes, refusals, and furloughs had been identified and accounted for in the numbers of excess reconciled medications. A review of the medication variances (Category A-E) reported by the Facility indicated the following: ▪ March 2013 – 402 variances, (including 278 unreconciled excesses); ▪ April 2013 – 354 variances, (including 243 unreconciled excesses);	

#	Provision	Assessment of Status	Compliance
		▪ May 2013 – 354 variances, (including 187 unreconciled excesses); ▪ June 2013 – 380 variances, (including 230 unreconciled excesses); ▪ July 2013 – 118 variances, (including 39 unreconciled excesses); and ▪ August 2013 – 261 variances, (including 133 unreconciled excesses). Based on observations of medication administration at Residence 5972 and 6521, the following problematic issues were found. Specifically, the nurse did not: ▪ Thicken the fluids to pudding consistency as required by Individual's #368 Physical Nutritional Management Plan (consistency was observed to be more honey-like than pudding); ▪ Consistently thicken Robitussin cough syrup when administering it as an "as needed" medication to Individual #368 from her report during the medication administration observation; ▪ Assess lung sounds until prompted by the Nurse Educator observing the medication pass, when an individual 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; ▪ Check the MAR as required, and almost gave a medication at the wrong time until Nurse Educator intervened; and ▪ Check the dosage of a liquid medication as required, and almost gave the wrong dosage until the Nurse Educator intervened. However, the Nurse Educator conducting the medication administration observations with the Monitoring Team did review the PNMPs in order to recognize if individuals' were in the appropriate positions, and paid close attention to all procedures and details regarding medication administration observations to the point of quickly recognizing, intervening, and thus preventing two potential medication variances. The attention to detail both Nurse Educators exhibited during the medication administration observations was very positive and a significant improvement from practices the Monitoring Team observed during past reviews. A number of problematic issues continued to be noted regarding the medication administration systems at ABSSLC. At the time of the review, the Facility clearly was taking steps to review and implement strategies to address some of the problematic elements of the medication administration system. As recommended in previous reports, 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	

#	Provision	Assessment of Status	Compliance
		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 and its correlation to clinical issues on an individual level. The Monitoring Team found the Facility was not in compliance with this provision, which was consistent with the Facility's finding of noncompliance in its 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 Any pharmacy surveys completed since the last Monitoring Team visit: plans of correction and/or internal auditing procedures and reports related to Pharmacy Services; o List of staff who work in the Pharmacy Department, including names, titles, and degrees; o All Drug Utilization Evaluations (DUE) reports completed since last Monitoring Team visit, including background information, data collection forms utilized, results, and any minutes reflecting action steps based on the results; o Any follow–up studies completed for any prior DUE reports; o Minutes of Pharmacy and Therapeutics (P&T) Committee meetings and any attachments since the Monitoring Team's last visit; o Minutes of any committee addressing polypharmacy for non-psychotropic medications; o Minutes of any committee addressing medication error/variance since the Monitoring Team's last visit; o Minutes of the committee addressing seizures with any attachments since the Monitoring Team's last visit; o DUE calendar for next 12 months, including whether calendar based on 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; o For Quarterly Drug Regimen Reviews, two most recent per residence 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, document (with date) in which rationale was discussed for polypharmacy for psychotropic and non-psychotropic polypharmacy including those for: Individual #359, Individual #54, Individual #30, Individual #324, Individual #95, Individual #430, Individual #462, Individual #98, Individual #139, Individual #136, Individual #530, Individual #502, Individual #115, Individual #159, Individual #224, Individual #301, Individual #27, Individual #17, Individual #467, Individual #73, Individual #415, Individual #77, Individual #232, Individual #216, Individual #105, Individual #242, Individual #165, Individual #469, Individual #400, Individual #193, Individual #379, Individual #81, Individual #37, Individual #447, Individual #284, Individual #150, Individual #417, Individual #377, Individual #204, Individual #5, Individual #499, and Individual #515; o For 10 most recent QDRRs in which recommendations were made and accepted, copies of physician orders for following individuals: Individual #347, Individual #422, Individual

	#217, Individual #77, Individual #206, Individual #201, Individual #498, Individual #377, Individual #69, and Individual #353; o For three 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 #203, Individual #304, and Individual #91; o All "single patient intervention reports" in WORx system for the 60 days prior to the Monitoring Team visit; o Since the last Monitoring Team review, copy of any internal Pharmacy Department audits/monitoring data to review Section N of the Settlement Agreement (i.e., Pharmacist review and placement of new orders in WORx system); o Copy of "notes extracts" associated with "single patient intervention reports" for the 60 days prior to the Monitoring Team visit; o For the past six months, any adverse drug reaction reports (ADR) 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 (e.g., 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.) since the Monitoring Team's last visit; o For the past two months, reports and/or summaries of any medication administration observations conducted; o Any policies, procedures and/or other documents addressing medication administration; o List of antibiograms per month for last six months by building; o Medication history for individuals with J or G/J-tubes (not G-tubes); o A schedule of when Quarterly Drug Regimen Reviews are conducted by residence/unit; o All documentation for each emergency chemical restraint, including restraint checklist. Information for the following individuals was submitted: Individual #99 - 4/3/13 - 1515hr, Individual #99 - 4/6/13 - 1239hr, Individual #397 - 4/24/13, Individual #397 - 5/1/13, Individual #323 - 4/28/13, Individual #231 - 5/13/13, Individual #423 - 5/28/13, Individual #199 - 7/4/13, Individual #298 - 8/8/13 - 1058hr, Individual #298 - 8/8/13 - 1420hr, Individual #379 - 10/19/13, Individual #379 - 10/27/13, and Individual #304 - 10/22/13; o Any trend analysis of chemical restraint use (graphs, etc.); o For each database maintained on use of chemical restraints, summary list(s) of all chemical restraints administered over the last six months, with the name/source of the database clearly identified; o For 10 orders involving drug-drug interactions, copies of serial computer screen shots for

	each step. For each new order, the following documents were requested: copy of new order, copy of patient intervention report documenting concern, communication to PCP, and documented response by PCP, copy of change in new order by PCP (if applicable), and snapshot verifying change in order received by Pharmacy, or copy of pharmacy label indicating Pharmacy processing of change of order. If documents were not available, this was indicated. Submitted documents were for the following 10 individuals: Individual #318, Individual #185, Individual #364, Individual #167, Individual # 256 (6/7/13), Individual #242, Individual #434, Individual #19, Individual #38, and Individual #256 (9/5/13); o For five orders involving potential allergic reactions for new orders, copies of serial computer screen shots for each step. For each new order, the following documents were requested: copy of new order, copy of patient intervention report documenting concern, communication to PCP, and documented response by PCP, copy of change in new order by PCP (if applicable), and snapshot verifying change in order received by Pharmacy, or copy of pharmacy label indicating Pharmacy processing of change of order. If documents were not available, this was indicated. Submitted documents were for the following individuals: Individual#83, Individual #279, Individual #234, Individual #518, and Individual #385; o For five orders involving drug dosages below or exceeding normally prescribed dosage regimens, copies of computer screen shots for each step. For each new order, the following documents were requested: copy of new order, copy of patient intervention report documenting concern, communication to PCP, and documented response by PCP, copy of change in new order by PCP (if applicable), and snapshot verifying change in order received by Pharmacy, or copy of pharmacy label indicating Pharmacy processing of change of order. If documents were not available, this was indicated. Submitted documents were for the following individuals: Individual #37, Individual #285, Individual #465, Individual #215, and Individual #437; o For five new orders in which labs were reviewed/monitored, copies of serial computer screen shots for each step. For each new order, the following documents were requested: copy of new order, copy of patient intervention report documenting concern, communication to PCP, and documenting response by PCP, copy of change in new order by PCP (if applicable), and snapshot verifying change in order received by Pharmacy, or copy of pharmacy label indicating Pharmacy processing of change of order. If documents were not available, this was indicated. Submitted documents were for the following individuals: Individual #434, Individual #306, Individual #541, Individual #325, and Individual #232; o For five new orders for which there was potential for significant side effects, copies of serial computer screen shots for each step, including any written documentation/information provided to the PCP and response of the PCP. For each new order, the following documents were requested: copy of new order, copy of patient intervention report documenting concern, communication to PCP, and documented response by PCP, copy of change in new order by PCP (if applicable), and snapshot verifying change in order received by Pharmacy, or copy of pharmacy label indicating Pharmacy processing of change of order. If documents were not available, this was

	indicated. Submitted documents were for the following individuals: Individual #217, Individual #470, Individual #42, Individual #518, and Individual #513; o For the self-assessment process: list of monitoring/audit tools used; for each tool, identification of the total number of the eligible population to be sampled, the sample size, clarification how the sample was chosen, the frequency of data collection, the staff that completed the audit/monitor survey/review, and whether any inter-rater 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/chart/table with date range of each database. When the data was collected periodically rather than continuously, the frequency of data collection was requested; o Most recent neurology consult for Individual #27; o Most recent annual medical summary for Individual #73; o Most recent neurology consult for Individual #216; o Most recent psychiatric quarterly review for Individual #242; o Most recent psychiatric quarterly review and cardiology consult (2/28/12) for Individual #165; o Most recent and prior annual medical summary for Individual #193; o Most recent psychiatric quarterly review for Individual #379; o Most recent psychiatric quarterly review for Individual #324; o Most recent psychiatric quarterly review for Individual #95; o Most recent annual medical summary for Individual #98; o Integrated Risk Rating Form (IRRF) 6/28/13 for Individual #502; o September and October 2013 Emergency Chemical Restraint - Face-to-Face debriefing forms; o Pharmacy and Therapeutics Committee meeting agenda, handouts, and minutes 11/6/13; o Medication variance committee agenda 11/6/13; and o Presentation Book for Section N. ▪ **Interviews with**: o Bonnie Burroughs, Pharmacy Director; and o Marla Knight, PharmD, Clinical Pharmacist. ▪ **Observations of**: o Pharmacy and Therapeutics Committee, on 11/6/13; and o Medication Variance Committee, on 11/6/13.
	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: lab order monitoring, pharmacy patient intervention log, QDRR monitoring tool, and order audit tracking tool.

	o These monitoring/audit tools included adequate indicators to allow the Facility to determine compliance with the Settlement Agreement in some areas, but additional audit tools needed to be created to include other areas of Pharmacy Services. 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 adequate methodologies, such as record reviews, review of ADR reports, etc. o The Self-Assessment identified the sample(s) sizes, including 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). This sample size(s) were adequate to consider them representative samples. o The following staff/positions were responsible for completing the audit tools: Clinical Pharmacist and Staff Pharmacist. o Adequate inter-rater reliability had been established between the various Facility staff responsible for the completion of the QDRR Monitoring tool, the order audit tracking tool, and the emergency chemical restraint tracking tool. ▪ 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 the databases was noted to be complete and accurate except in the area of medication variances. ▪ Except for the area of medication variances, the Facility consistently presented data in a meaningful/useful way. Specifically, the Facility's Self-Assessment: o Presented findings consistently based on specific, measurable indicators. o Consistently measured the quality as well as presence of items where applicable. ▪ The Facility rated itself as being in substantial compliance with the following sub-sections of Section N: N.1, N.2, N.3, N.4, N.5, N.6, and N.7. This was consistent with the Monitoring Team's findings. The Facility remained in noncompliance with Sections N.8. ▪ The Facility data identified areas of need/improvement. For those areas of need, the Facility Self-Assessment provided some analysis of the information, identifying, for example, the need to address the continued excess unknown medications returned to the Pharmacy, and the medication variances within the Pharmacy Department. The following are examples of internal monitoring that the Pharmacy was completing: ▪ The Pharmacy Department completed an internal QA review of the new order process. Each month, two Pharmacists randomly selected 20 copies of new orders from the prior month (10 each). A series of eight indicators were then reviewed for each order. For inter-rater reliability, a third Pharmacist sampled five new orders from each of the two Pharmacists doing the initial review with the same questions. Monthly results were submitted for April through August 2013. Results indicated 100 percent compliance. Over that time span 100 new orders were reviewed from a total of 4403 new orders. Inter-rater reliability was 100 percent. ▪ From a separate document, for the time period of 4/1/13 through 8/31/13, 50 lab orders were reviewed by Pharmacy to determine appropriate oversight. Fourteen of the 50 required further explanation. One hundred percent of the orders had explanations documented.

	▪ The Pharmacy Department developed an internal QI process to monitor the quality of the QDRR content. This was implemented on 2/1/13. On a monthly basis, 10 QDRRs were reviewed (five residences were chosen and two QDRRs were randomly selected by the QA Department). An assigned Pharmacist reviewed the QDRR for specific clinical indicators of metabolic risk factors, benzodiazepine use, anticholinergic use, polypharmacy, lab results, and MOSES/DISCUS. The QA Department also reviewed five of the 10 for inter-rater reliability (as of 9/1/13). Results were submitted for the months of April through August 2013. Based on the Facility's data, scores were 100 percent for all categories except for the months of June and July, in which metabolic risk scored 88 percent for June and zero percent for July (there was only one applicable QDRR for that category). Inter-rater reliability was 100 percent during each month. ▪ To monitor the psychiatry and PCP review of the Pharmacist recommendations and comments, two QDRRs from each of three residences was randomly selected for review each month, for a total of six QDRR reviews each month for this component. Based on the Facility's data, for the months of April through September 2013, compliance with review and documentation was 100 percent for the psychiatrist and PCP.
	Summary of Monitor's Assessment: The Monitoring Team found the Facility remained in substantial compliance with subsections N.1, N.2, N.4, N.5, and N.7. Since the last review, the Facility also had achieved compliance with Section N.3 and N.6. The following strengths were noted: ▪ The Pharmacy Department initiated a number of QA monitoring tools for new orders and QDRR quality. ▪ The new order process, with review of drug-drug interactions, lab, allergies, correct dosage, and side effects, was in place and the system appeared to be efficient and effective. ▪ A system was in place to bring information to the morning medical meeting for missed anti-epileptics or constipation medications, and to correlate this information with any recent seizure, or problem with constipation, respectively. ▪ Timely QDRR completion approached 100 percent. ▪ The chemical restraint form had an entry area for the Psychiatrist to comment on effectiveness of the restraint. Some of the remaining concerns included: ▪ Additionally, the problem of excess/unknown medication returns continued, and the Pharmacy is encouraged to continue to seek new ways to assist nursing in reducing this concern. ▪ The number of medication variances originating from the Pharmacy Department continued to improve, but further improvement was indicated, and sustainability of that improvement will be needed. ▪ The medication variance data provided needed to be in a user-friendly format demonstrating data consistency across documents. It should consist of a series of documents that is self-explanatory and easily understood by a wide audience.

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td>N1</td><td>Commencing within six months of the Effective Date hereof and with full implementation within 18 months, upon the prescription of a new medication, a pharmacist shall conduct reviews of each individual's medication regimen and, as clinically indicated, make recommendations to the prescribing health care provider about significant interactions with the individual's current medication regimen; side effects; allergies; and the need for laboratory results, additional laboratory testing regarding risks associated with the use of the medication, and dose adjustments if the prescribed dosage is not consistent with Facility policy or current drug literature.</td><td>
The Pharmacy Department staffing included the following: A Pharmacy Director (i.e., Doctor of Pharmacy), a Clinical Pharmacist (i.e., Doctor of Pharmacy), two Pharmacists (i.e., B.S. in Pharmacy), and four Pharmacy Technicians (i.e., C.Ph.T, and Ph.T.R.).

"Patient intervention" entries for new orders entered into the WORx software program were submitted for review for 60 days prior to the Monitoring Team's visit. The data print date was 10/16/13, and the data period was 8/16/13 through 10/16/13. There were a total of 73 entries submitted for this time period.

<table>
<tr><th>Month</th><th>Number of Patient Intervention Entries</th><th>Number of Entries with Medication Name</th><th>Number of Entries with Medication Dosage</th></tr>
<tr><td>August 16 to 31, 2013</td><td>16</td><td>16</td><td>15</td></tr>
<tr><td>September 2013</td><td>50</td><td>50</td><td>47</td></tr>
<tr><td>October 1 to 16, 2013</td><td>7</td><td>7</td><td>6</td></tr>
<tr><td>Total</td><td>73</td><td>73</td><td>68</td></tr>
</table>
Of the 73, the name of the medication ordered that was of concern was listed in 73 (100%) of the patient intervention entries. Sixty-eight of 73 (93%) included the dosage schedule.

Some of the interventions were broken down into different clinical categories. The categories and numbers of patient interventions for each category follows:

<table>
<tr><th>Category</th><th>Number of Patient Interventions</th><th>Category</th><th>Number of Patient Interventions</th></tr>
<tr><td>Adverse Drug Reactions</td><td>1</td><td>Allergy/Disease State Contraindication</td><td>3</td></tr>
<tr><td>Interaction/Compatibility Intervention</td><td>18</td><td>Drug Information</td><td>5</td></tr>
<tr><td>Patient Care</td><td>6</td><td>Therapeutic Consultation</td><td>1</td></tr>
<tr><td>No category listed</td><td>39</td><td></td><td></td></tr>
</table>
Although categorization was not complete, it provided a review of the types and frequency of concerns the Pharmacy Department addressed. The Pharmacy Department is encouraged to categorize all patient interventions for internal review. Sharing the type of concerns the Pharmacy Department addressed with the Medical Department might provide educational opportunities for the PCPs.
</td><td>Substantial Compliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		A sample of 30 new prescriptions was reviewed. The following summarizes the results: ▪ Ten new orders were submitted in which the Pharmacy found concerns with **drug-drug interactions** with the current drug regimen. A copy of the physician order was submitted in 10 of 10 new orders. A computer screen shot verifying the Pharmacy Department entry of the medication order into the pharmacy system was submitted in 10 of 10. A copy of the patient intervention report was submitted for 10 of 10. A copy of the change of order was submitted for three of three new orders (all were orders to discontinue the medication). For five, additional lab work was ordered. For one, additional monitoring was ordered. For one, the Psychiatrist wrote an IPN discussing justification of continuation of the order. The patient intervention note documented Pharmacy communication with the Medical and Psychiatry Departments concerning the order. Based on this information, adequate documentation of the new order process for drug-drug interactions occurred in 10 of 10 (100%) of submitted cases. ▪ Five new orders were submitted in which **allergies** were reviewed and determined by pharmacy as a concern. A copy of the physician order was submitted in five of five new orders. A computer screen shot verifying the Pharmacy Department entry of the medication order into the pharmacy system was submitted for five of five. A copy of the patient intervention or equivalent screenshot was submitted in five of five. As a result of the pharmacy review, there was a documented change in order for one of five orders. There was confirmatory documentation of no change for four of five orders. There was rationale for not changing the order documented by the Pharmacy Department in four of these four. Based on this information, adequate documentation of the new order process for allergies occurred in five of five (100%) of submitted cases. ▪ Five new orders were submitted in which **significant side effects** were reviewed by Pharmacy and determined to be a concern. A copy of the physician order was submitted in five of five new orders. A computer screen shot verifying the Pharmacy Department entry of the medication order into the pharmacy system, or a copy of the pharmacy label was submitted for five of five. A patient intervention note or equivalent was submitted for five of five. Evidence of an order change was submitted in three of five. For one of five there was no change indicated, because the Pharmacy provided a lab calculation indicating the medication could be administered. For one of five, there was no new order, but an IPN provided a plan based on pending laboratory values. In summary, for these five orders submitted, five (100%) had adequate documentation concerning side effect review/collaboration with the PCP. ▪ Five new orders were submitted in which **current laboratory results and potential need for further testing** were identified by the Pharmacy during initial review. A copy of the physician order was submitted in five of five new orders. A computer screen shot verifying the Pharmacy Department entry of the medication order into the pharmacy system, a copy of the Medication Administration Record (MAR) which included the new order, or a copy of the pharmacy label was submitted for five of five.	

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		A copy of the patient intervention or equivalent screenshot was submitted in five of five. An order for a follow-up lab to address concerns of the Pharmacy was verified in five of five cases. Documentation was adequate in five of five (100%) of submitted cases. ▪ Five new orders were submitted in which Pharmacy had concerns about the potential need for **dosage adjustments**. A copy of the physician order was submitted in five of five new orders. A computer screen shot verifying the Pharmacy Department entry of the medication order into the pharmacy system was submitted for five of five. A copy of the patient intervention or equivalent screenshot was submitted in five of five. A change of order based on Pharmacy review and PCP contact occurred in two of five. Rationale for not changing the order was documented in three of five. In summary, there was adequate documentation of the process in five of five (100%). Additionally, a "Clozapine Pharmacy Procedure" (undated) was created for dispensing of the medication, which was a positive addition to the Pharmacy procedures. Based on this review, the Facility remained 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 2013. The campus was divided into six cycles of quarterly deadlines for QDRR completion. The due date was provided for each cycle. Current information indicated Cycle One included four residences, with 77 names listed for 2013. Cycle Two included three residences, with 51 individuals listed. Cycle Three included four residences (there was the recent addition of one residence as of 7/16/13) and 68 individuals listed. Cycle Four included three residences and listed 71 individuals. Cycle Five included three residences (one additional residence had closed on 8/30/13) and listed 76 individuals (14 had moved to a Cycle Three residence). Cycle Six included four residences and listed 75 individuals. For the entire Facility, 51 individuals had moved within the ABSSLC campus. From this list, entries for individuals totaled 418. Within this list, 41 had moved to other cycles and were counted twice. Three individuals had died, and 17 were listed as having moved to the community. For the 418, there was no irregularity, except for one individual that had moved within the campus. The actual date of completion of the QDRR for this one individual was after the due date in the new cycle. It was noted, that the new due date was earlier than 90 days due to moving between residences, and would have not been considered late, but within the accepted timeframe for the prior cycle. However, all other individuals that moved had actual dates of completion of the QDRR within the due date guidelines. Those that moved were an exception to the time period of completion of seven days prior to the due date through 13 days after the due date. When the move had been completed to the new residence, then the due date for that cycle became the new due date. In all instances except the one noted, the actual date of QDRR completion for those that moved was within the agreed upon time period surrounding	Substantial Compliance

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		the new established due date. In these instances, they were often completed considerably earlier than the prior due date to allow synchrony of scheduling after moving to the newly assigned residence. Compliance with timeliness of QDRR completion approached 100 percent. 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 (100%) QDRRs. ▪ The lab results included exact values or indication of normal range for 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). ▪ Forty-two (100%) labs had the date the lab was drawn. ▪ When applicable, abnormal values were listed under the notes/comments section line for that particular lab in 31 of 31 (100%). ▪ The lab testing that was completed, and the frequency with which laboratory testing was completed indicated that the PCPs generally were providing appropriate lab monitoring of medication side effects, adverse effects, and therapeutic drug levels. The Facility remained 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, and polypharmacy, to ensure clinical justifications and	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 13 chemical restraints used from 4/3/13 to 10/27/13. These are listed above in the documents reviewed section. Nine individuals received these 13 chemical restraints. For the 13 chemical restraints, the pharmacy sections were reviewed for adequacy of completion and compliance. The following summarizes the review of these documents: ▪ Of the 13 chemical restraint forms, 13 (100%) forms included information concerning the justification of use due to the behavior. ▪ Effectiveness of the chemical restraint was documented in five out of the 13 chemical restraint forms completed. The Pharmacy routinely documented effectiveness in an alternative database the Clinical Pharmacist had created. For the Monitoring Team's initial pre-visit document request, documentation for 10 chemical restraints from April	Substantial Compliance

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	attention to associated risks; and in monitoring metabolic and endocrine risks associated with the use of new generation antipsychotic medications.	through August 2013 was submitted. There was documentation of review by the Clinical Pharmacist in the alternative database for effectiveness in 10 of 10 (100%) cases. For the three most recent chemical restraints in September 2013, this document was not submitted (the August through November 2012 database was submitted in error). However, this also indicated effectiveness for the chemical restraints during this time period of August through November 2012, indicating the database was in place and had been used for several quarters. To ensure the IDTs received the pharmacist review of effectiveness of the chemical restraint, it is recommended that this information be directly recorded on the "Crisis Intervention Restraint Checklist Form" rather than only in a separate database. It was not clear, otherwise, how the IDT received this pharmacy review of effectiveness since it was not part of the Facility form. ▪ Side effects/drug-drug interactions were noted in 13 of 13 (100%) of the completed chemical restraint forms. ▪ There were three statements that were considered recommendations/important findings. ▪ The range of time for completion of the forms from the date of the emergency chemical restraint was one to 10 days. The Psychiatrist also had a designated space for completion on the Face-to-Face Assessment, Debriefing, and Reviews for Crisis Intervention Restraint. Review of these documents showed: ▪ Of the 13 completed, there were 13 (100%) forms on which the psychiatry comment section was completed. ▪ For 13 of 13 (100%), clinical justification was documented. ▪ Concern for medication related risks (i.e., side effects/drug interactions) was reviewed in 13 of the 13 (100%) reviews. ▪ Effectiveness was documented in six of the 13 reviews. Since the Monitoring Team's last visit, an additional entry was added to the "Psychiatrist Review" of the chemical restraint form. Prior to this additional question being added to the form, one of eight chemical restraint forms addressed effectiveness by the Psychiatrist from April through July 2013. For the most recent emergency chemical restraint forms dated August through October 2013, there were five chemical restraints. Five of these five (100%) included a determination of effectiveness by the Psychiatrist. Documentation of effectiveness appeared to be in place with this change on the form. ▪ There were no recommendations documented. ▪ The range of time for completion of the forms from the date of the emergency chemical restraint was one to 10 days. ▪ The range of time for completion of the forms from the date of the emergency chemical restraint was one to 11 days. The psychiatry section of the "post chemical restraint clinical review" had been modified. For consideration of a review of behaviors and prior steps taken pre-restraint, an entry was added	

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		to the "Psychiatry Review" section: "Description of behaviors and prior steps taken before the chemical restraint was used are described on the Restraint Debriefing Form of this document." An entry was placed in the template for "was the restraint effective?" If the Psychiatrist indicated there were "potential medication-related risks," the template indicated the reader was to "see pharmacy notes above." There was also an entry for whether the psychiatrist "agreed or disagreed with any Pharmacy recommendations." Separately, the Pharmacy Department provided a graph of emergency chemical restraint use from October 2012 through September 2013. There appeared to be a decreasing trend over the prior 12 months. Additionally, to ensure all chemical restraints were reviewed, an Avatar database was reviewed monthly, entitled "Audit Report: Crisis Intervention Restraint Entries 4/1/2013-9/27/13 ensuring all components are entered into Avatar." Pharmacy also noted that two chemical restraints from this time period were not in the Avatar database, indicating that further review of this database was needed to ensure completeness and accuracy. <u>Polypharmacy</u> Of the 42 QDRRs reviewed, polypharmacy was noted in 16 reviews. ▪ Justification by diagnosis for each of the medications listed in the polypharmacy regimen was documented in 16 of 16 (100%). ▪ Clinical justification for the use of polypharmacy was addressed in 16 of 16 (100%). Clinical justification of the polypharmacy included references to specific documentation in the active record (i.e., annual medical assessment, psychiatric quarterly review, specialty consultant reports, etc.). ▪ Potential interactions with other drugs/side effect risk was reviewed in 16 of 16 (100%) ▪ For 16 of 16 (100%), the QDRRs reviewed whether monitoring/evaluation had occurred of effectiveness of the drug regimen. The November 6, 2013 P&T Committee documented that there had been a 48 percent reduction in the number of psychotropic medications prescribed over 13 quarters that had been tracked. Additionally, the average number of psychotropic medications prescribed had been reduced from greater than three per person to approximately two per person over 12 quarters. Polypharmacy also was reviewed through the Psychiatric Polypharmacy Committee. Trend data indicated that the total number of individuals on psychiatric mediation had continued to decline from June 2012 through August 2013 (i.e., from 194 to 173 individuals). Those considered to have stable polypharmacy (i.e., justification was considered complete) continued on an upward trend, consistent with the goal of the Psychiatry Department. Those for whom justification or adjustment of medication was in process were categorized as active	

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		polypharmacy, and the data indicated a downward trend for this classification of psychiatric medication. Individuals who were newly admitted were tracked separately. <u>Benzodiazepine Use</u> Benzodiazepine use was noted in nine of the 42 QDRRs. ▪ Of these, nine of nine (100%)documented justification with appropriate diagnoses; and ▪ Nine of nine QDRRs (100%) indicated whether side effects or other adverse risks were present. <u>Anticholinergic Monitoring</u> Of the 42 QDRRs, 42 (100%) were screened for medications associated with potential significant anticholinergic side effects. Twenty-nine QDRRs identified anticholinergic medications. The results of the review of the QDRRs are as follows: ▪ The anticholinergic section of the QDRR was completed in 29 of 29 (100%) of cases with this medication prescribed. ▪ Twenty-nine of 29 (100%) documented clinical justification of the use of each of the medications contributing to anticholinergic load/effect. The clinical burden of the side effects was less than the benefit. ▪ Twenty-nine of 29 (100%) QDRRs listed/addressed side effects/significant risks. Separately, it was noted that the Pharmacy Department had completed follow-up on Metoclopramide use noted in an earlier DUE. PCPs were trained on the use of Metoclopramide on 4/11/13, and distributed lists of individuals with orders for this medication. Twenty-one individuals were noted to be on Metoclopramide. Follow-up of 7/23/13 indicated that 52 percent of individuals had the original order discontinued, 30 percent of those currently prescribed Metoclopramide had documentation of justification, and 70 percent of those currently prescribed Metoclopramide were on tapering doses. The November 6, 2013 P&T Committee meeting referenced that there had been a 44 percent reduction in use of high anticholinergic medications over the prior 13 quarters. <u>New Generation Antipsychotic Endocrine and Metabolic Side Effects</u> Out of the 42 QDRRs reviewed, 13 listed atypical antipsychotic medication. Of these, 13 of 13 (100%) included lab values that reviewed endocrine and metabolic risks (i.e., BMP, glucose level, Hgb A1C, and/or lipid panel as appropriate). On another positive note, to improve the basis of knowledge and quality of care related to the use of medications, the Pharmacy Department provided periodic PCP training on a variety of clinical areas. The forum was the morning medical meeting or the "lunch and learn" sessions held twice weekly. The following were submitted as examples of the training sessions: ▪ Lamictal side effects, on 5/9/13, with six medical staff in attendance;	

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		▪ Florastor, on 7/23/13, with six medical staff in attendance; ▪ J-tube drug information, on 7/23/13, with six medical staff in attendance; ▪ WORx Universal Training for Providers, on 7/24/13, with five medical staff in attendance; ▪ Side effects of Thorazine therapy, on 6/18/13, with six medical staff in attendance; ▪ FDA warning – fluoroquinolones, on 8/30/13, at the morning medical meeting; ▪ Acetaminophen - dermatologic side effects, on 8/12/13, at the morning medical meeting ▪ Chloral Hydrate liquid form, on 9/6/13, at the morning medical meeting; and ▪ Risperdal Consta medication recall, on 9/13/13, at the morning medical meeting. Based on this review, the Facility was found to be in substantial compliance with this provision.	
N4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, treating medical practitioners shall consider the pharmacist's recommendations and, for any recommendations not followed, document in the individual's medical record a clinical justification why the recommendation is not followed.	Review of 42 QDRRs showed the following: ▪ Of the 42, 42 (100%) QDRRs had the PCP signature. ▪ Of the 42, 42 (100%) QDRRs had the date the PCP reviewed the document. ▪ Seventeen of 42 QDRRs had Pharmacy recommendations. ▪ Evidence of PCP review of recommendations and agreement or disagreement with information provided, including justification and plan was documented in 42 out of 42 (100%). o Agreement was documented in 41 out of 42. o There was disagreement by the PCP for recommendations of one QDRR. For one of one (100%), a note of justification and plan was recorded on the QDRR. o The PCP responded within 14 days of the QDRR being completed by Pharmacy in 38 of 42 (90%) QDRRs. ▪ Psychiatry reviewed the QDRR when psychotropic medication was prescribed. This included a subset of seven QDRRs in which there was polypharmacy due to psychotropic medication. Twenty-three QDRRs included use of psychotropic medication. ▪ A psychiatrist reviewed 23 of 23 (100%) QDRRs documenting psychotropic medication use. ▪ Agreement was documented in 23 of 23 (100%). ▪ The psychiatrist responded within 14 days of the QDRR being completed by Pharmacy in 23 of 23 (100%) QDRRs. 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.	Substantial Compliance

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		The Facility submitted three active records in which recommendations from the QDRR were not followed, which are listed in the documents reviewed section. In three (100%) cases, the response, rationale, and plan were written on the QDRR. Although 10 QDRRs were requested, the Pharmacy Department could only find three in which the PCPs disagreed with the recommendations. Based on this review, the Facility remained 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. 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 practitioner. The review of the sample of the records for 25 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 for 24 of the 25 (96%) individuals. The documentation for Individual #462 contained a gap in the MOSES completion from 4/10/12 to 4/23/13. The records of 24 of the 25 (96%) individuals contained documentation that the prescribing practitioner 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 #2. This record contained a gap from 9/30/13 to 10/24/13. 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 25 individuals indicated that the Facility carried out quarterly evaluations with the DISCUS of all individuals receiving psychotropic medications, regardless of whether or not one of these medications was an antipsychotic agent. This was similar to the findings of the Monitoring Team's previous reviews, 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 reflected an internal mechanism to routinely administer these evaluations to ensure completion for all who required them. In regard to the DISCUS, it also provided a baseline of	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		evaluations if an individual should be started on antipsychotic medication in the future. The DISCUS had been performed quarterly for 24 of the 25 (96%) individuals. The exception was Individual #478, for whom there was a gap between the 8/20/13 and the 2/5/13 DISCUS. The documentation related to the DISCUS was reviewed with regard to the length of time between when the nurse performed the evaluation, and when the prescribing practitioner reviewed the results. The individual whose records indicated there was a significant delay was Individual #2 (9/30/13 to 10/24/13). Thus, the prescribing practitioner reviewed the DISCUS in a timely manner for 24 of the 25 (96%) 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 eight individuals receiving Reglan who were not also prescribed a psychotropic medication. This was a significant decrease in the use of Reglan, as there were 18 such individuals at the time of the May 2013 review. The following sample included four of the eight (50%) individuals who fit the above criteria, including: Individual #19, Individual #226, Individual #385, and Individual #261. 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 (100%) of the four individuals in the sample. 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 the review by the prescriber had been completed in a timely manner for all (100%) of the four individuals. With regard to the completion of the DISCUS for the individuals in the sample, these evaluations were completed as specified for two of the four (50%) individuals. Once completed, the prescribing physician had reviewed the DISCUS evaluations in a timely manner for all (100%) of the four individuals in the sample. The individuals for whom there was a gap of greater than three months between evaluations were: Individual #26 (gap between 3/14/13 and 9/5/13) and Individual #220 (gap between 10/5/12 and 8/19/13). 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	

#	Provision	Assessment of Status	Compliance
		evaluations with the Quarterly Psychiatry Reviews appeared to have been a key intervention. 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 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. Since the Monitoring Team's prior review, there was evidence of training for the nurses on the appropriate use of the DISCUS, which occurred on 6/18/13, and for the PCPs on 6/25/13. ABSSLC had made significant progress in both the completion of the MOSES and DISCUS evaluations on schedule, and the timely review by the prescribing practitioner. ABSSLC was found to be in substantial compliance with this provision at the time of the prior review. 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 25 individual records of those prescribed psychotropic medication indicated that the MOSES was completed as specified for 96 percent of the individuals, and also had been reviewed in a timely manner for 96 percent. The corresponding review of the DISCUS for those 25 individuals in the sample indicated that it had been performed as specified for 96 percent of individuals and reviewed in a timely manner for 96 percent. Review of the administration and timely review of the MOSES for the sample of individuals prescribed Reglan indicated that the evaluations had been conducted at least every six months, and reviewed in a timely manner by the prescriber for 100 percent of the individual records reviewed. However, this was not the case for the administration of the DISCUS, which indicated that it had only been administered every three months for two of the four (50%) individuals, although all of the examinations completed had been reviewed by the prescriber in a timely manner. The specific individual information for the evaluation with the DISCUS for individuals prescribed Reglan is detailed above. The Facility can determine if this finding was related to filing or other administrative errors. The deficits in the administration of the DISCUS reduced the overall completion rate for the DISCUS from 24 of the 25 (96%) to 26 of 29 (90%) individuals.	

#	Provision	Assessment of Status	Compliance
		Based on the Facility's overall compliance rates with these evaluations, the finding of substantial compliance was continued from the prior review. However, the Facility is encouraged to ascertain the reasons for the deficits in the administration of the DISCUS to those individuals prescribed Reglan, and make corrections, if necessary.	
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.	From the 5/8/13 P&T Committee meeting, the Chief Nurse Executive reported that 100 percent of nursing staff had been trained on the curriculum "Recognizing and Reporting of Adverse Drug Reactions." This curriculum had become part of Nursing Orientation classes. Signed, new employee training rosters were submitted for nurses. A total of 34 nurses completed this course from 4/18/13 through 9/24/13. It was not clear whether the nurses completed an annual, refresher course in this clinical area. Newly employed direct support professionals were required to complete a course entitled: "Observing and Reporting Clinical Indicators of Health Status Change." This in-service provided information on the identification of adverse drug reactions, including when to report, to whom to report, and how to document observations. From 4/1/13 through 9/30/13, the Pharmacy Department indicated that 194 direct support professionals were trained. From the document entitled: "Active Employee Course Participation Report," it appeared there were 192 trained from several departments, including residential care, nursing, QIDP, risk management, etc. A total of 786 current employees (all staff) were required to complete this training. From a document entitled "Course Delinquency List," of 786 required to complete the training, only one employee was considered delinquent. Cumulative data indicated that since 1/1/2011, 1,738 employees completed this training, according to a document entitled: "Course Participation Report 1/1/2011 - 10/30/13" for the session: "Observing and Reporting Clinical Indicators of Health Status." On 7/23/13, PCPs completed training on ADRs. Seven Medical Department staff attended this session. It was not clear if annual refresher training was expected or tracked for the PCPs. The 5/8/13 P&T Committee meeting documented that five adverse drug reaction investigations had been completed and presented at the meeting. These included: Thorazine on 4/8/13, Thioridazine on11/28/12, Lortab on 2/22/13, Chlorpromazine on 1/24/13, Prolia on 1/29/13. One case, involving Prolia on 1/29/13, was considered an adverse drug reaction and reported to the FDA. Follow-up information was presented on two prior ADR events. The 8/21/13 P&T Committee meeting documented that three adverse drug reaction investigations were reviewed. These included Baclofen on 6/29/13, Chlorpromazine and Phenytoin on 6/18/13, and Thorazine on 7/10/13. Two cases, Baclofen on 6/29/13, and Chlorpromazine and Phenytoin on 6/18/13, were considered and reported as adverse drug reactions.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		The 11/6/13 P&T Committee meeting discussed two adverse drug reaction investigations. These included Alendronate on 7/9/13, and Cymbalta on 9/16/13. The ADR for Alendronate was considered an adverse drug reaction and reported to the FDA. On 9/16/13, the review of Cymbalta concluded the signs and symptoms were unrelated to the Cymbalta and were neither an adverse drug reaction nor a side effect. The process of identifying and verifying ADRs, and reporting of ADRs appeared to be efficient and accurate. The Facility was found to be in substantial compliance with this provision.	
N7	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall ensure the performance of regular drug utilization evaluations in accordance with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	The parties agreed the Monitoring Team would not monitor this provision, because the Facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance
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	<u>Policies and Procedures regarding Medication Variances</u> The Pharmacy Department submitted a copy of "DADS: SSLC Procedure: Medication Administration Guidelines," dated August 2013. This included guidance on splitting scored tablets for administration and the procedure to dispose of the other half. Also submitted was correspondence from the State Office Pharmacy Services Coordinator and Nursing Services Coordinator. Also submitted were "DADS SSLC Nursing Procedure: Enteral Medication Administration," dated August 2013 (revised), and "DADS SSLC Nursing Procedure: Injections," dated August 2013 (revised).	Noncompliance

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<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>potential medication variances.</td><td>
The Pharmacy Department submitted a document entitled: “ABSSLC: Policy for Procurement of Medications after hours,” which the Policy Review Committee approved on 9/13/13. Also submitted was a “Procedure for consultant provider orders: ABSSLC,” dated 9/2013, which provided guidance in processing these orders. These additional policies and procedures provided further clarity when administering medications.

A policy entitled “ABSSLC: Medication Variance,” dated 1/14/13, remained in draft form. Several areas were either amended or expanded under the subtitle “AbSSLC Process.” Included were new or expanded clinical areas such as: discovering medication variance, excess omission medications returned to the Pharmacy, discovering variance during auto-fill verification, review of severity index category, Pharmacy technician preparation variances, pharmacy dispensing variances, and medication station survey.

<u>Pharmacy Review of Categorization of Errors</u>
The Pharmacy Department was not active in verifying that the Nursing Department’s categorization of medication errors was consistent with the Pharmacy’s interpretation of the medication error categorization.

<u>Committee Monitoring of Medication Errors/Variances</u>
The development, progress, and tracking of a medication variance process and trend analysis were reflected in the minutes of the Medication Variance Committee meetings, which the CNE chaired. Meetings were held on 5/8/13, 5/22/13, 6/26/13, and 7/24/13. There were no meetings in August or September 2013, because the Nursing Department canceled the meetings due to schedule conflicts. The following describes some of the findings of this committee:

Medication Variances per Department
<table>
<tr><th>Month</th><th>Pharmacy Department</th><th>Nursing Department</th><th>Medical Department</th><th>Dental Department</th><th>Unknown Department</th><th>Total</th></tr>
<tr><td>March 2013*</td><td>98*
64****</td><td>326*
335****</td><td>1</td><td>NR</td><td>3</td><td>428*
402****</td></tr>
<tr><td>April 2013</td><td>57</td><td>285**
296****</td><td>1</td><td>NR</td><td>0</td><td>343**
354****</td></tr>
<tr><td>May 2013</td><td>115</td><td>238</td><td>1</td><td>NR</td><td>NR</td><td>354****</td></tr>
<tr><td>June 2013</td><td>83</td><td>259</td><td>NS</td><td>NR</td><td>NR</td><td>343***</td></tr>
<tr><td>July 2013</td><td>NS</td><td>NS</td><td>NS</td><td>NS</td><td>NS</td><td>NS</td></tr>
<tr><td>August 2013</td><td>NS</td><td>NS</td><td>NS</td><td>NS</td><td>NS</td><td>NS</td></tr>
</table>
</td><td></td></tr>
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#	Provision	Assessment of Status	Compliance

*From 5/8/2013 Medication Variance Committee meeting
**From 5/22/13 Medication Variance Committee meeting. The total did not appear to include the Medical Department variance. Number of variances in the minutes was 342. The total of the three departments was 343.
*** From 7/24/13 Medication Variance Committee meeting
**** From report entitled "Medication Variances Quarter 3 report"
NR –not recorded
NS – not submitted

This information was obtained from the above-mentioned documents. Several examples were found of inconsistency between reports. There was no information regarding whether Dental Department orders were tracked for medication variances. Concerning data for July and August 2013, the member of the Monitoring Team noted that no specific information was submitted. There was a trend toward reporting only quarterly data. Given the large number of medication variances, monthly data and tracking along with monthly medication variance meetings would appear imperative. However, as noted previously, no meetings were held in August or September 2013. To resolve the problem of medication variances to the extent possible, the Facility will need to make this concern of high priority, such that consistent data is made available, it is discussed monthly for trend analysis, and action plans are developed and implemented.

Data was provided at the November P&T Committee which summarized the trend in medication variances per quarter:

Quarter	Total Number of Medication Variances
Fiscal Quarter 1	601
Fiscal Quarter 2	1784
Fiscal Quarter 3	1110
Fiscal Quarter 4	759

Medication Variances by Severity

Fiscal Quarter	Category A	Category B	Category C	Category D	Category E
Q1 summary	235	249	108	9	0
Q2 summary	375	1116	277	15	1
Q3 summary	232	708	169	9	1
Q4	190	402	148	18	1

#	Provision	Assessment of Status	Compliance

summary					

It is recommended that this data be recorded on a monthly basis, and discussed at the monthly meetings, rather than only on a quarterly basis. Categories C, D, and E would otherwise not be discussed in a timely manner (i.e., up to four-month lag time if the error occurred at the beginning of a quarter). Category E is defined as "an error that may have contributed to or resulted in temporary harm to the patient and required intervention," and suggests the need for review and committee discussion in a timely manner.

Excess Unknown and Known Omission Medication Variances

Month	Excess Unknown Returns (Doses)	Unknown Shortage (Doses)	Un-reconciled Medications	MAR Not Initialed	Documented Omission
March 2013*	252* 269****	NS	NS	1	15 or 23*
April 2013	244 or 241****	NS	NS	NS	14
May 2013	183****	NS	NS	NS	15
June 2013***	183	NS	NS	NS	NS
Q1 summary	244	NS	249	NS	60
Q2 summary	912	NS	1116	NS	235
Q3 summary	696	NS	708	NS	44
Q4 summary	NS*****	NS	402	NS	NS

*From 5/8/13 Medication Variance Committee meeting - 15 listed in text (four pharmacy omissions, 11 nursing omissions), and the graph: "Type: Omission of Medication" listed 23.
***From 7/24/13 Medication Variance Committee meeting
****Medication Variances Quarter 3 Report. The April 2013 data listed 244 on a chart "Type: Omission of Medication" and 241 in a chart "Reconciled vs. Un-reconciled."
*****Data provided included "omission of medication" which was not the same as excess unknowns. True omissions were also not tracked for Q4.
NS – Not submitted

The Monitoring Team found the Facility's data difficult to interpret. The definition of reconciled medication and unreconciled medications would have provided clarity. It is recommended that unknown excesses and shortages be tracked separately, because the reasons for these might be different. Monthly data was not available after June, and for all months, some data was not available in the submitted documents. This might have been discussed at meetings, or available

#	Provision	Assessment of Status	Compliance

in the database or through a PowerPoint presentation, but the reason was not precisely stated in charts, graphs, or notes that were submitted. This was problematic as the Facility attempted to move forward in resolving medication variances. The data should be of such quality that it is self-explanatory and consistent.

Separately, graphs were submitted that tracked the Pharmacy Department's medication variances. These included the following graphs: Total number of pharmacy medication variances per quarter, Total number of pharmacy medication variances monthly, Pharmacy medication variances by type (medication labeled incorrectly, wrong number of medications dispensed/delivered, wrong dosage/medication dispensed, and omission of medication by pharmacy) per quarter, medication labeled incorrectly per month, wrong number of medications dispensed/delivered per month, wrong dosage/medication dispensed, omission of medication by pharmacy, pharmacy variances discovered during auto-fill or discovered during pre-dispensing check by pharmacist by quarter, pre-dispensing variances per month, and auto-fill variances per month.

The following data from the P&T Committee minutes represented the Pharmacy medication variances per quarter:

Quarter	Number of Medication Variances	Quarter	Number of Medication Variances
Quarter 1 summary	199/208*	Quarter 3 summary	236
Quarter 2 summary	353/354*	Quarter 4 summary	170

*From the August 21, 2013 P&T Committee minutes, different values were recorded in charts entitled: "Medication Variance by Department Quarterly" and "Total Number of Pharmacy Mediation Variances Quarter." The reason for the discrepancy could not be determined.

Types of Pharmacy medication variances were listed in the P&T Committee minutes:

Quarter	Medication Label Incorrect	Wrong Number of Medications Dispensed/Delivered	Wrong Dosage/ Medication	Omission of Medication
Q1 summary	5	29	143	31
Q2 summary	4	248	79	22
Q3 summary	1	173	58	4

Types of Pharmacy medication variances during the medication cart fill process also were listed

#	Provision	Assessment of Status	Compliance

in the P&T Committee minutes:

Quarter	Auto-fill Variances	Pre-dispensing Checks
Q1 summary	NR	199
Q2 summary	241	113
Q3 summary	188	47

Medication Error Reports

Copies of the last 10 medication error forms were requested for review. However, the submitted medication error forms were all old, dating from 3/25/13 to 3/27/13. The 10 medication errors were categorized as follows: zero Class A medication errors, one Class B medication error, six Class C medication errors, and zero Class D medication errors. Three were not classified. All 10 were medication omissions, and should have been Class C medication errors.

Medication Room Inspections

The Pharmacy technicians completed a survey of each medication room for each month. This information was then provided to the nurse managers. Findings reported at the 5/8/13 Medication Variance Committee meeting included refrigerator temperatures not being recorded, expired medications were found, the medication cart was unable to be locked, and the refrigerator lock box was not locked. Data per quarter was also provided on the percentage compliance with 26 separate indicators. Areas falling below 90 percent compliance included the following: Q1 summary reported concerns with controlled drugs being double locked, medication cart being attended if unlocked, all refrigerator temperatures being charted and being between 36 to 46 degrees; Q2 summary reported concerns with medication cart being attended if unlocked, all refrigerator temperatures being charted and being between 36 to 46 degrees, and vial puncture date being noted, if required; and Q3 summary reported concerns with all refrigerator temperatures being charted and being between 36 to 46 degrees.

According to the 7/24/13 Medication Variance Committee minutes, the Nurse Educators were to begin inspecting the medication rooms as of 7/1/13, utilizing an audit form the State Office developed.

Medication Observation Monitoring

Documents the Facility provided included the following information:

Month	Number Pass	Number Fail
March 2013	9	0
April 2013 (?)*	10	0
May 2013	NS	NS

#	Provision	Assessment of Status	Compliance

June 2013**	2	0
July 2013***	25	6
August 2013***	15	2

NS = not submitted
*From 5/22/13 Medication Variance Committee minutes, it was not clear if this was April or May 2013 data. However, if this was May 2013 data, then there was no reporting of April 2013. There was no further information until the June 2013 data was reported.
**From 7/24/13 Medication Variance Committee minutes
***From the "Medication Observation Report for 07/2013-08/2013." This report listed the indicators of the medication pass observation that were below compliance. These included problems with the following: using the PNMP, or using a current PNMP, adaptive and positioning equipment per the PNMP was accessible and used during the medication pass, nurse knowledge of who to contact with equipment concerns and steps to be taken until resolved, ensuring correct positioning during the medication pass, communicating with the individual the steps the nurse is undertaking prior, during, and after the medication pass, pouring liquid medication at the appropriate time, counting control drugs according to policy, steps in identification of the individual prior to the medication pass, privacy during the medication pass, including Self-administration of Medication training skills during the medication pass, disposal of contaminated medications, ensuring swallowing after medications have been administered, and checking residual volume prior to medication administration through the G-tube.

Interventions/steps taken to reduce the numbers of medication errors included the following:

- Specific medications were found to have an increased number of medication variances. From the 5/8/13 Medication Variance Committee minutes, wrong dosage of Levetiracetam, Phenytoin, and Vitamin D were discussed. The system resolution was for the Pharmacy to add to the MAR the number of tablets per full dose or number of milliliters for medication suspensions.
- Other medications that were tracked per month due to frequency of association with medication variance included: Colace, Periostat, Florastor, and Miralax. The submitted graphs did not include titles, and it is recommended that graphs/charts, etc., include titles to ensure the correct interpretation/meaning.
- To decrease medication variance during auto-fill, the Pharmacy implemented a system to decrease distractions by having a technician assigned to the auto-fill in a room dedicated for that purpose. The technician was not to be disturbed while completing the auto-fill. Two Pharmacy Technicians were assigned to auto-fills. A Pharmacist then verified correct filling of orders. Non-pharmacy staff were not to enter the Pharmacy Department. Filling of medication orders was to be verified by the National Drug Code number of the medication.
- The Pharmacy decreased the number of medications available through the Floor Stock

#	Provision	Assessment of Status	Compliance
		as an additional approach to reducing medication variances. This list was revised on 10/29/13, and the P&T Committee approved it at the November 6, 2013 meeting. ▪ For some homes, medications were bagged per shift for each day. Any medication remaining in the bag at the end of the shift was a medication variance and identified prior to the next shift, with specific information concerning the individual and time of administration. This system was believed helpful in reducing the number of medication variances. This was considered a short-term program until a system could be implemented to resolve medication variances in the homes. According to the minutes of the 6/26/13 Medication Variance Committee, the CNE and Nursing Operational Officer met with several LVNs on 6/25/13 to discuss ways to decrease medication variances. Suggestions included the need for improved organization of storage of medication not able to fit into the medication cart, increased focus on the MAR when preparing and administering the medication, and bagging of medications per shift. For anti-epileptic medicines with variances, the case managers and nurse managers were to review the recent seizure history of the individual to determine if there was an increase in frequency of seizure activity. The Pharmacy was to report to the Nursing Department when they received of a significant number of anti-seizure medication returns. In addition to focusing on reducing numbers of unexplained excesses and shortages, the Monitoring Team recommends that the Facility continue to focus on identifying causes of and resolving to the extent possible Pharmacy medication variances.	

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 #394, Individual #386, Individual #74, Individual #406, Individual #435, Individual #265, Individual #167, Individual #515, Individual #378, Individual #503, Individual #91, Individual #9, Individual #344, Individual #470, and Individual #290) including: Registered Dietician (RD)/OT/PT/SLP consultations from May to October 2013; annual ISP with IRRF and IHCP including signature page; Change of Status (COS) IRRF or IHCP; PNMP with additional written or pictorial instructions; dining plan; PNMP Revision documentation from August to October 2013; if current and addresses most recent change of status, the OT/PT/SLP/RD assessments; PNMT Post Hospitalization assessment; IPNs for May to October 2013; and ISPAs for May through October 2013; o For Sample O.2, the following documents for five individuals (i.e., Individual #399, Individual #443, Individual #201, Individual #377, and Individual #395) on the PNMT caseload, who were assessed or reviewed in the last six months; and a sample of three individuals who had been discharged by the PNMT (i.e., Individual #414, Individual #17 and Individual #27): Preferences and Strengths Inventory, list of assessments/reports needed for the annual ISP meeting, list of IDT members required 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 PNMPs for the following 27 individuals: Individual #162, Individual #212, Individual #122, Individual #53, Individual #385, Individual #156, Individual #347, Individual #344, Individual #23, Individual #514, Individual #326, Individual #123, Individual #511, Individual #206, Individual #368, Individual #75, Individual #468, Individual #359, Individual #147, Individual #281, Individual #443, Individual #382, Individual #18, Individual #541, Individual #278, Individual #343, and Individual #232; o Dining Plans for the following 21 individuals: Individual #3, Individual #439, Individual

	#5, Individual #489, Individual #54, Individual #353, Individual #234, Individual #176, Individual #360, Individual #320, Individual #336, Individual #138, Individual #535, Individual #536, Individual #196, Individual #509, Individual #415, Individual #223, Individual #23, Individual #164, and Individual #138; 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 in which PNMT members participated; 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/or Dining Plans for the following 47 individuals: Individual #162, Individual #212, Individual #122, Individual #53, Individual #385, Individual #156, Individual #347, Individual #344, Individual #23, Individual #514, Individual #326, Individual #123, Individual #511, Individual #206, Individual #368, Individual #75, Individual #468, Individual #359, Individual #147, Individual #281, Individual #443, Individual #382, Individual #18, Individual #541, Individual #278, Individual #343, Individual #232, Individual #3, Individual #439, Individual #5, Individual #489, Individual #54, Individual #353, Individual #234, Individual #176, Individual #360, Individual #320, Individual #336, Individual #138, Individual #535, Individual #536, Individual #196, Individual #509, Individual #415, Individual #223, Individual #164, and Individual #138; o List of tools that 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 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 Copy of competency performance check-off form for Mealtime Coordinators; o Facility-specific policies related to the PNM beyond HT policies; o Copy of Skin Integrity training curriculum; o Copy of weekly PNMT reports presented by the PNMT Nurse at the Medical Morning meetings from September to October 2013; o Habilitation Therapies Conference continuing education documentation for ABSSLC therapists; o Instructions for Standard Oral Care Process; o Program Implementation Plan meeting minutes from May to October 2013; o Number of staff who have completed Mealtime Management Training; o Mealtime Management Meeting minutes from May to October 2013; o Number of staff who have completed PNM Annual Refresher training; o Number of staff who are delinquent with PNM Annual Refresher training; o Compliance Monitoring reports for September and October presented at QA/QI meetings; and o Completed Wheelchair Check Sheets for residences 6370 and 6500. ▪ **Interviews with:** o Bobbie Holden, OTR, Director of Habilitation Therapies (HT); 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; o Jolene Willis, Assistant Director of Programs;

	○ June Baysinger, Unit Director; and ○ Leslie Riggins, SLP Assistant. ▪ **Observations of:** ○ Individuals in multiple residences, dining rooms, and day programs; and ○ PNMT meeting, on 11/4/13.
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section O, updated 10/21/13. 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: ○ The monitoring/audit tools the Facility used to conduct its self-assessment included: the Facility-based audit tools (e.g., PNMP audit tool). The Director of HT indicated the State Settlement Agreement Monitoring Tool for Section O and/or the Facility-developed monitoring tool for Section O had not been used over the past six months. ○ The data presented in the Self-Assessment reflected the completion of additional activities and audits, such as tracking attendance at PNMT meetings, content of PNMT meeting minutes, etc. ○ The monitoring tool and audits included adequate methodologies (such as observations, record review, and staff interview), but did not include standards, and criteria. ○ The Self-Assessment identified the sample sizes, which included the information necessary to determine the percent sample in comparison with the overall population. ○ The following staff/positions were responsible for auditing: the Director of HT, PNMT members, therapists, and PCM. ○ Adequate inter-rater reliability had not been established between the Director of HT, PNMT members, therapists, and the PCM. ▪ The Facility used some other relevant data sources, including, for example, the HT Department database(s) (e.g., continuing education, PNMP); NEO, veteran staff and annual refresher staff PNM training databases; and data related to ISPs. ▪ The Facility presented some data in a meaningful/useful way, but more work was needed. Specifically, the Facility's Self-Assessment: ○ Presented findings consistently based on specific, measurable indicators. ○ Did not consistently measure the quality as well as presence of items. ▪ The Facility rated itself as being in noncompliance with all subsections of Section O. This was consistent with 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's PNMT had the required qualified core members as outlined in the Settlement Agreement, and was meeting regularly. However, a couple of members (i.e., OT, and PT) were not in attendance at a significant number of meetings. PNMT members had completed continuing education relevant to physical and nutritional supports that were transferrable to the population served, within the past 12 months. The Facility-based PNMT policy was in draft form and awaiting the Facility's policy review committee's approval. However, the draft policy was missing some elements related to quality assurance and PNM monitoring. The PNMT members were identifying systemic issues in meeting minutes, but documentation was missing for resolution of these issues. PNMT meeting minutes were missing important information. For example, the minutes did not consistently identify individualized clinical indicators, individuals' progress or lack thereof, and results of PNMT recommendations. The PNMT and the PNMT Medical Liaison had developed a PNMT referral/consultation form. However, individuals were identified within the Monitoring Team's sample that met the PNMT referral criteria, but had not been referred to the PNMT. The PNMT assessment content had improved since the last review, but additional work was needed to ensure all elements were addressed in PNMT assessments. Additional work also was needed to integrate PNMT recommendations in IHCPs and, most importantly, implement them. The Facility had made substantial progress in providing PNMPs for individuals with PNM needs. Since the last review, progress had been made with individuals' PNMPs having more of the necessary components. The Monitoring Team observed PNMT members doing an exceptional job of auditing Individual #156's PNMP. The Facility had revised the dining plan template. These revisions included: pictures of the individual's primary and secondary position for meals; pictures of assistive equipment; enhanced status of individualized dining techniques, including mealtime skill acquisition programs; diet textures for meat, vegetables, bread, and dessert; fluid consistency for liquids; and risk related to mealtimes. The stated goal was to convert all individuals' dining plans to the revised format by the end of 2013. These revisions and additions to the dining plan template were viewed as a positive addition for individuals and staff in support a safe mealtime environment. A member of the Monitoring Team, the PNMT RN, OT, Facility PT, Unit Director, two PNMP Coordinators, and a Habilitation Technician completed multiple direct observations of staff's implementation of individuals' PNMPs and dining plans. On a positive note, the two PNMP Coordinators and one Habilitation Technician were able to successfully intervene and provide coaching and mentoring to staff to demonstrate correct implementation of individuals' PNMPs. The observations the Monitoring Team completed showed that some staff were not competent and/or compliant in implementing foundational PNMP and dining plan strategies. This was concerning in that the staff's failure to implement PNMPs was an issue during the Monitoring Team's previous onsite reviews, and, unfortunately, continued to be of concern during this review. On a positive note, the Facility had begun to implement a Mealtime Management System. At the time of the

	review, 247 staff had been trained. A Unit Director had been reassigned to provide leadership in the implementation of the Mealtime Management System. This was viewed as a constructive appointment and significantly expanded the responsibility of mealtime management beyond the Habilitation Therapy (HT) Department. The development and implementation of a Mealtime Management System was a significant positive initiative in enhancing a safe environment for individuals during mealtimes and snacks. The ABSSLC Provision Action Information, updated 10/21/13, reported the following for Sections O.6, O.7 and O.8: No new initiatives started since last visit.

#	Provision	Assessment of Status	Compliance
O1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide each individual who requires physical or nutritional management services with a Physical and Nutritional Management Plan ("PNMP") of care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan. The PNMP will be reviewed at the individual's annual support plan meeting, and as often as necessary, approved by the IDT, and included as part of the individual's ISP. The PNMP shall be developed based on input from the IDT, home staff, medical and nursing staff, and the physical and nutritional management team. The Facility shall maintain a physical and nutritional management team to	As noted above with regard to the documents reviewed section, three 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, or osteoporosis], requiring mealtime assistance and/or prescribed a dining plan, 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 emergency room, and/or hospital). Individuals within this sample could meet one or more of the preceding criteria. These 15 individuals were: Individual #394, Individual #386, Individual #74, Individual #406, Individual #435, Individual #265, Individual #167, Individual #515, Individual #378, Individual #503, Individual #91, Individual #9, Individual #344, Individual #470, and Individual #290. ▪ **Sample O.2** consisted of individuals who were assessed, reviewed, and/or tracked by the PNMT over the last six months, including the following five individuals: Individual #399, Individual #443, Individual #201, Individual #377, and Individual #395. In addition, a sample of three individuals who had been discharged by the PNMT was selected, including: Individual #414, Individual #17 and Individual #27. ▪ **Sample O.3** was not selected for this review, due to the reduced monitoring conducted for Section O.8. ▪ **Sample O.4** consisted of 47 individuals (i.e., Individual #162, Individual #212, Individual #122, Individual #53, Individual #385, Individual #156, Individual #347, Individual #344, Individual #23, Individual #514, Individual #326, Individual #123, Individual #511, Individual #206, Individual #368, Individual #75, Individual #468, Individual #359, Individual #147, Individual #281, Individual #443, Individual #382, Individual #18, Individual #541, Individual #278, Individual #343, Individual #232, Individual #3, Individual #439, Individual #5, Individual #489, Individual #54, Individual #353, Individual	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	#234, Individual #176, Individual #360, Individual #320, Individual #336, Individual #138, Individual #535, Individual #536, Individual #196, Individual #509, Individual #415, Individual #223, Individual #164, and Individual #138) observed in the residences, dining rooms, 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. The ABSSLC Provision Action Information, updated 10/21/13, reported the following for Section O.1: ▪ 5/6/13 – PNMT now conducting PNMP audits as part of the PNMT assessment; ▪ 5/13/13 – PNMT now conducting an efficacy monitoring during the assessment process; and ▪ 6/1/13 – PNMT conducting research based on current cases thus producing evidence-based practice recommendations. The Presentation Book for Section O.1 included an action plan with the following action steps and completion status: ▪ Revise Physical Nutritional Management Team policy to reflect necessary changes (completion status –in process); ▪ Train Inter-disciplinary teams on implementation of the policy at the unit meetings (completion status – not started); ▪ Analyze information from the self-assessment to identify potential causes for the issues and to connect the findings to actions put into place to correct the issues (completion status – in process); ▪ Implement an effectiveness monitoring system to assess the progress of	

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		individuals with PNM difficulties, or provide evidence that interventions were modified if an individual was not making progress (completion status – in process); ▪ Revise monitoring/audit tool to include adequate indicators to allow the Facility to determine compliance with the Settlement Agreement (completion status – not started); ▪ Develop adequate instructions for monitoring/audit tool (completion status – not started); and ▪ Designate a therapist to train so that inter-rater reliability will be established between the staff responsible for completing the tool. This will be a limited number of staff (completion status – not started). These action steps appeared to be appropriate in working to achieve substantial compliance with Section O. However, some the action steps should have been placed in other subsections of Section O. For example, the implementation of an effectiveness monitoring system would be more appropriately placed in Section O.7. **PNM Policy and Role of the PNMT** The Facility submitted the following policies/procedures: ▪ State Policy 012.3: Physical Nutritional Management, effective 3/4/13; ▪ State Policy 006.3 At Risk Individuals, effective 12/7/12; ▪ State Policy 003.1 Quality Assurance, effective 1/26/12; ▪ Draft ABSSLC Physical Nutritional Management Team Policy: Supplemental to State PNM Policy Number 012.3; ▪ ABSSLC PNMT Process Flow Chart, revised 9/30/13; ▪ ABSSLC Skin Integrity Committee, Policy 03-05.02, initiated 9/4/09; and ▪ ABSSLC Dental Policy and Procedures, published and approved 9/24/12. ABSSLC had established a draft PNM policy that had been submitted to the Facility's policy review committee for approval. This policy and DADS policies (i.e., At-Risk, Physical Nutritional Management, and QA) included the following elements: ▪ Definition of the criteria for individuals who require a Physical and Nutritional Management Plan; ▪ 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	

#	Provision	Assessment of Status	Compliance
		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 Integrated Health Care Plans; ▪ The PNMT consultation process with the IDT; ▪ Method for establishing triggers/thresholds; ▪ Evaluation process for individuals who are enterally fed; ▪ PNMT follow-up; and ▪ Collaboration with the Dental Department to address the risk of aspiration during and after dental appointments, including after the use of general anesthesia (not stated specifically in the policy, but clearly in practice). The Facility policies/procedures did not include the following elements: ▪ A system of effectiveness monitoring; ▪ Description of a sustainable QA system for resolution of systemic concerns negatively impacting outcomes for individuals with PNM concerns, including: 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 Habilitation Therapies and the PNMT to present the identified systemic issue requiring resolution to entities with responsibilities for the resolution of such issues (e.g., Medical Providers 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. ▪ A comprehensive PNM monitoring process designed to addresses all areas of the	

#	Provision	Assessment of Status	Compliance
		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; 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. The Facility did not yet have a comprehensive PNM policy that included the preceding elements. **Core PNMT Membership** There had been no changes to the PNMT membership since the Monitoring Team's last visit. The ABSSLC 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. Although not a requirement of the Settlement Agreement, three back-up members (i.e., OT, PT and SLP) had been identified. **Consultation with Medical Providers and IDT Members** The Facility reported the PNMT Physician Liaison was the Settlement Agreement Compliance Physician. The PNMT meeting minutes provided multiple instances of conversations with the PNMT Physician Liaison as well as other Primary Care Physicians. However, the Facility Self-Assessment for Section O.1 did not provide any data that documented consultation with a medical provider, which will be an important component for the Facility to measure moving forward. For five the five individuals in Sample O.2 (i.e., Individual #399, Individual #443, Individual #201, Individual #377, and Individual #395) (100%), evidence was provided of medical providers' participation (i.e., primary care physician, nurse practitioner and/or PNMT Physician Liaison) in the review of the individual's initial PNMT assessment. There was limited attendance by the PNMT Physician Liaison at PNMT	

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		follow-up meetings and/or PNMT/IDT meetings, but RN Case Managers did attend these meetings to provide updates for individuals on the PNMT caseload. The PNMT Meeting minutes provided updates from completed medical appointments and consultations. The RN Case Manager was able to communicate with the individual's primary care practitioner, if questions arose during the meeting that could not be answered. In addition, the PNMT Nurse and/or a designee attended the daily Medical Morning meetings to receive current updates on individuals who had experienced a change in status. The PNMT Nurse also provided members of the Medical Morning meetings an update on the status of individuals on the PNMT caseload every Thursday morning. For five of the five (100%) (i.e., Individual #399, Individual #201, Individual #377, Individual #395, and Individual #443) individuals in Sample 0.2, evidence was provided of routine participation of other IDT members (i.e., QIDP, RN Case Manager, Home Supervisor, and Psychologist/Psychology Assistant) in meetings, review of assessments, and other needed activities. **Qualifications of PNMT Members** Six of six (100%) PNMT core 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: Equipment and Positioning – DADS Webinar (2/7/13), Contoured Seating Using Foam in Place Technology (2/27/13), Equipment Webinar – Mexia SSLC (3/14/13), Advances in Motor Control and Learning for Neurological Rehab (5/30/13), Conquering Pain (7/11/13), and Habilitation Therapies Conference (10/31/13 to 11/1/13); ▪ SLP attended: 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), Swallow Screening: How and Why (3/9/13), Performing a Clinical Swallow Evaluation (3/9/13), AAC [Alternative or Augmentative	

#	Provision	Assessment of Status	Compliance
		Communication]: 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), Equipment Webinar – Mexia SSLC (3/14/13), Is This Ethical? Use of an Ethical Decision-Making Model to Address Ethical Issues in the Workplace (6/8/13), AAC and Aphasia (6/8/13, Professional Ethics in a Changing Professional Landscape (6/8/13), Siemens Earmolds: Your Connection for Best Sound (6/9/13), Microtia/Aural Atresis: A Parent's Perspective (6/9/13), Swallowing Physiology: Understanding Its Relationship to Traditional Swallowing Treatments (6/19/13), Conquering Pain (7/11/13), The MBSIMP [Modified Barium Swallow Impairment Profile] and Dysphagia Practice: Target Intervention Through Standardized Physiologic Swallow Assessment (9/28-29/13); and Habilitation Therapies Conference (10/31/13 to 11/1/13); ▪ OT attended: Improving Quality Indicators with Medical Foods (5/7/13), Effective Sensory Diets (6/18/13), Conquering Pain (7/11/13), and Annual Habilitation Therapies Conference (10/31/13 to 11/1/13); ▪ RN attended: Equipment and Positioning – DADS Webinar (2/7/13), Type 2 Diabetes Management (2/7/13), Equipment Webinar – Mexia SSLC (3/14/13), Improving Quality Indicators with Medical Foods (5/7/13), and Annual Habilitation Therapies Conference (10/31/13 to 11/1/13); ▪ RD attended: Enteral Nutrition: Role in Maintaining Gut Structure and Function (1/24/13), Recognizing and Defining Adult Malnutrition: An Etiology Based Approach (1/24/13), Equipment and Positioning – DADS Webinar (2/7/13), Celiac Disease, Gluten Sensitivity and the Gluten-Free Diet (5/22/13), Improving Patient Outcomes: Considerations in the New Healthcare Landscape (6/25/13), Role of the RD in Health Care Reform: Managing GI Function, Wound Healing, Glycemic Control, and Aspiration with Enteral Nutrition (7/10/13), Conquering Pain (7/11/13), The Obesity Paradox: Is It All About Cardiovascular Fitness (7/17/13), The Hunger Games: Applying the Science of Satiety to Fuel Health (7/18/13), Improving Patient Outcomes: Interdisciplinary Approach to Recognizing and Treating Malnutrition (7/25/13), Improving Patient Outcomes: Effectively Managing Malnutrition Risk After Discharge (8/13/13), and Annual Habilitation Therapies Conference (10/31/13 to 11/1/13); and ▪ RD attended: Equipment and Positioning – DADS Webinar (2/7/13), Improving Quality Indicators with Medical Foods (5/7/13), Celiac Disease, Gluten Sensitivity and the Gluten-Free Diet (5/22/13), Improving Patient Outcomes: Considerations in the New Healthcare Landscape (6/25/13), Advances in the Clinical Management of Infants and Children with Gastrointestinal Allergy (7/9/13), Role of the RD in Health Care Reform: Managing GI Function, Wound Healing, Glycemic Control, and Aspiration with Enteral Nutrition (7/10/13), Conquering Pain (7/11/13), The Obesity Paradox: Is It All About Cardiovascular	

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		Fitness (7/17/13), The Hunger Games: Applying the Science of Satiety to Fuel Health (7/18/13), Improving Patient Outcomes: Interdisciplinary Approach to Recognizing and Treating Malnutrition (7/25/13), and Habilitation Therapies Conference (10/31/13 to 11/1/13). **PNMT Meetings** From May 1, 2013 to September 25, 2013, the PNMT met 95 times. Attendance by core PNMT and back-up members, if available, for 95 meetings conducted during the time frame from May 1, 2013 to September 25, 2013 was: ▪ RN: 92% attendance by core member (there was no back-up nurse identified); ▪ RD: 90% attendance by core member; ▪ PT: 77% attendance by core member, 2% by back-up PT, overall 79%; ▪ OT: 80% attendance by core member; and ▪ SLP: 88% percent attendance by core member. None of the 95 (0%) PNMT meeting minutes (May 2013 to September 2013) consistently 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. PNMT meeting minutes presented information on PNMT referrals and possible discharges, individual-specific information from post-hospitalization results, discussion of systemic issues, and PNMT actions and follow-up. However, there were missing elements. The review of the PNMT minutes identified the following concerns: ▪ Individual-specific clinical health indicators had not been consistently identified and monitored; ▪ The absence of these clinical indicators made it difficult for the PNMT to discern if the individual had become "better or worse;" ▪ Implementation of PNMT recommendations were not consistently tracked; ▪ The fields in the PNMT meeting minutes for action step, person responsible, date due, and date done were blank. ▪ Clinical indicators were needed to enable nursing to notify the PNMT of a change in status; ▪ The meeting minutes did not identify individual-specific triggers to be monitored by direct support professionals; and ▪ It was challenging to identify an individual's progress toward established goals. **Resolution of Systemic Concerns** PNMT Meeting Minutes identified systemic issues, but there was no documentation in PNMT meeting minutes to discern if these issues had been resolved. Some examples of systems issues contained in PNMT meeting minutes included:	

#	Provision	Assessment of Status	Compliance
		▪ PNMT meeting minutes, dated 5/13/13: 1. Thickening of Elive/Breeze – have a current list of those who receive this supplement; 2. Questions regarding mixing Lactulose with pre-thickened liquids…is this a problem? 3. 2Cal with Miralax – any problems with combining these here? Dieticians report that no one is receiving this by mouth. ▪ PNMT meeting minutes, dated 5/24/13, PNMT watched SimpleThick thickening video. The consensus was that it should be shown in New Employee Orientation and possibly to homes that have been found noncompliant in providing correct thickened liquids. ▪ PNMT meeting minutes, dated 6/3/13, indicated: "Lactulose in pre-thickened prune juice (nectar and honey); Dietitians and OTs met on 5/31/31 to Enlive, Breeze, psyillium fiber, nutrisource fiber, utiStat, and Fiber Stat, utiMax and HyFiber. Discussion regarding high rate of enteral feedings on current consults. PNMT RN to follow up with PNMT Liaison." ▪ PNMT meeting minutes, dated 6/4/13, system issues: "question to Dr. Craig re: how soon to do a follow-up chest x-ray post pneumonia to see if it has resolved. Rec is 4-6 weeks post." ▪ PNMT meeting minutes, dated 7/22/13: "re-training on PNMT referral and flow chart. Possible set up a training on I-Learn." ▪ PNMT meeting minutes, dated 9/23/13: "clarify when to have a trigger sheet in place. Just because triggers are identified on the PNMP, do we need to track them or is it just when IDT, PNMT, etc., requests documentation for a limited amount of time? The Facility PNMT did not have a sustainable system fully implemented for resolution of systemic issues/concerns. At the time of the Monitoring Team's review, the Facility's Physical and Nutritional Management Team (PNMT) had the required qualified core members as outlined in the Settlement Agreement, and was meeting regularly. However, several members (i.e., OT, and PT) were not in attendance at a significant number of meetings. PNMT members had completed continuing education relevant to physical and nutritional supports that were transferrable to the population served, within the past 12 months. The Facility-based PNMT policy was in draft form and awaiting the Facility's policy review committee's approval. However, the draft policy was missing some elements related to quality assurance and PNM monitoring. The PNMT members were identifying systemic issues in meeting minutes, but documentation was missing for resolution of these issues. PNMT meeting minutes were missing important information. For example, the minutes did not consistently identify individualized clinical indicators, individuals' progress or lack	

#	Provision	Assessment of Status	Compliance
		thereof, and results of PNMT recommendations. Additional work needed to be completed to achieve substantial compliance with this section. 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.	The ABSSLC Provision Action Information, updated 10/21/13, reported the following for Section O.2: ▪ 8/9/13 – Meeting of OT and SLP to develop process for modified barium swallow studies; and ▪ 9/1/13 - Completed database reflecting persons with PNM needs and interventions/supports provided. The Presentation Book for Section O.2 included an action plan with the following action steps and completion status: ▪ Develop database reflecting persons with PNM needs and interventions/supports provided (completion status – in process); ▪ Develop policy/procedure for discharge process from PNMT (completion status – in process); ▪ Develop process for modified barium swallow studies (completion status – in process); and ▪ Develop policy/procedure to define criteria for development of lists for those requiring mealtime assistance, who are at high and medium risk for aspiration (including those who are enterally fed), at high and medium risk for choking, those with difficulty swallowing, and/or those who require positioning assistance associated with swallowing (completion status – not started). These action steps appeared to be appropriate in working to achieve compliance within this section. **<u>Identification of PNM Risk</u>** The Facility produced lists that identified individuals who required mealtime assistance, who required positioning assistance associated with swallowing activities, who had a diagnosis of dysphagia (i.e., difficulty swallowing), or who were at risk of choking or aspiration (collectively, "individuals having physical or nutritional management problems"). None of these lists were dated. 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 with PNM needs. As stated in the previous report, 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. The Presentation Book for Section O.2 provided a list of the fields in the PNM database.	Noncompliance

#	Provision	Assessment of Status	Compliance
		This database had the following fields: last name, first name, case number, home, type of assistive equipment rationale, assistive eating equipment rationale, programming rationale, formal positioning program, formal PT service plan, sensory, no program, PNMP, lifting assessment, mobility level, assistive mobility and assistive eating equipment, wheelchair priority, wheelchair, wheelchair type (i.e., standard/non tilt, tilt in space, and/or orbital), wheelchair use primary, wheelchair use transport, lap tray, walkers/canes, gait belt, shoes/inserts/orthotics/braces/build ups, helmet, wedge for head of bed elevation, hand care/splints, other equipment, enteral feedings, and assistance with feeding. This database could also track individuals who required positioning assistance associated with swallowing activities, and who had a diagnosis of dysphagia (i.e., difficulty swallowing). This database was a positive step forward in being able to identify individuals' PNM needs. **Physical and Nutritional Management Team Referral Process** The PNMT Referral form, undated, was to be used by the IDT for an initial and/or follow-up referral. The form requested the following information: request date, reason for requested consultation, chief compliant/symptoms, history of present illness (i.e., date of onset of and circumstances, ISP addendum and documented discussions, and IHCP including monitoring forms/tracking sheets for the past three months), past medical history, family history, social history, surgical history, current medications and recent changes, allergies, recent and pending labs within the last six months, diagnostic reports, and other supporting health data information (i.e., hospitalizations, emergency room visits, and consultations with the last year). The Draft Facility PNMT policy required the IDT and primary care practitioner to utilize the PNMT consultation form to refer individuals to the PNMT. The ABSSLC PNMT referral criteria were identical to the State PNM policy. Individuals in Sample O.1 were reviewed to determine if they had been appropriately referred to the PNMT. Four of 14 individuals that should have been referred to the PNMT were appropriately referred (29%). More specifically: ▪ Four individuals (i.e., Individual #394, Individual #290, Individual #167, and Individual #9) were referred and/or reviewed by the PNMT based on the referral criteria. ▪ However, there were multiple individuals who should have been referred to the PNMT, but had not been referred. In addition to the four individuals referred, ten additional individuals of the 15 individuals in Sample O.1 met the referral criteria and should have been referred to the PNMT, but were not. More specifically: o Individual #74 experienced a choking incident, but was not referred to the PNMT. o Individuals experienced unplanned weight loss of 10% or greater over a	

#	Provision	Assessment of Status	Compliance
		six-month period. Individual #386 and Individual #479 experienced weight loss that met the PNMT referral criteria, but they were not referred. o Although the State Office policy indicated referrals should be made after two diagnoses of aspiration pneumonia in a year, the Monitoring Teams have indicated that given the risk aspiration pneumonia poses to individuals, any diagnosis of aspiration pneumonia should result in a referral to the PNMT. The following individuals had been hospitalized with an admitting and/or discharge diagnosis of aspiration pneumonia: Individual #435, Individual #265, Individual #378, Individual #515, Individual #503, and Individual #91. o Individual #406's IRRF, dated 7/3/13, stated: "Hip is healing; stage III pressure ulcer noted began in February 2013 – resolved June 26, 2013." Individual #406 met the PNMT referral criteria and should have been referred to the PNMT as a result of the delayed healing for her decubitus. In addition, based on a review of the individuals in Sample O.2 (i.e., individuals on or discharged from the PNMT), the Monitoring Team had concerns that individuals who's IDTs had referred them to the PNMT were exhibiting clinical indicators that should have initiated an earlier referral. More specifically: ▪ On 5/6/13, Individual #443 was referred to the PNMT. However, the PNMT meeting minutes, dated 5/17/13, indicated: "IDT reports that the excessive vomiting has really been going on for the last 6 months." ▪ Individual #395's PNMT meeting minutes, dated 9/20/13, noted she was referred to the PNMT: "for recurrent episodes of vomiting 18 [times] in 1 year and possible assistance with right arm fracture," and on 9/23/13: "PNMT reported that more episodes of vomiting were found than what was reported on the trigger data sheet." ▪ Individual #377's PNMT assessment, dated 8/21/13, confirmed that Individual #377 had "vomited 37 recorded times since 1/30/13." For two of the four individuals in Sample O.1 (i.e., Individual #9 and Individual #394) (50%) referred to the PNMT as noted above, a referral had been made within five working days of an ISP and/or ISPA meeting. One of one (100%) (i.e., Individual #9) individuals who received an emergency feeding tube placement since the last Monitoring Team review had been referred to the PNMT after the emergency feeding tube placement. Two of two individuals (100%) (i.e., Individual #201 and Individual #377) who received	

#	Provision	Assessment of Status	Compliance
		a feeding tube (not on an emergency basis) since the last review had been referred to the PNMT prior to the placement of the tube. **PNMT Assessment** The PNMT members had revised three PNMT assessment formats: ▪ PNMT assessment template, undated; ▪ PNMT assessment addendum template, undated; and ▪ PNMT enteral nutrition assessment, undated. For the five individuals in Sample O.2, none of five PNMT assessments (0%) were initiated at a minimum within five working days of the referral (or sooner as specified in the PNMT policy). Four of five (80%) (i.e., Individual #443, Individual #201, Individual #377, and Individual #395) PNMT assessments were completed in no more 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: ▪ Five of five (100%) contained date of referral by the IDT; ▪ Three of five (60%) (i.e., Individual #399, Individual #201, and Individual #395) contained the date the assessment was initiated; ▪ Five of five (100%) contained evidence of review and analysis of the individual's medical history; ▪ Four of five (80%) (i.e., Individual #443, Individual #201, Individual #377, and Individual #395) identified the individuals' current risk rating(s), including the current rationale; ▪ One of five (20%) (i.e., Individual #201) included updated risk ratings based on the PNMT's assessment and analysis of relevant data; ▪ Five of five (100%) 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 five (0%) contained assessment of current physical status; ▪ None of five (0%) contained assessment of musculoskeletal status; ▪ None of five (0%) contained evaluation of motor skills; ▪ None of five (0%) contained evaluation of skin integrity; ▪ Five of five (100%) contained evaluation of posture and alignment in bed, wheelchair, or alternate positioning, including during bathing and oral hygiene;	

#	Provision	Assessment of Status	Compliance
		▪ Five of five (100%) contained evaluation of current adaptive equipment. ▪ Five of five (100%) contained nutritional assessment, including, but not limited to history of weight and height, intake, nutritional needs, and mealtime/feeding schedule; ▪ None of five (0%) contained evaluation of potential or actual drug/drug and drug nutrient interactions; ▪ None of two (0%) (i.e., Individual #443 and Individual #395) identified residual thresholds, if enterally nourished. This was not applicable for three individuals at the time of the PNMT assessment (i.e., Individual #399, Individual #201, and Individual #377), because they ate orally; ▪ Three of five (60%) (i.e., Individual #443, Individual #201, and Individual #377) contained a tableside oral motor/swallowing assessment, including but not limited to mealtime observation. ▪ None of five (0%) contained respiratory status; ▪ None of five (0%) contained evidence of review/analysis of lab work; ▪ None of five (100%) contained evidence of review/analysis of medication history over the last year and current medications, such as changes, dosages, administration times, and side effects; ▪ Five of five (100%) contained discussion as to whether existing supports were effective or appropriate; ▪ One of five (20%) (i.e., Individual #443) contained oral hygiene status; ▪ Five of five (100%) contained evidence of observation of the individual's supports at their residence and day/work programs; ▪ Five of five (100%) contained evidence that the PNMT conducted hands-on assessment; ▪ Five of five (100%) identified the potential causes of the individual's physical and nutritional management problems; ▪ Five of five (100%) identified the physical and nutritional interventions and supports that were clearly linked to the individuals' identified problems, including an analysis and rational for the recommendations; ▪ None of five (0%) contained recommendations for measurable skill acquisition programs, as appropriate; ▪ None of five (0%) contained the establishment and/or review of individual-specific clinical baseline data to assist teams in recognizing changes in health status; ▪ None of five (0%) contained measurable outcomes related to baseline clinical indicators, including but not limited to when nursing staff should contact the PNMT; ▪ Five of five (100%) contained evidence of revised and/or new interventions initiated during the 30-day assessment process (i.e., revision of the individual's PNMP); and	

#	Provision	Assessment of Status	Compliance
		▪ Five of five (100%) contained recommendations for monitoring, tracking or follow-up by the PNMT. PNMT assessments had improved in that they contained more of the necessary elements than during the last review. However, additional work will be required to include all of these elements in PNMT assessments. The PNMT members should review and/or assess all of these elements, and if they are not relevant to the individual being assessed, the assessment should indicate why a particular element was not assessed and/or was not relevant. **Integration of PNMT Recommendations into IHCPs and/or ISPs** For none of the five (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 five individuals' plans reviewed (0%), the plans addressed the individual's identified PNM needs as presented in the PNMT assessment. ▪ For five of the five individuals for whom HOBE assessments were conducted (100%), the HOBE recommendations were integrated into individuals' plans. ▪ In none of the five individuals' plans reviewed (0%), there were appropriate, functional, and measurable objectives to allow the PNMT to measure the individual's progress and efficacy of the plan. "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 five individuals' plans reviewed (0%), there were established timeframes for the completion of action steps that adequately reflected the clinical urgency. ▪ In none of the five individuals' plans reviewed (0%), the plans included the specific clinical indicators of health status to be monitored. ▪ In none of the five individuals' plans reviewed (0%), the plans defined triggers. ▪ In five of the five individuals' plans reviewed (100%), the frequency of monitoring was included in the plans. **PNMT Follow-up and Problem Resolution** With regard to plan implementation: ▪ In none of five individuals' documentation reviewed (0%), supporting documentation was present to confirm implementation of individuals' action plans within 14 days, or sooner as needed, of the plan's finalization. The Monitoring Team was not able to discern if the PNMT action plans had been implemented within 14 days. ▪ In none of the five individuals' plans reviewed (0%), documentation was	

#	Provision	Assessment of Status	Compliance
		provided to show action plan steps had been completed within established timeframes, or IPNs, consultations and/or follow-up reports provided an explanation for any delays, including a plan for completing the action steps. The following comments are provided based on the reviews completed of individuals' PNMT plans and associated documentation (i.e., as provided in individual-specific PNMT meeting minutes and IHCPs): ▪ PNMT assessment recommendations were not consistently incorporated into plans (i.e., IHCPs). ▪ Completion of recommendations could not be tracked in PNMT meeting minutes, IPNs, and/or IHCPs. ▪ Plans included multiple service recommendations, but did not consistently identify individual-specific baseline clinical indicators and then ongoing measurement of these indicators to enable the PNMT members to monitor the effectiveness of their recommendations. ▪ Individual-specific triggers were not missing from IHCPs, and/or were incongruent between an individual's PNMP and IHCP. ▪ Recommended PNMP monitoring results were not consistently reported in PNMT meeting minutes **<u>Individuals Discharged by the PNMT</u>** Review of three individuals' PNMT discharge summaries (i.e., Individual #414, Individual #17, and Individual #27) and ISP/ISPAs found: ▪ None of the two (0%) individuals had a meeting with the PNMT and IDT to discuss the discharge of the individual from the PNMT to the IDT. Individual #414 had been discharged from the PNMT on 8/9/12. The Monitoring Team requested ISPA documentation from November 2012 to October 2013. Consequently, Individual #414's ISPA for discharge was outside the timeframe that was requested, and so this could not be evaluated for this individual. ▪ None of the three (0%) individuals' discharge summary/action plans provided objective clinical data to justify the discharge. ▪ None of the two (0%) individual's ISPA meeting documentation provided evidence that any new recommendations, as appropriate, were integrated into the IHCP. Individual #414 was not included in this portion of the evaluation. ▪ One of the three (33%) (i.e., Individual #414) individuals' discharge summaries included criteria for referral back to the PNMT if they differed from the criteria included in the PNMT policy. The development of an HT database to track individuals with PNM needs and adaptive/assistive equipment was a positive development. The implementation of a PNMP audit tool used during the PNMT assessment process provided a comprehensive	

#	Provision	Assessment of Status	Compliance
		review of individuals' PNMPs. Additional work was needed to ensure IDTs referred individuals to the PNMT when they met referral criteria, PNMT assessments and plan elements were all included, PNMT recommendations were integrated into IHCPs, and individuals were properly discharged from the PNMT. The Facility remained out of compliance with Section O.2.	
O3	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall maintain and implement adequate mealtime, oral hygiene, and oral medication administration plans ("mealtime and positioning plans") for individuals having physical or nutritional management problems. These plans shall address feeding and mealtime techniques, and positioning of the individual during mealtimes and other activities that are likely to provoke swallowing difficulties.	The ABSSLC Provision Action Information, updated 10/21/13, reported the following for Section O.3: ▪ 8/1/13 – Began auditing PNMP in preparation for the ISP; and ▪ 8/9/13 – Meeting of OT and SLP to develop protocol for eating evaluations. The Presentation Book for Section O.3 included an action plan with the following action steps and completion status: ▪ Develop policy for PNM criteria for individuals who require a Physical Nutritional Management Plan (completion status – in process); ▪ Develop policy/procedures to address the implementation of PNMPs off campus (community outings, transportation to the emergency room), and monitoring responsibility for staff compliance (completion status – in process); ▪ Develop protocol for eating evaluations (completion status – in process); ▪ Conduct observations/audits quarterly to ensure PNMP Coordinators and Habilitation Technicians are competent in performance of their duties (completion status – not started); ▪ Provide retraining or other appropriate follow-up- if problem areas are identified (completion status – not started); and ▪ Place pictures related to positioning into the PNMP (completion status – not started). **IDTs' Reviews of PNMPs** Three hundred fifty-one (351) of the 378 individuals (93%) living at ABSSLC had 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, residential 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	Noncompliance

#	Provision	Assessment of Status	Compliance
		individuals' care and treatment do not need to attend. The absence of team members (i.e., RD, OT, PT, SLP, Dental, psychologist, and medical provider) impacted the team's ability to provide adequate input in a review of the effectiveness of an individual's PNMP and the need for revision of an individual's PNMP, if appropriate. The review of an individual's PNMP should be an important factor when identifying disciplines that should be present during the annual ISP meeting. Four of 15 (27%) (i.e., Individual #344, Individual #394, Individual #9, and Individual #406) PNMPs in Sample O.1 were adequately reviewed by the individual's IDT in the annual ISP meeting. More specifically: ▪ Individual #290's annual ISP incorporated the actual content of her PNMP without any acknowledgement of discussion by IDT members. ▪ Individual #74's ISP noted: "PNMP was reviewed and updated" which did not describe an adequate review by IDT members of an individual's PNMP, including a description of the changes that were made. ▪ The following statement often was included in individuals' ISPs: "the IDT reviewed, updated, and approved the revised PNMP to ensure that all supports related to the individual's abilities, alignment, comfort, communication, mobility and safety have been addressed." This did not provide evidence that the IDT members addressed the effectiveness of the PNMP and/or discussed specific updates and/or revisions to an individual's PNMP. **PNMP Format and Content** A review of 15 PNMPs for the individuals in Sample O.1 found the following: ▪ PNMPs for 15 of 15 (100%) individuals were current within the last 12 months. ▪ PNMPs for 15 of 15 (100%) individuals included a list of risk levels and triggers. ▪ In none of 15 (0%) PNMPs, there were large and clear photographs with instructions. ▪ Thirteen of 15 (87%) PNMPs (i.e., Individual #394, Individual #74, Individual #406, Individual #435, Individual #167, Individual #515, Individual #378, Individual #503, Individual #91, Individual #9, Individual #344, Individual #470, and Individual #290) listed the adaptive equipment required by the individual with rationale. ▪ In none of 10 (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 used a wheelchair for transport only (i.e., Individual #386, Individual #74, Individual #167, Individual #9, and Individual #470);	

#	Provision	Assessment of Status	Compliance
		▪ The following could not be assessed, because with the limited documents provided for the modified review, the Monitoring Team did not obtain copies of the OT/PT assessments: In __ of ___ PNMPs, positioning was adequately described per the individuals' assessments. ▪ In 15 of 15 (100%) PNMPs, the type of transfer was clearly described, or the individual was described as independent. ▪ In seven of 15 (47%) PNMPs (i.e., Individual #394, Individual #386, Individual #74, Individual #167, Individual #503, Individual #470, and Individual #290), bathing instructions were provided. For the remaining individuals, no instructions were provided for level of staff assistance. ▪ In five of 15 (33%) PNMPs, (i.e., Individual #74, Individual #406, Individual #503, Individual #9, and Individual #344) toileting-related instructions were provided, including check and change. For the remaining individuals, no instructions were provided to identify the level of independence, and/or level of staff assistance required during toileting. ▪ In 15 of 15 (100%) PNMPs, handling precautions or movement techniques were provided for individuals who were described as requiring assistance with mobility or repositioning. ▪ In 15 of 15 (100%) PNMPs/dining plans, instructions related to mealtime were outlined, including for those who received enteral nutrition. ▪ Fifteen of 15 (100%) dining plans were current within the last 12 months. ▪ Eight individuals had feeding tubes with no oral intake (i.e., Individual #386, Individual #406, Individual #435, Individual #265, Individual #515, Individual #378, Individual #91, and Individual #9). Eight of eight (100%) PNMPs/dining plans indicated the individual was to receive nothing by mouth. ▪ In two of 15 (13%) PNMPs/dining plans (i.e., Individual #394, and Individual #290), position for meals or enteral nutrition was provided via photographs, and the pictures were large enough to show sufficient detail. ▪ Seven individuals ate orally within this sample (i.e., Individual #394, Individual #74, Individual #167, Individual #503, Individual #344, Individual #470, and Individual #290). o In seven of seven (100%) PNMPs/dining plans for individuals who ate orally, diet orders for food texture were included. o In seven of seven (100%) PNMPs/dining plans for individuals who received liquids orally, the liquid consistency was clearly identified. o In seven of seven (100%) (i.e., Individual #315) 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 15 of 15 (100%) PNMPs medication administration instructions were	

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		included in the plan, including positioning, adaptive equipment, diet texture, and fluid consistency. ▪ In 15 of 15 (100%) PNMPs, oral hygiene instructions were included, including general positioning and brushing instructions. ▪ Fifteen of 15 (100%) PNMPs included information related to communication (i.e., how individual communicated, and how staff should communicate with individual). The PNMT completed the PNMP audit tool as a component of the PNMT assessment process. On 11/4/13, during the PNMT meeting, the Monitoring Team had the opportunity to observe the PNMT completing a PNMP audit for Individual #156. This audit produced a comprehensive review of his PNMP. A minimum element score and content score was calculated at the end of the audit process. The audit results were emailed to the individual's OT, PT, and SLP for revision. The PNMP audit completed was comprehensive and addressed the necessary PNMP elements. The PNMT members did an exceptional job of auditing Individual #156's PNMP. This process should be memorialized through policy and/or procedures to provide further guidance for Facility therapists in the development of PNMPs. The Facility had revised the dining plate template. These revisions included: pictures of the individual's primary and secondary position for meals; pictures of assistive equipment; enhanced description of individualized dining techniques, including mealtime skill acquisition programs, diet textures for meat, vegetables, bread, and dessert; fluid consistency for liquids; and risk related to mealtimes. In addition, an IDT could decide to place a red dot in the upper right hand corner of the dining plans that would alert staff to an individual's high risk for aspiration and choking. The stated goal was to convert all individuals' dining plans to the revised format by the end of 2013. In addition, a dining room book would include individuals' dining plans and documentation of staff training for individuals at high risk for aspiration and choking. These revisions to the dining plan template were viewed as positive additions for individuals and staff. **<u>Change in Status Update for Individuals' PNMPs Conducted by the IDT/PNMT</u>** For the ten individuals in Sample O.1 with PNMPs for whom the IDT and/or PNMT identified changes needed to be made to the PNMP after the annual ISP meeting, ten of the ten records (100%) (i.e., Individual #386, Individual #406, Individual #435, Individual #167, Individual #515, Individual #378, Individual #503, Individual #344, Individual #470, and Individual #290) contained a Revision PNMP Tracking form which indicated the OT, PT, and/or SLP had completed PNMP changes, the final PNMP was printed and routed, and an email was forwarded to the OT, PT, and SLP that the final version had been sent.	

#	Provision	Assessment of Status	Compliance
		For individuals for whom the PNMP was revised, there was supporting documentation that none of the ten (0%) revised PNMPs had been implemented. Such documentation would include acknowledgment by Home staff of the receipt of the revised PNMP and staff acknowledgement of the PNMP changes. The Facility should memorialize the procedures for PNMP revisions in policy. The Facility had made substantial progress in providing PNMPs for individuals with PNM needs. Since the last review, progress had been made with individuals' PNMPs having more of the necessary components. The PNMT members did an exceptional job of auditing Individual #156's PNMP. This process should be memorialized through policy and/or procedures for Facility therapists. To achieve substantial compliance with this section, IDTs need to review and document their decisions about PNMPs, and missing elements should be added to PNMPs. 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.	The ABSSLC Provision Action Information, updated 10/21/13, reported the following for Section O.4: ▪ 8/1/13 – Began taking pictures for the new dining plans; and ▪ 8/28/13 – Began entering data into the new dining plans. The Presentation Book for Section O.4 included an action plan with the following action steps and completion status: ▪ Conduct PNMP compliance monitoring by a limited number of personnel to ensure PNMPs are not breached (completion status – in process); ▪ Create new dining plans which will include positioning pictures, pictures of adaptive equipment, risks/triggers, and simplified dining techniques in a bigger font (completion status – in process); ▪ Return to basic four textures (whole, chopped, ground and pureed) to get better quality control of textures (completion status – in process); and ▪ Develop spreadsheet to ensure that therapists and supervisor are notified when staff are not compliant in implementing the PNMPs and that re-training was completed (completion status – not started). **<u>Monitoring Team's Observation of Staff Implementation of Individuals' PNMPs</u>** Observations were completed in the Infirmary, residences, and activity centers with the Facility PNMT RN and OT, a Facility PT, PNMP Coordinators, and a Habilitation Technician. Based on the Monitoring Team's mealtime observations, one of the 16 individuals' dining plans (6%) (i.e., Individual #353) were being implemented as written. The remaining 15	Noncompliance

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		individuals' dining plans (i.e., Individual #3, Individual #439, Individual #5, Individual #489, Individual #54, Individual #234, Individual #176, Individual #360, Individual #336, Individual #138, Individual #164, Individual #23, Individual #415, Individual #223, and Individual #232) were not implemented as written. During observations of snacks with the Unit Director, none of the five individuals' dining plans (0%) (i.e., Individual #138, Individual #535, Individual # 536, Individual #196, and Individual #509) were implemented as written. During these observations, staff were observed not using prescribed adaptive equipment, presenting food at too fast a pace and/or too large a bite which resulting in an individual coughing multiple times, diet texture was not correct, and staff were not following cross contamination procedures. On a positive note, the Unit Director intervened with staff to correct their mistakes. Based on observations the Monitoring Team conducted with a Facility OT, PT, PNMP Coordinators, and Habilitation Technician: ▪ Five of 22 individuals (23%) (i.e., Individual #212, Individual #344, Individual #368, Individual #468, and Individual #27) were positioned correctly in their seating systems. The remaining 17 individuals (i.e., Individual #162, Individual #53, Individual #23, Individual #514, Individual #326, Individual #511, Individual #206, Individual #377, Individual #201, Individual #281, Individual #232, Individual #343, Individual #278, Individual #541, Individual #18, Individual #382, and Individual #443) were not positioned correctly in their seating systems. ▪ Five of eight (63%) (i.e., Individual #156, Individual #385, Individual #123, Individual #75, and Individual #147) individuals' alternate positioning plans were implemented as written. The alternate positioning plans for Individual #359, Individual #296, and Individual #17 were not followed as written. ▪ None of two (0%) pivot transfers (i.e., Individual #320 and Individual #232) performed by staff were completed correctly. ▪ In none of one (0%) (i.e., Individual #347) observations of a mechanical lift transfer in the bathroom did staff complete a mechanical transfer correctly. This individual was in the Infirmary with a fracture. Her PNMP had not been revised at the time of the observation to provide staff with instructions to protect her leg during the transfer. On a positive note, the two PNMP Coordinators and one Habilitation Technician were able to successfully intervene with staff and provide coaching and mentoring to staff in repositioning individuals who were not correctly positioned. The PNMP provides the foundation for health and safety. The observations the Monitoring Team completed showed that some staff were not competent and/or	

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		compliant in implementing foundational PNMP and dining plan strategies. This was concerning in that the staff's failure to implement PNMPs was an issue during the Monitoring Team's previous onsite reviews, and, unfortunately, continued to be of concern during this review. On a positive note, the implementation of the Mealtime Management System should provide a system of accountability to support staff in the correct implementation of individuals' dining plans. The Facility should also initiate an interdisciplinary problem-solving approach, as it had with mealtimes, to analyze why staff were not implementing PNMPs and develop strategies to reverse this practice. The Facility should move forward to provide additional support to staff to enhance their competency in and/or require the implementation of PNMPs, most importantly, for those individuals at highest risk. To achieve substantial compliance within this section, the Facility should, with a sense of urgency, 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.	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., updates only) for this subsection, because the Facility had made limited progress due to the decision to prioritize other subsections and the mealtime initiatives discussed below. The noncompliance finding from the last review stands. Facility Updates for Section O.5 through Section O.8 were conveyed through information provided in the Facility Self-Assessment, Provision Action Information, Action Plans, documents provided in response to the Monitoring Team's pre-review document request, and interviews conducted with the Director of HT, PNMT members, Facility therapists, and a SLA. The ABSSLC Provision Action Information, updated 10/21/13, reported the following for Section O.5: ▪ 5/31/13 – Completed and implemented protocol for food service staff to mix food supplement "Benecalorie" into food properly; ▪ 6/1/13 – Continuing competency-based training with food service managers, cooks and food service staff to ensure textures are consistent. Action Plan indicated this training was in process; ▪ 7/1/13 – Implemented mealtime management training with unit staff at several homes; and ▪ 8/6/13 – Meeting with OT and Dietitians to update their portions of New Employee Orientation. The Presentation Book for Section O.5 included an action plan with the following action steps and completion status:	Noncompliance

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		▪ Conduct competency based training with food service managers, cooks and food service staff to ensure textures are consistent (completion status – in process); ▪ Implement mealtime management training with unit staff to create a quality controlled system with lead staff in charge to ensure staff are always seated at each table to assist, redirect, and teach during mealtime (completion status – in process); ▪ Update the Dietitian/OT portion of New Employee Orientation for diet/textures/feeding techniques to include specific diets, choice menu, reading menus, and diet/dining plans (completion status – in process); and ▪ Develop performance check offs for PNMPs (completion status – not started). These action steps were appropriate in working toward achieving substantial compliance with Section O.5. In addition, the Facility should implement a training database to document the completion of PNM foundational training for required veteran staff. **<u>New Employee Orientation (NEO) Orientation</u>** **Update:** The following curricula were provided in the pre-document request: ▪ Nutrition Services; and ▪ Aspiration Pneumonia. These curricula did not have any changes highlighted. Highlights, as requested, would indicate a change had occurred in the curriculum content since the last review. The last report stated: "the PNM related core competencies (i.e., foundational skills) were comprehensive." The Facility Self-Assessment indicated 253 new employees had completed NEO from April 2013 to September 2013. Two hundred forty seven (247) new employees received competency-based PNM training prior to working with individuals. Six of the 253 new employees did not work directly with individuals. The ABSSLC Course Participation Report, date range from 4/1/13 to 9/30/13, provided during the pre-document request indicated the following: ▪ Food Service Modification course was completed by 314 staff; ▪ Preventing Aspiration course was completed by 312 staff; and ▪ Physical Management course was completed by 312 staff. This report included the employee identification number and name, business unit, department, date of course completion and session number. This report did not indicate if employees had successfully completed PNM competency-based performance check-offs. During the Monitoring Team's next review, the following will be reviewed:	

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		_____ of _____ new employees (%) successfully completed the PNM NEO core competencies (i.e., foundational skills) performance check-offs since the last onsite review. **<u>PNM Core Competencies for Current Staff</u>** PNMP Foundational Training - Six months worth of forms were provided for 23 homes, including: 5961, 5962, 5971, 5972, 6330, 6350, 6360, 6370, 6380, 6400, 6450, 6480, 6500, 6510, 6521, 6522, 6690, 6710, 6720, 6730, 6740, 6750, and 6760. These forms tracked training for veteran staff that had occurred over the past six months. The form provided a completion date, competency score, employee name and identification number, and trainer. However, these forms did not indicate the total number of veteran staff in each home who needed to complete training (i.e., N), and the total number that had successfully completed PNM foundational training (i.e., n). During the Monitoring Team's next review, the following will be reviewed: ▪ ____of ___current staff that require training (%) successfully completed the current PNM core competencies (i.e., foundational skills) performance check-offs. ▪ ____of ____ staff (%) responsible for training other staff successfully completed competency-based training for PNM core competencies (i.e., foundational skills) prior to training other staff. **<u>Annual Refresher Training</u>** **Update:** There was no progress in this area. The pre-document requests for annual refresher training indicated: "none available at this time." During the Monitoring Team's next review, the following will be reviewed: ▪ _____ of _____ current staff that require training have completed annual refresher competency-based training and performance check-offs within the last 12 months. **<u>Individual Specific Training</u>** **Update:** There was no progress in this area. The pre-document request for individual-specific training indicated: "none available at this time." During the Monitoring Team's next review, the following will be reviewed: ▪ 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.	

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		▪ ____ of ____ staff responsible for training other staff successfully 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. ▪ The Facility **did/did not** have a process to validate that staff responsible for training other staff are competent to assess other staff's competency. **<u>Mealtime Management System</u>** The Monitoring Team completed an interview with the Assistant Director of Programs and a Unit Director to learn more about the implementation of the Mealtime Management System. A Unit Director had been reassigned to provide leadership in the implementation of the Mealtime Management System. This was viewed as a constructive appointment, and significantly expanded the responsibility of mealtime management beyond the HT Department. The Monitoring Team had the opportunity to observe snacks in day programs and a dinner meal with this Unit Director. These observations showed that the Unit Director had a strong understanding of safe mealtime practices. Beginning in July 2013, the Facility implemented staff training using two curricula: ▪ ABSSLC Meal Time Coordinator; and ▪ Eating, Meal Time Management, and Nutrition. The training focused on the responsibilities of the Meal Time Coordinators (MTC) and Table Captains. Meal Time Coordinators were defined as the person Residential Services designated to coordinate the services provided to the individuals during mealtime. The MTC designated a Table Captain to assist and support individuals at dining tables. The training defined the responsibilities of the MTC prior to, during, and after the meal, including documentation requirements. In addition, cross-contamination prevention strategies were presented. The Eating, Mealtime Management, and Nutrition Services curriculum objectives included understanding the stages of oral motor development, how to prevent aspiration at mealtimes, identification of different types of food textures, identification of different consistencies of thickened liquids, understanding the diet cards, understanding what a dining plan is and how to use it (i.e., adaptive dining equipment, positioning and dining strategies), identification of where food allergies are listed, and identification of snack times. These training curricula provided relevant mealtime skill content. At the time of the review, 247 staff had completed this training which included unit staff at all main campus homes. Training for Unit staff in the cottages was to begin in December. The Facility set a goal to have all required staff complete training by December 2013. At the time of the review, the Unit Director was co-training these curricula with Facility therapists. The plan was to expand the pool of trainers beyond Facility therapists to	

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		include staff Home Supervisors, Unit Directors, PNMP Coordinators, and staff development trainers. In addition, this training was to be incorporated into NEO orientation and annual refresher training. Members of the Mealtime Management group (i.e., Unit Director, Director of Residential Services, Director of Active Treatment, Director of HT, and Lead OT) had reviewed the two mealtime competency performance check-off tools from Lubbock SSLC. The members of this group had made revisions to these tools and had finalized the ABSSLC Mealtime Coordinator Competency Check-Off. This tool had not been implemented at the time of the review. Home Supervisors were to submit the names of assigned MTCs to the Unit Director by November 15th. The competency check-off process had not been implemented at the time of the review. This group had reviewed the monitoring tools that were being used at Lubbock SSLC. The Facility was in the process of revising the monitoring tool and had not finalized the tool. The members of this group had decided to focus on completing training for staff, and giving MTCs a chance to implement the system before initiating monitoring. Mealtime monitors could include Home Supervisors, Unit Directors, PNMP Coordinators, Habilitation Technicians, Therapists, Infection Control and QA Nurses, and Program Compliance Monitors. The future monitoring data was to be presented at QA/QI Council meetings. Prior to the implementation of monitoring, monitoring training would be implemented. This training would include: ▪ Teaching/training on the residential monitoring forms and the use of probe questions; ▪ Review of MTC competency sheets by home; ▪ Videos of meals to review and practice completion of the monitoring tool; and ▪ Observation/monitoring at homes. Inter-rater reliability for the monitoring forms was to be completed by QA/PCMs per the direction of the State Office. The Unit Director was to be responsible for submitting quarterly reports at the QA/QI Council meetings. An ABSSLC Mealtime procedure was in the process of being developed but had not been finalized. The final draft of the procedure was to be presented to the QA/QI Council. The development and implementation of a Mealtime Management System was a significant positive initiative in enhancing a safe environment for individuals during mealtimes and snacks.	
O6	Commencing within six months of the Effective Date hereof and with full implementation within three	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., updates only) for this subsection, because the Facility had made limited progress due to the decision to prioritize other subsections. The noncompliance finding from the last	Noncompliance

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	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.	review stands. **Updates** The ABSSLC Provision Action Information, updated 10/21/13, reported the following for Section O.6: ▪ 9/1/13 – No new initiatives started since last visit. The Presentation Book for Section O.6 included an action plan with the following action steps and completion status: ▪ Develop policy to define the monitoring system to test staff compliance with PNMPs, including the definition of a monitoring process, training and validation process by therapists, identification of PNM risk factors, formal schedule for monitoring to occur, requirement that all monitoring forms provide instructions, defining an auditing process, development of a system to track and trend monitoring results, and establishment of a threshold for staff re-training (compliance status – not started). The development and implementation of a Facility policy/procedure for PNM monitoring would assist the Facility in achieving compliance within this section. **<u>Facility's System for Monitoring of Staff Competency with PNMPs</u>** During the Monitoring Team's next review, the following will be reviewed: ▪ Monitoring tools **did/did not** include adequate indicators to determine whether or not "staff demonstrated competency in safely and appropriately implementing" mealtime and positioning plans. ▪ Monitoring tools **did/did not** include adequate instructions. ▪ The staff conducting monitoring **were/were not** competent in the areas they were monitoring. The PNMP monitoring process did/did not cover all areas that were likely to provoke swallowing difficulties or increase PNM risk, based on the following. ▪ ____ 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. ▪ ____ of the ____ occurred during first shift; ▪ ____ of the ____ occurred during second shift; and ▪ ____ of the ____ occurred during third shift. **<u>Monitoring for Individuals in Samples</u>** During the Monitoring Team's next review, the following will be reviewed:	

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		▪ For individuals in Sample O.1, PNM compliance monitoring over the past three months for ____ of ____ individuals (%), the frequency of monitoring occurred as per the individuals' assessment and/or the individuals' plans/IHCPs. ▪ For individuals in Sample O.2, PNM compliance monitoring over the past three months for ____ of ____ individuals (%), the frequency of monitoring occurred as per the individuals' PNMT assessment and/or the individuals' plans/IHCPs. ▪ For the past three months, problems were noted on ____ of ____ monitoring forms. Of these, documentation of adequate follow-up was provided on the form for ____ (%).	
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.	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., updates only) for this subsection, because the Facility had made limited progress due to the decision to prioritize other subsections. The noncompliance finding from the last review stands. **Updates** The ABSSLC Provision Action Information, updated 10/21/13, reported the following for Section O.7: ▪ 9/1/13 – No new initiatives started since last visit. The Presentation Book for Section O.7 included an action plan with the following action steps and completion status: ▪ Implement an effectiveness monitoring system to assess the progress of individuals with PNM difficulties, or provide evidence that interventions were modified if an individual was not making progress (completion status – in process). The development and implementation of a Facility policy/procedure for effectiveness monitoring would assist the Facility in achieving compliance within this section. **<u>IDT and PNMT Monitoring to Assess Individual's Progress and/or Effectiveness of Plans</u>** During the Monitoring Team's next review, the following will be reviewed: ▪ ____ of ____ (%) individuals' records in Sample O.1, and ____ of ____ (%) individuals in Sample O.2 contained evidence of indicators integrated as part of the IHCPs to assess the individuals' PNM status. ▪ ____ of ____ (%) individuals' records in Sample O.1, and ____ of ____ (%) individuals in Sample 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 ____ of ____ (%) individuals receiving direct therapy, the record contained evidence that documentation was reviewed of the plan's effectiveness based on	Noncompliance

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		objective clinical data included in the plan. ▪ _____ of the _____ individuals' records showed a change of status based on the 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. Based on review of trigger sheets and supporting documentation for individuals in Sample O.1: ▪ ____ of ____ (%) individuals' records included evidence that the team discussed the need for and developed individualized triggers as appropriate to the clinical needs of the individual. ▪ ____ of ____ (%) individuals' Trigger sheets included individualized triggers as indicated. ▪ ____ of ____ (%) individuals' Trigger sheets were completed correctly. ▪ ____ of ____ (%) individuals' Trigger sheets were reviewed by the RN on a daily basis.	
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.	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., updates only) for this subsection, because the Facility had made limited progress due to the decision to prioritize other subsections. The noncompliance finding from the last review stands. **Updates** The ABSSLC Provision Action Information, updated 10/21/13, reported the following for Section O.8: ▪ 9/1/13 – No new initiatives started since last visit The Presentation Book for Section O.8 included an action plan with the following action steps and completion status: ▪ Develop policy/procedure for maintaining and updating a list of individuals who receive enteral nutrition (completion status – not started); and ▪ Develop Policy/procedure for returning an individual to a less restrictive approach to receiving enteral nutrition or, if appropriate, a return to oral eating (completion status – not started). Again, the development of a Facility policy/procedure would assist the Facility in achieving compliance within this section. **Assessment of Individuals Who Receive Enteral Nourishment** During the Monitoring Team's next review, the following will be reviewed: ▪ The Facility **did/did not** have a sustainable system to maintain and update a list of individuals who were enterally fed.	Noncompliance

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		▪ ___of____ individuals who receive enteral nutrition were evaluated at a minimum annually. ▪ ____ of ____ (%) individuals reviewed 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: o Nutritional assessment of current type of formula and schedule; o Identification of primary medical diagnoses that contributes to the need for non-oral means of nutrition; and o 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. ▪ ____ of the ____ (%) 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. **Pathway to Return to Oral Intake and/or Receive a Less Restrictive Approach to Enteral Nutrition** During the Monitoring Team's next review, the following will be reviewed: ▪ ____ of ____ (%) individuals in Sample 0.3 who received 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: o 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. o 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. ▪ ____ of the ____(%) individuals 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. The plan should include all of the following components: o Staff training required prior to implementation; o Staff roles and responsibilities (e.g., implementation and monitoring); o Time and schedule of interventions;	

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		o Specific triggers for when the plan should be stopped; o Milestones for progressing with the plan; o Documentation requirements (i.e., method for tracking progress); and o Frequency of subsequent assessments and staff responsible. ▪ ____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 should 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 the ____ (%) 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 it is a critical concern, when a change is indicated such as for a change in status or based on effectiveness monitoring findings.	

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 OT/PT assessments for the following three individuals the Facility selected: Individual #334, Individual #206, and Individual #502; 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; o Physical Nutritional Management Maintenance Log; o OT/PT Assessments and Updates (templates) with changes made since the Monitoring Team's last review; o Tracking Log of completed individual assessments; o Wheelchair seating and PNM clinic assessment (templates); o Compliance Monitoring form template; o Competency-based performance check-off sheet templates for PNM core competencies and individual-specific PNMPs along with dining plans and other intervention plans; o OT/PT assessments for new admissions completed after the submission of the pre-document request; o Summary reports and monitoring results related to OT/PT; and o List of individuals receiving direct OT and/or PT services and focus of intervention. ▪ **Interviews with**: o Bobbie Holden, OTR, Director of Habilitation Therapies; o Amy Gleaton, PNMT Coordinator and PNMT OT; and o Leslie Riggins, SLP Assistant. ▪ **Observations of**: o Individuals in residences, dining rooms, and day programs.
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section P, dated 10/21/13. 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. ▪ Based on a review of the Facility Self-Assessment and interviews with the Director of HT, the

	following was found: o The monitoring/audit tools the Facility used to conduct its self-assessment included: Facility-developed audit tools (i.e., OT/PT assessment and PNMP audit tool). The Director of HT indicated the State Settlement Agreement Monitoring Tool for Section P and/or the Facility-developed Monitoring Tool for Section P that incorporated indicators from the Monitoring Team's reports had not been used over the past six months. o The data presented in the Self-Assessment indicated that multiple audits were conducted using the review of OT/PT assessments for individuals newly admitted, review of ISPs for incorporation of OT/PT assessment recommendations, the OT/PT assessment audit tool, analysis of PNM foundational training databases for NEO, and annual refresher training for PNM foundational training, etc. o The Self-Assessment identified the sample sizes used to complete audits, which included the information necessary to determine the percent sample in comparison with the overall population. o The Facility-based audit tools did not have adequate instructions/guidelines to ensure consistency in monitoring and the validity of the results. o The following staff/positions were responsible for completing the audit tool: the Director of HT, therapists, 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 databases and/or spreadsheets. ▪ 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 not being in compliance with the subsections of Section P. This was consistent with the Monitoring Team's findings. ▪ 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 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: Six of the seven individuals newly admitted to the Facility received an OT/PT assessment within 30 days. Since the last review, the Facility's OT/PT assessment content had improved. However, additional work was needed to ensure necessary assessments elements were completed. The Facility's Provision Action Information, Presentation Book, and staff interviews indicated that no initiatives had been started for Section P.3 and P.4 since the last review. However, the action plans for these subsections included valuable action steps. If implemented, they should move the Facility towards substantial compliance.

#	Provision	Assessment of Status	Compliance
P1	By the later of two years of the Effective Date hereof or 30 days from an individual's admission, the Facility shall conduct occupational and physical therapy screening of each individual residing at the Facility. The Facility shall ensure that individuals identified with therapy needs, including functional mobility, receive a comprehensive integrated occupational and physical therapy assessment, within 30 days of the need's identification, including wheelchair mobility assessment as needed, that shall consider significant medical issues and health risk indicators in a clinically justified manner.	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., a smaller sample the Facility selected) for this subsection. This was because the Facility recently had implemented a new assessment format and requested feedback on the newest assessments, recognizing that previous assessments needed improvement. The noncompliance finding from the last review stands. **Definition of Samples** ▪ **Sample P.1** consisted of the following three individuals the Facility selected: Individual #334, Individual #206, and Individual #502. **Updates** The ABSSLC Provision Action Information, updated 10/21/13, reported the following for Section P.1: ▪ 8/14/13 – Meeting with OT and PT to revise the OT/PT evaluation template. The Presentation Book for Section P.1 included an action plan with the following action steps and completion status: ▪ Analyze information from the self-assessment to identify potential causes for the issues and to connect the findings to actions put into place to correct the issues (completion status – in progress); ▪ Revise OT/PT evaluation template (completion status – in progress); ▪ Implement schedule for monitoring persons with PNMPs and dining plans. This monitoring will address the status of their identified OT/PT therapy needs and the effectiveness of their programs. It will also address assessment of all prescribed adaptive equipment for condition, availability, and effectiveness (completion status – not started). These action steps were applicable to Section P. However, some of these action steps were not relevant to reaching substantial compliance with Section P.1. For example, the action step related to monitoring would be applicable to Section P.4. The Facility should review the findings in the Monitoring Team's reports related to the Section P subsections to determine the appropriateness of action steps. **Timeliness of Assessments** Since the last review, six of seven (86%) newly admitted individuals (i.e., Individual #298, Individual #336, Individual #354, Individual #455, Individual #299, and Individual #379) received an OT/PT assessment within 30 days of admission or readmission. Individual #81's OT/PT assessment was not completed within 30 days of admission. For one of two applicable individuals in Sample P.1 (50%) (i.e., Individual #206), the OT/PT assessment and/or update was dated as having been completed at least 10 days	Noncompliance

#	Provision	Assessment of Status	Compliance
		prior to the annual ISP. Individual #502's OT/PT assessment was completed on 10/18/13, and his annual ISP date was 1/15/13. Individual #334 had been newly admitted to the Facility on 9/5/13. The Facility alpha list of individuals and their ISP dates did not include Individual #334, so timeliness could not be calculated. Three of three (100%) 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 three OT/PT assessments in Sample P.1, the comprehensiveness of the OT/PT assessments was as follows: ▪ Three of three (100%) individuals' OT/PT assessments were signed and dated by both the OT and PT clinicians upon completion of the written report. ▪ One of three (33%) (i.e., Individual #206) assessments included medical diagnoses and relevance to functional status. ▪ One of three (33%) (i.e., Individual #206) 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. ▪ Three of three (100%) assessments addressed health status over the last year. ▪ Two of three assessments (67%) (i.e., Individual #334 and Individual #502) 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. ▪ Two of three assessments (67%) (i.e., Individual #206 and Individual #502) included a section that reported health risk levels that were associated with PNM supports. This information was generally utilized for planning interventions and supports and for recommendations related to changes in the existing risk levels. ▪ Three of three (100%) assessments listed medications and potential side effects relevant to functional status. ▪ Three of three (100%) individuals' OT/PT assessments included individual preferences, strengths, and needs. ▪ Three of three (100%) assessments included evidence of observations by OTs and PTs in the individuals' natural environments (i.e., day program, home, work). ▪ Three of three (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. ▪ One individual used a wheelchair as a primary mobility device. One of the one	

#	Provision	Assessment of Status	Compliance
		assessments (100%) (i.e., Individual #206) included a description of the current seating system with a rationale for each component and need for changes to the system outlined as indicated, also with sufficient rationale. Two individuals (i.e., Individual #334 and Individual #502) did not use wheelchairs for their primary mobility. ▪ None of three assessments (0%) included discussion of the current supports and services provided throughout the last year and effectiveness, including monitoring findings. ▪ Three of three assessments (100%) included recommendations for services and supports. ▪ Three of three (100%) assessments 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. ▪ Two of three assessments (67%) (i.e., Individual #206 and Individual #502) included documentation of the efficacy and/or introduction of new supports in the PNMP that addressed the individuals' PNM risk levels; ▪ Two of three (67%) assessments (i.e., Individual #334 and Individual #502) 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. ▪ Three of three (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 provided clinical justification related to recommendations for direct therapy interventions and/or skill acquisition programs. ▪ None of three (0%) assessments included a monitoring schedule. The OT/PT assessment should recommend a monitoring schedule for the upcoming year for individuals with PNMPs. The therapist should describe the monitoring form(s) to be utilized. ▪ Three of three (100%) assessments included a reassessment schedule. ▪ Three of three (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 needed were missing in the community. ▪ Three of three (100%) assessments recommended ways in which strategies,	

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		interventions, and programs should be utilized throughout the day. The content of individuals' OT/PT assessments had improved since the last review. Because of the limited review, the following could not be reviewed, but will be during the next review: ▪ For _____ of ___ (%) 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, the three OT/PT assessments reviewed had improved, as more of the necessary elements had been addressed within the assessments.	
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.	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., updates only) for this subsection, because the Facility had made limited progress due to the decision to prioritize other subsections. The noncompliance finding from the last review stands. **Updates** The ABSSLC Provision Action Information, updated 10/21/13, reported the following for Section P.2: ▪ 6/30/13 – Keeping all therapist positions filled with contract therapists The Presentation Book for Section P.2 included an action plan with the following action steps and completion status: ▪ Meet with QDDP Coordinator to develop a plan to ensure recommendations of the OT/PT assessment are implemented within 30 days (completion status – not started). This action step was relevant to Section P.2, and should assist the Facility in working toward achieving compliance with Section P.2. **<u>Direct OT/PT Interventions</u>** During the next review, the following will be reviewed for individuals receiving direct therapy intervention: ▪ ___ of ___ (%) individual direct intervention plans were implemented within 30 days of the plan's creation, or sooner as required by the individual's health or safety. ▪ For ___ of ___ (%) individuals' records reviewed, the current OT/PT	Noncompliance

#	Provision	Assessment of Status	Compliance
		assessment and/or consultation identified the need for direct intervention with rationale. ▪ For ___ of ___ (%) individuals' records reviewed, there were measurable objectives related to functional individual outcomes included in the ISP or ISPA. ▪ 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 with regard to 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** During the next review, the following will be reviewed: ▪ ___ of ___ individuals' ISPs noted that the OT or PT attended the ISP meeting, if the individual was receiving any direct or indirect OT/PT service, or adequate justification was provided. ▪ For individuals receiving OT/PT supports and services, ___of _____plans (%) were developed within 30 days of the date of the ISP, or an ISPA following the assessment/update, or sooner as indicated by need. ▪ For ___ of ___ individuals, (%), the ISP, or an ISPA following the assessment/update, addressed recommendations outlined in the current OT/PT assessment. ▪ In ___ of ___ (%) ISPs or ISPAs reviewed, skill acquisition programs that had been recommended in the OT/PT assessment were present. ▪ For ___ of ___ individuals (%), the ISP/ISPAs contained measurable objectives related to interventions. ▪ ___ of ___ (%) individuals receiving direct OT/PT services was provided with comprehensive progress notes (IPNs) at least monthly. The progress notes should: o 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); o Describe the benefit of the goal to the individual; o Report the consistency of implementation; o Identify recommendations/revisions to the OT/PT intervention plan as indicated related to the individual's progress or lack of progress; and	

#	Provision	Assessment of Status	Compliance
		o 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 (i.e., indirect OT and/or PT programs), for ___ of ___ individuals (0%), monthly documentation from the OT and PT and/or QIDP was present, including the following: o Information regarding whether the individual showed progress with the stated goal(s), including a summary of clinical data to substantiate progress and/or lack of progress with the therapy goal(s); o A description of the benefit of the program; o Identification of the consistency of implementation; and o Recommendations/revisions to the indirect intervention and/or program as indicated in reference to the individual's progress or lack of progress.	
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 parties agreed the Monitoring Team would conduct reduced monitoring (i.e., updates only) for this subsection, because the Facility had made limited progress due to the decision to prioritize other subsections. The noncompliance finding from the last review stands. **Update** The ABSSLC Provision Action Information, updated 10/21/13, reported the following for Section P.3: ▪ 9/1/13 – No new initiatives started since last visit. The Presentation Book for Section P.3 included an action plan with the following action steps and completion status: ▪ Develop individual-specific competency-based performance check-offs for the implementation of indirect OT or PT programs (completion status – not started); and ▪ Conduct observations/audits quarterly to ensure PNMP Coordinators and Habilitation Technicians are competent in performance of their duties (completion status – not started). These action steps were relevant to Section P.3 and should assist the Facility in working toward achieving compliance with Section P.3. **<u>Competency-Based Training</u>** Competency-based training for, and monitoring of, continued competency and compliance of direct support professionals related to implementation of PNMPs are	Noncompliance

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		typically addressed in detail with regard to Section O.5. Substantial compliance with O.5 is the standard for compliance with this section.	
P4	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall develop and implement a system to monitor and address: the status of individuals with identified occupational and physical therapy needs; the condition, availability, and effectiveness of physical supports and adaptive equipment; the treatment interventions that address the occupational therapy, physical therapy, and physical and nutritional management needs of each individual; and the implementation by direct care staff of these interventions.	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., updates only) for this subsection, because the Facility had made limited progress due to the decision to prioritize other subsections. The noncompliance finding from the last review stands. **Update** The ABSSLC Provision Action Information, updated 10/21/13, reported the following for Section P.4: ▪ 9/1/13 – No new initiatives started since last visit. The Presentation Book for Section P.4 included an action plan with the following action steps and completion status: ▪ Implement a standard wheelchair cleaning and maintenance protocol (completion status – not started); ▪ Implement a standard wheelchair maintenance schedule (completion status – not started); ▪ Develop procedures for PNMP clinic which include: identifying medium and high risk indicators that might impact therapeutic interventions; therapist evaluation/review of prescribed equipment for condition, availability, and effectiveness; signatures of therapists present; and recommendations which identify the responsible therapist, date of work order and delivery of equipment and frequency of equipment monitoring (completion status – not started); ▪ Develop a protocol to define seating system priority levels (completion status – not started); ▪ Revise/update OT/PT policy (completion status – not started); ▪ Implement effectiveness monitoring of wheelchairs to develop a priority list for individuals without an adequate seating system and needing a comprehensive seating assessment (completion status – not started); and ▪ Implement a system to monitor and address the status of individuals with identified OT and PT needs; condition, availability and appropriateness of physical supports and assistive equipment; the effectiveness of treatment interventions that address OT, PT, and PNM needs of each individual; and the implementation of programs carried out by the direct support professionals (completion status – not started). These action steps were relevant to Section P.4 and should assist the Facility in working toward achieving compliance with Section P.4.	Noncompliance

#	Provision	Assessment of Status	Compliance
		<u>Monitoring System</u> The Facility did not implement a system for the adequate monitoring of PNMPs. The Facility did not have a revised/updated comprehensive OT/PT policy or set of policies and procedures. When finalized, the Facility OT/PT policies should include the following elements and/or reference the State Occupational/Physical Therapy Services Policy 014: ▪ 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 for individuals receiving direct services. During the next review, the following will be reviewed: ▪ For ____ of ____ (%) 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 means that therapists or designated staff reviewed equipment at least monthly. ▪ ___ 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.	

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 highlighted areas of approved change; 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: (a) For newly admitted individuals, were seen for dental services, including date of admission, and date of initial evaluation; (b) Were seen for dental services during the past six months other than for the annual exam, date of visit, and reason or type of visit; (c) Have refused dental services; (d) 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; (e) Have had a tooth/teeth extraction, including name, date of extraction, and number of teeth extracted; (f) 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 documentation confirming pain (yes or no), and treatment documented; (g) Have had preventative dental care; (h) Have had restorative dental care including name, date of completed restorative work, and for each appointment completed, type of restorative work; and (i) 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 form active record of same visit, including source of documentation (i.e., IPN or dental section of active record/dental office record) for: Individual # 176, Individual #262, Individual #35, Individual #240, Individual #167, Individual #94, Individual #36, Individual #233, Individual #435, Individual #485, Individual #137, Individual #144, Individual #49, Individual #307, Individual #37, Individual #456, Individual #379, Individual #210, Individual #180, Individual #280, Individual #302, and Individual #460; o Five most recent offsite oral surgery consults and progress notes past six months; Individual #119, Individual #156, Individual #379, Individual #74, and Individual #547; 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 (i.e., prophylaxis, annual, etc.), name, 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 Monitoring Team's last onsite visit, and those who have become edentulous since that time; o List of other reasons for missed appointments per date for past six months (including reason for appointment – prophylaxis, annual, etc.); o List of no shows/missed appointment per building per month for the last six months; o List of refusals per building per month for the last six months; o List of interventions per individual for missed appointments (i.e., follow-up appointment scheduled, whether follow-up completed, any correspondence to QIDP, residential 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 ISPA that documented discussion/action plans concerning dental refusals and other dental missed appointments; o For five most recent emergency exams, IPN from start of emergency to closure, and copy of dental department evaluation and treatment including time and date of first symptom/concern, and time/date first seen in the dental office for: Individual #290, Individual #74, Individual #92, Individual #239, and Individual #247; 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 five 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 (i.e., medical, anesthesia clearance, etc.), and post-operative checklist or monitoring forms, IPN on date of procedure, etc., for: Individual #239, Individual #261, Individual #318, Individual #379, and Individual #497; o For the past six months, copies of any correspondence concerning restraint and sedation use at time of office visit (to QDDP, team, psychologist, etc.); o For five 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 #363, Individual #455, Individual #69, Individual #526, and Individual #486;

	o Current list of HRC approved dental medical restraints with sedation, including type of sedation, such as by mouth (PO) sedation, Intravenous (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 In past six months, per month, percentage of individuals utilizing general anesthesia/IV sedation for dental exam and treatment; o In past six months, per month, percentage of individuals utilizing oral sedation for dental visits; o In past six months, per month, percentage of individuals utilizing mechanical restraints for dental visits; o For most recent five extractions in past six months, copy of initial evaluation for this, second opinion, and subsequent documentation until closure, for: Individual #469, Individual #379, Individual #497, Individual #261, and Individual #479; 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 (i.e., 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 #526, Individual #545, Individual #159, Individual #18, Individual #505, Individual #137, Individual #235, Individual #544, Individual #76, and Individual #118; o Dates 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 #222, Individual #138, Individual #126, Individual #19, Individual #429, Individual #427, Individual #162, Individual #55, Individual #530, and Individual #129; o The most recent/current Facility oral hygiene data for all individuals in past year, including numbers and percentages of good, fair, poor ratings, with date of data; also, a list of individuals for whom an oral hygiene rating was not obtained during this time; o For those individuals for whom care plans/ISP indicate they brush their own teeth, the oral hygiene scores, with dates of the scores, over the prior one year; 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, the reason for not flossing their own teeth. Requested submitted information included whether a skill acquisition plan had been created or implemented for flossing; o For those that are edentulous, list of those with dentures;

	○ For those edentulous without dentures, list of reasons with documentation as indicated; ○ Summary information on desensitization plans since Monitoring Team's last visit, including any evidence of implementation of plan, progress logs, etc.; ○ For those undergoing Total Intravenous Anesthesia (TIVA), any incident of injury in 24 hours following TIVA administration in prior six months; ○ For those with documented pneumonia, for each individual, date pneumonia documented, date of the most recent dental visit prior to the pneumonia, type of procedure/visit completed, and type of anesthesia (i.e., TIVA, oral, local, none, etc.) in past six months; ○ For the self-assessment process: list of monitoring/audit tools used; for each tool, identification of the total number of the eligible population to be sampled, the number of the sample, clarification of how the sample was chosen, the frequency of data collection, the staff that completed the audit/monitor survey/review, and whether any inter-rater reliability data was obtained/analyzed for the audit/monitoring review; ○ For the self-assessment process, a list of the databases utilized (other than audit information), including title of each database/chart/table with date range of each database, and for data collected periodically rather than continuously, the frequency of data collection; ○ Desensitization program (plans and strategies): percent of change in oral hygiene levels; ○ Examples of home oral hygiene assessments; ○ Examples of Habilitation Therapy consult to address sensory issues versus oral hygiene resistance; ○ Roster of new employee hygiene training for 12 months; ○ Database information for chair side oral hygiene information for individuals for the last six months; ○ Number of employees required to have refresher training for oral hygiene for DSPs for six months; ○ Copy of power-point presentations: "ABSSLC Intermediate Oral Hygiene Training Part I;" "Intermediate Oral Hygiene Training Part II/vacuum brushing system;" and ○ Presentation Book for Section Q. ▪ **Interviews with**: ○ Jerry Griffin, DDS, Dental Director; and ○ Pam Acevedo, RDH.
	Facility Self-Assessment: For Section Q, 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: ABSSLC Texas Health Monitoring Instrument, dated 11/1/12. ○ This monitoring/audit tool included adequate indicators to allow the Facility to determine compliance with most areas of the Settlement Agreement. Some areas needed additional indicators. 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 adequate methodologies, such as active record reviews, and dental records review. o The Self-Assessment identified the sample size, including 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). This sample size was adequate to consider them representative samples. o The following staff/positions were responsible for completing the audit tools: Dentists and the QA Department monitor. o Adequate inter-rater reliability had been established between the various Facility staff responsible for the completion of the tools. ▪ 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 the databases was noted to be complete and accurate. ▪ The Facility consistently presented data in a meaningful/useful way. Specifically, the Facility's Self-Assessment: o Presented findings consistently based on specific, measurable indicators. o Consistently measured the quality as well as presence of items. However, there were other areas of quality care that needed development of clinical indicators. ▪ The Facility rated itself as being in substantial compliance with Section Q.1. This was not consistent with the Monitoring Team's findings. ▪ The Facility Self-Assessment provided data on many aspects of dental services. It did not identify specific areas needing improvement, such as issues related to the current dental assessments utilized to create the dental summaries for the ISP process. For this area of need, the Facility Self-Assessment did not provide an analysis of the information. For other areas, such as desensitization, ensuring IDT review of refusals and missed appointments, there was adequate analysis.
	Summary of Monitor's Assessment: The Dental Department continued to improve. Some of the areas of strength included: ▪ Annual dental assessments were completed in a timely manner. ▪ The Dental Department responded rapidly to emergencies. ▪ The dental desensitization/compliance improvement program continued to make a positive impact on dental care of some individuals that would otherwise be resistant or uncooperative. The data collection was occurring, but as discussed below, needed to be more sensitive to changes. A number of dental plans and strategies were in place, but a number of additional individuals had been identified as needing them. Concerns included: ▪ At times, the annual dental summary was based on annual dental assessments that might be outdated. A more recent exam would assure the IDT had access to current information. ▪ The annual dental summary appeared to not include some important areas of oral health.

	▪ With the challenge of sustaining good and fair oral hygiene rating scores, little information was available concerning teaching tooth brushing in the residences to both individuals and staff. ▪ Guidance was needed in developing measurements for the dental desensitization program. The tools currently being used might not be sensitive enough to measure progress. Dental administration might need to assist in this process. ▪ The Dental Department will need ongoing Behavioral Health Services Department/consultant assistance for some challenging individuals with sensory defensiveness. ▪ Additional clinical indicators were needed to measure the quality of dental services.

#	Provision	Assessment of Status	Compliance
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 Dental Assistants (one registered), and two registered Dental Hygienists staffed the Dental Department. Additionally, the Dental Department had an Administrative Assistant. CPR certification was submitted for the Dental Department staff. For six clinical dental staff, six (100%) were current in CPR. <u>Annual Assessments</u> A list of those individuals having annual examination appointments was submitted for the time period from 2010 through October 2, 2013 in a document entitled: "Scheduling annual examinations and recall FY 2013 annual clinical assessment review," undated, but copied 10/2/13. This was reviewed to determine timeliness of annual examination completion. The most recent two dates were taken from the list. The list included names of 384 individuals. Seventeen were new admissions in the past year or were temporarily placed at another State facility. These were removed, because there was no prior annual examination date to determine timeliness. Of the remaining 367 individuals, 367 were listed with prior annual examination dates. Of these 367, 358 had an annual examination date completed within 365 days of the prior annual exam. This was a compliance rate of 98 percent. There were nine overdue annual examinations. It appeared the internal Dental Department goal was to complete the annual dental examination in the month prior to the month in which the most recent examination occurred, or at an 11-month interval (i.e., July 2012 examinations would be followed by a June 2013 examination). It was noted that four individuals did not adhere to that plan and were overdue according to the internal QA process. However, for the Monitoring Team's compliance scoring described above, they were still within 365 days of the prior examination. The Dental Department documented that there was one individual residing at ABSSLC who had not seen a dentist in the prior 365 day time period. This was due to a data entry error. The date of the annual examination was incorrectly entered into the database as October instead of September. The individual was edentulous and without dentures.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Separately, copies of 10 annual dental assessments completed in the 30 days prior to the Monitoring Team's visit, along with the prior year's completed assessments were submitted. For nine out of 10 (90%) of these individuals, an annual dental assessment had been completed within 365 days. Copies of the ten most recent annual dental assessments provided for the ISP process were submitted. The contents of these documents included the following components: ▪ Ten of the 10 (100%) assessments included an entry concerning cooperation, behavioral issues, and need for sedation/restraint use. ▪ Ten of the 10 (100%) summaries had entries for oral hygiene rating. ▪ Nine of the nine (100%) submitted summaries for individuals with teeth had entries for periodontal condition/type. ▪ Of those with teeth, a periodontal chart or periodontal screening/probe record was completed/documented in nine of nine (100%) records. One was edentulous. ▪ Ten of the 10 (100%) summaries had entries for oral cancer screening (i.e., intra-oral exam and extra oral exam screening/soft tissue exam). ▪ Ten of the 10 (100%) summaries documented findings/treatment during the annual visit. ▪ A summary of findings/treatment during other dental visits since the prior annual dental assessment was recorded in zero of 10 (0%) assessments. There was no information about any other dental visits (i.e., number of preventive care visits, emergency visits, fluoride treatment, desensitization visits, etc.) from the summaries submitted. There was no notation of the number of missed appointments or refused appointments since the prior annual dental assessment. ▪ 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%) assessments documented risk rating. ▪ Ten of the 10 (100%) submitted summaries documented community placement recommendations. Additionally, one of the individuals with a desensitization plan indicated: "significant improvement in behavior today without sedation." Even though this was a small sample size, one documented improvement in cooperation due to the desensitization plan in place. <u>New admissions</u> From a document entitled: "Admission tracking worksheet ABSSLC Dental," during the time period from April 11, 2013 through September 5, 2013, 12 individuals were admitted to ABSSLC. Twelve of 12 were offered an initial dental evaluation. Nine of 12 completed the initial dental assessment on the first visit. Three of 12 completed the initial dental assessment in two visits (one had refused the initial visit). Eleven of 12 completed the initial dental assessment within 30 days. One of 12 had an initial visit, but a follow-up visit was required for successful completion of the initial dental assessment beyond the 30-day guideline (62 days following admission). In summary, 12 of 12 had a	

#	Provision	Assessment of Status	Compliance

complete or partial initial dental exam within 30 days (all were seen by the dental office within 30 days). The data submitted indicated the individual who were newly admitted were tracked to completion, offered initial visits within 30 days, and additional follow-up visits occurred in a timely manner to complete the initial dental assessment.

Oral Hygiene

An oral hygiene index was completed on each individual at the time of the annual exam. The most recent oral hygiene scores were submitted for the entire campus, in a document entitled: "ABSSLC Oral Hygiene Values for all 10-2012 to 9-2013 - 12 Months." Due to the numbers of individuals that were edentulous, additional documents were submitted providing the oral hygiene score for those with dentition (document entitled: "ABSSLC Oral Hygiene Values for those with teeth 10-2012 to 9-2013 - 12 Months"), and the oral hygiene score for those that were edentulous (document entitled: "ABSSLC Oral Hygiene Values for Edentulous [sic] 10-2012 to 9-2013 - 12 Months)."

Oral Hygiene Rating	All Campus Number	All Campus Percent	With Dentition Number	With Dentition Percent	Edentulous Number	Edentulous Percent
Good	319	74%	156	59%	152	100%
Fair	81	19%	81	30%	0	0%
Poor	28	7%	28	11%	0	0%
Total	428	100%	265	100%	152	100%

Data was also available for the most recent six months in documents entitled: "ABSSLC Oral Hygiene Values for all 4-2013 to 9-2013 (6 months)," "ABSSLC Oral Hygiene Values for those with teeth 4-2013 to 9-2013 (6 months)," and "ABSSLC Oral Hygiene Values for Edentulous [sic] 4-2013 to 9-2013 (6 months)."

Oral Hygiene Rating	All Campus Number	All Campus Percent	With Dentition Number	With Dentition Percent	Edentulous Number	Edentulous Percent
Good	232	71%	145	61%	84	100%
Fair	54	17%	54	22.5%	0	0
Poor	37*	12%	40*	16.5%	0	0
Total	323	100%	239	100%	84	100%

*This table represents the data the Facility submitted. However, it was evident that if there were 37 out of the entire campus with poor oral hygiene ratings, then those with dentition in that category would not have totaled 40. The reason for the discrepancy was not identified.

Oral Hygiene Training

The Dental Department submitted training documentation for new employees for the prior year. The

#	Provision	Assessment of Status	Compliance

course was entitled: "Basic Oral Hygiene for Direct Care Staff." The Department listings indicated it included new employees from other departments such as campus nursing, occupational therapy, psychology, risk management, etc. Trainings per month included the following numbers of new employees:

Month	Number of New Employees Trained	Month	Number of New Employees Trained
September 2012	23	April 2013	46
October 2012	44	May 2013	57
November 2012	67	June 2013	49
December 2012	49	July 2013	36
January 2013	0	August 2013	47
February 2013	59	September 2013	46
March 2013	47	October 2013	63
Total	633		

As mentioned, this total of 633 was for several departments. It was noted that the Dental Department Manual that all direct support professionals were offered the course "Intermediate Oral Hygiene training." The reason for the discrepancy in the new employee course title and the Dental Department manual was not indicated, or if these were two different trainings offered at different times in a direct support employee's tenure at the Facility. A copy of the PowerPoint presentation used by the Dental Department for "Intermediate oral hygiene training Part I, and Intermediate oral hygiene training Part 2 (Vacuum brushing system)" was submitted.

The Dental Department provided information from the Facility Competency Training Department, which provided the number of staff trained in oral hygiene in the past year. This included the new employees that were direct support professionals and were a percentage of the 633 completing new employee orientation training. The annual refresher course was entitled: "Basic Oral Hygiene and Vacuum Tooth brushing Care and Use." There were 606 direct support professionals that completed new employee training or annual refresher training. There were 624 staff classified as direct support professionals. This was a training completion rate of 97 percent. A document entitled "Campus Training Percentages" was updated weekly.

When individuals received oral hygiene instruction during a dental office visit, this was recorded in a dental database. The following table lists the information from this database for the number of individuals receiving oral hygiene instruction per month:

Month	Number of individuals receiving oral hygiene instruction	Month	Number of individuals receiving oral hygiene instruction

#	Provision	Assessment of Status	Compliance

April 2013	113	August 2013	77
May 2013	94	September 2013	80
June 2013	74	October 2013	83
July 2013	107	Total OHI	628

At this time, there did not appear to be a program of tooth brushing training of employees or individuals in the residences. For individuals with oral hygiene scores that were poor, training in the residence might be an alternative approach for improving oral health. Further, periodic monitoring of tooth brushing techniques by employees responsible for assisting individuals would ensure adequate oral hygiene is being provided in the residences.

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 of aspiration, history of aspiration, risk of silent aspiration, unable to manage thin liquids safely, unable to spit, and unable to brush independently. A list submitted indicated 149 individuals received suction tooth brushing, which was 149 out of 380 (39%) of the population.

According to a submitted document entitled: "Those identified as needing vacuum tooth brushing and waiting for vacuum tooth brushing equipment or supplies as of 10/2/13," no additional individuals were identified as qualifying for suction tooth brushing.

Individuals with self brushing plans

Sixty-two individuals had care plans/ISPs that included brushing one's own teeth. The oral hygiene scores of 56 individuals were submitted for the prior two ratings completed at the time of the annual exam. For six individuals, only one rating was submitted (i.e., individuals that were new admission, etc.).

Thirty-four remained in the same category of oral hygiene rating. There were 22 that maintained a good oral hygiene rating. For nine, the individuals maintained a fair oral hygiene rating. For three, the individuals continued to have poor oral hygiene ratings. For these three individuals, it was not determined whether the IDT and/or the Dental Department had implemented a plan of improvement, with evidence of steps taken. One or more might have had an IDT meeting and ISPA if there was a component of refusal to comply with a dental visit, but there was no information whether these individuals were tracked specifically for poor oral hygiene.

- For eight individuals that brushed their own teeth, there was improvement in the oral hygiene ratings.
  - For two individuals the ratings improved from poor to fair.

#	Provision	Assessment of Status	Compliance
		○ For five individual the ratings improved from fair to good. ○ For one individual, the rating improved from poor to good. ▪ For 14 individuals, the oral hygiene ratings worsened ○ For six individuals, the rating changed from good to poor. ○ For three individuals, the ratings changed from good to fair. ○ For five individuals, the ratings changed from fair to poor. For these 14 individuals, it was not determined whether the IDT and/or Dental Department had implemented a plan of improvement, with evidence of steps taken. One or more might have had an IDT meeting and ISPA if there was a component of refusal to comply with a dental visit, but there was no information whether these individuals were tracked specifically for poor oral hygiene. <u>Flossing</u> From a document entitled: "List of those individuals that floss their own teeth," the Dental Department listed zero individuals that flossed their own teeth. There were four individuals with skill acquisition plans in place for flossing or the use of a proxy brush system. One of these individuals also had a tooth brushing skill acquisition plan. One additional individual had a written skill acquisition plan for a proxy brush system, but the Dental Department had not yet determined the appropriate size of the proxy brush. Separately, a document was submitted entitled: "Self Brushers who are not flossing with reason and skill acquisition plan," undated. This listed 27 individuals with a tooth brushing SAP and 12 individuals with a flossing SAP. Two of those with a flossing SAP moved to the community. For the additional five individuals remaining at ABSSLC identified on this list (i.e., in addition to the list previously discussed that had a total of five individuals), the documentation indicated that three needed further improvement of self-brushing prior to moving to a proxy SAP or a floss SAP, and two had a prescription for a flossing SAP (it appeared training had not begun for these two individuals, but further information was not provided). 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. Reasons provided included: behavioral, brushing skills needed to improve first, dexterity problems, refusal, length of time to floss would frustrate, essential tremors, skill difficulty for flossing, in process of assessment of new admission, frustration with skill, and oral self-injurious behavior. Separately a list was provided entitled: "Self brushers who are not flossing with reason and skill acquisition plan: Proxy brush Potential." This listed the current status of these individuals, some of whom appeared to use a proxy brush and some had reasons listed for not using a proxy brush by listing the current status of this potential: brushing first- then decide, stay with brushing SAP, continue with brushing SAP, leaving at brushing SAP for now (seven); possibly self/staff assist, self if wants to, self/some assistance (27); safety issue/concern (one); if unsuccessful with floss (four); staff	

#	Provision	Assessment of Status	Compliance
		assist only, full assist due to tremors, full staff due to behaviors, staff assist or full assist, fully staff (16); do Waterpik instead (one); further assessing needed (four), and off campus (two). A document was submitted entitled: "Dates of floss training per each individual April 1, 2013 - September 30, 2013." From this document, in the prior six months, there was training of 112 individuals in flossing their own teeth. This was likely completed during a dental visit. Dates of training were provided. One hundred twelve individuals completed one floss training session, 25 individuals completed two floss training sessions, four individuals completed three floss training sessions, and one individual completed five floss training sessions. Flossing requires training and skill development with identification of several steps in the process. The Facility appeared to be making progress in determining the eligible population, and providing a step-wise approach in skill development. Providing data focused on the number of those screened for flossing skill acquisition, the number that were eligible for training, the number currently in a teaching/training program for flossing specifically (separate from tooth brushing), and the number of steps completed in that program would provide clarity of the impact of such training. <u>Pneumonia</u> The Facility submitted a list of those with a diagnosis of pneumonia from 4/7/13 through 9/9/13, along with the date of the dental appointment prior to the pneumonia, and the procedure completed during that appointment. Of a list of 13 individuals that had pneumonia, one individual had a dental appointment within eight days prior to the date of the pneumonia diagnosis. The procedure type was a recall prophylaxis in which no anesthesia was given. The individual was diagnosed with pneumonia the same day. That the individual did not utilize anesthesia, and developed pneumonia several days following a non-invasive procedure suggested the development of pneumonia was independent of the dental procedure. For such cases in which pneumonia occurs within a few days of a dental visit, a QA review is recommended to determine date of onset of symptoms, whether the individual was well at the time of the dental visit, whether vital signs were recorded according to policy/procedure, the dental equipment was in working condition, the documentation was complete, etc. Such a process would assist in identifying concerns, if any, related to the dental supports. It is also recommended that the Dental Department create a dental policy to determine when a review should be considered for pneumonias post-dental visit (e.g., the time period following a dental visit, etc.), the template to be utilized, the auditor appointed to complete the review (e.g., QA, dental, etc.), and the follow-up analysis and report. <u>Preventive, Restorative, Emergency Dental Services</u> The Dental Department provided the breadth of services required to care for the individuals at ABSSLC. From April 1, 2013 through September 30, 2013, 600 individuals (duplicate count) were seen for prophylactic care. From a document entitled: "Clinical Summary Preventative Procedures," 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	

#	Provision	Assessment of Status	Compliance

per month of the number of prophylactic care treatments completed:

Month	Number of Preventive Care Treatments
April 2013	121
May 2013	105
June 2013	88
July 2013	120
August 2013	83
September 2013	83
Total	600

According to a submitted document entitled: "Clinical Summary Data Restorative by name" (dated October 1, 2013), 26 individuals underwent restorative care during 28 appointments. The following was the number of restorations completed at each visit, along with the number of visits in which this occurred:

Number of Restorations Per Visit	Number of Visits
1	15
2	2
3	7
4	1
9	1
13	1
14	1
Total: 80	28

The following were the number of visits per month for restorations, and the total number of restorations completed per month:

Month	Number of Visits	Number of Restorations Per Visit	Total Number of Restorations Per Month
April 2013	3	3 to 9	15
May 2013	6	1 to 4	10
June 2013	5	1 to 14	22
July 2013	7	1 to 13	25
August 2013	7	1 to 2	8
September 2013	0	0	0

#	Provision	Assessment of Status	Compliance

The Dental Department submitted monthly documents entitled: "Dental Emergency Log" for the months of April through September 2013. The following information was derived from the data provided in these monthly reports:

Month	Number of Emergencies	Resolved	Month	Number of Emergencies	Resolved
April 2013	11	10	July 2013	8	6
May 2013	4	4	Aug 2013	9	7
June 2013	6	6	Sept 2013	5	5
Total	**21**	**20**		**22**	**18**

For the three cases in which closure was not documented, additional information indicated follow-up visits had been scheduled.

The following data was obtained from a document entitled: "Clinical Summary Data Extractions by Name:"

Month 2013	Number of Visits with Extractions	One Tooth Extracted	Two Teeth Extracted	Three Teeth Extracted	Four Teeth Extracted	>Four Teeth Extracted
April	5	3	1	0	0	1
May	6	3	0	0	1	2
June	4	3	0	1	0	0
July	7	1	1	1	1	3
August	4	1	1	1	0	1
September	4	1	1	1	1	0
Total	**30**	**12**	**4**	**4**	**3**	**7**

For the seven visits with greater than four extractions, the number of extractions ranged from five to 15. A total of 25 individuals underwent extractions. One individual had five visits, with extraction of one tooth at each visit. One other individual had two visits, with one tooth extracted at each visit. One individual had five visits for 16 extractions. Four of the twenty-five individuals had been admitted to the Facility within a year of the extractions. There were several individuals, however, that had resided at ABSSLC for greater than this time period that had multiple extractions. Given the availability of dental services, it was not identified the reason for the multiple extractions. It is recommended that the Dental Department track and analyze the cause for dental extractions (e.g., new admissions, trauma, etc.) to assist in determining common causes for which preventive strategies could potentially be developed.

From a document entitled: "Clinical Summary Data Annual Exam," dated 10/1/13, and 209

#	Provision	Assessment of Status	Compliance
		individuals completed an annual dental exam from April through September 2013. These annual exams were done as the only procedure, or were completed in combination with prophylactic treatment, x-rays, consultations, etc. Although the document included a column "procedures completed," there were seven appointments listed which did not lead to a completed annual exam (i.e., refused, ill, conflict in schedule, etc.). These were removed prior to further review. The following number of annual exams were completed per month:	

Month 2013	Number of Completed Annual Exams	Month 2013	Number of Completed Annual Exams
April	38	July	41
May	37	August	25
June	30	September	38
Total	105		104
Grand Total	**209**		

X-rays

The Dental Department provided a clinical rationale for the Dental Department obtaining dental radiographs. The Dental Department confirmed that every individual with dentition at ABSSLC had a left and right oblique radiograph within the past 18 months. Additionally, peri-apical films were obtained on specific teeth depending on cooperation and need. The Dental Department had a new digital medical x-ray system installed and operational, which provided "exceptional accuracy and diagnostic clarity" to the extra oral oblique radiographs.

The Dental Department provided a list of risks in attempting to obtain intraoral radiographs. The list included: movement during the placement of the film and exposure to the x-ray would require "enormous clinical" time to obtain, and at times, requiring oral sedation or general anesthesia; the placement of the intra-oral film may cause gagging and choking; the placement of the intra-oral films reduced the cooperation of the individual, even for those who were usually cooperative; the placement of intra-oral film increased the oral fluids produced and increased risk for aspiration; placement of intra-oral films increased risk of injury to the individual and staff when there were sudden unexpected movements; sequelae potentially would include swallowed dental film, aspirated dental film, broken film holders and lacerations from these holders; and using the extra-oral approach avoided these risks, and the new equipment provided the clarity needed. The radiographic approach used at ABSSLC appeared to meet the needs of the individuals' dental care.

Additionally, nine individuals completed the equivalent of full mouth x-ray series under general anesthesia through local community services (i.e., oral surgeon office or hospital).

The Dental Department indicated that all individuals were current with dental radiographs and there

#	Provision	Assessment of Status	Compliance
		were none that needed updated films. Edentulous individuals/dentures Information submitted in a document entitled: "ABSSLC Individuals without Teeth," dated 10/1/13) indicated 147 individuals residing at ABSSLC were edentulous, for a rate of 147 out of 380 (39%). One individual became edentulous in 2012. Three became edentulous since January 1, 2013. The Dental Department provided information for each individual without teeth. From this information, the following was tabulated: ▪ Fifteen individuals were admitted edentulous. ▪ Five individuals became edentulous prior to 1980. ▪ Five individuals became edentulous from 1980 through 1989. ▪ Twenty-four individuals became edentulous from 1990 through 1999. ▪ Sixty-four individuals became edentulous from 2000 through 2005. ▪ Thirty individuals became edentulous from 2006 through 2010. ▪ Four individuals became edentulous from 2011 through October 1, 2013. Eleven of 152 individuals that were edentulous had dentures. Ten of the 11 had full dentures and one of the 11 had partial dentures. One hundred forty-one individuals that were edentulous did not have dentures. Reasons given were: ▪ Six inadequate cooperation for denture fabrication to be completed; ▪ One hundred eight complex oral anatomy; ▪ Twelve inadequate muscle coordination, uncontrolled muscle movements, or excessive gag reflex; ▪ Fifty-three refused dentures when offered; ▪ Two prior poor dental experience; ▪ One recent extraction; and ▪ Zero undergoing dental procedures that might lead to dentures in the future. Some individuals had more than one reason listed for not having dentures. Oral Sedation Monitoring and evaluation of use of oral sedation was reviewed. Five active records were submitted for individuals who underwent oral sedation. The following summarizes the results of this review: ▪ Five out of the five (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. ▪ Five of five (100%) listed the medication administered, the dose, and the route. ▪ Five of five (100%) listed pre-treatment sedation vital signs in the home. ▪ Five of five (100%) had an examination note/operative IPN/dental progress note (DPN) on the date of the visit. ▪ Four of four (100%) documented pre-procedure vital signs at the dental office. For one	

#	Provision	Assessment of Status	Compliance

individual, the sedation was not effective and the individuals did not go to the dental office.

- Four of four (100%) documented intra-procedure vital signs or attempts at vital signs.
- Five of five (100%) documented post-treatment sedation vital signs.
- Adequate documentation regarding effectiveness of sedation was found in five of the five (100%) of the active records.
- Zero of five (0%) included documentation of a Dental Department follow-up (phone or visit) the next business day.
- Zero of five (0%) included documentation of current sedation consent from guardian/LAR.
- Zero of five (0%) included documentation of HRC review and approval.
- Five of five (100%) included a restraint checklist.

General Anesthesia/TIVA

The Dental Department submitted the general anesthesia appointment schedule for the time period April 2013 through September 2013. The number of appointments utilizing general anesthesia/TIVA completed per month follow:

Month 2013	Number of Scheduled Visits With General Anesthesia	Number of Completed Visits with General Anesthesia	Number of Scheduled Visits with General Anesthesia Not Completed	For Missed Appointments, Follow-Up Indicates Closure
April	7	5	2*	0*
May	7	7	0	0
June	8	7	1	1
July	6	6	0	0
August	7	5	2**	1**
September	8	8	0	0
Total	**43**	**38**	**5**	**2**

*For these two missed appointments, there was no indication of a follow-up general anesthesia appointment through October 2013 at ABSSLC or through the community oral surgeon service.
**The two appointments that were cancelled were rescheduled. Follow-up indicated one remained incomplete.

The active record was submitted for five individuals who had undergone general anesthesia/TIVA from 8/9/13 through 9/17/13. One individual underwent two dental procedures under general anesthesia. 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: extractions, x-rays, and restorations. Review of these records revealed the following:

- Consent by the guardian/LAR for the dental procedures/anesthesia was current (defined as

#	Provision	Assessment of Status	Compliance
		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. ▪ A pre-operative anesthesia record/clearance by anesthesia was completed and submitted in five of six (83%). A blank form was submitted in one of six. ▪ Pre-operative vital signs were recorded in four of six (67%) cases. In one of six, there appeared to be vital signs, but the entry was illegible or poorly copied. For one individual, documents including pre-operative vital signs were not submitted either from the home or during the dental visit. ▪ 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, Aldrete Score, or other equivalent assessment was submitted in six of six (100%) of the active records. ▪ A Dental Department recovery note was submitted for six of six (100%). ▪ A post-operative vital sign flow sheet was submitted in six of six (100%). ▪ Pain medication was prescribed in five of five (100%) cases in which extractions or dental surgical procedures occurred. ▪ An annual dental assessment was completed while under general anesthesia/TIVA in zero of six cases. The Dental Department reviewed 43 records and found there were no injuries for the two days following a dental procedure using gas anesthesia for any individual. It was not determined if the number 43 referred to 43 procedures or 43 individuals. <u>Extractions</u> For five individuals that underwent extractions on campus, the dental record was submitted. The following findings were made: ▪ From the submitted documentation, guardian/LAR consent was current in five of five (100%). ▪ A dental IPN/DPN indicating the need for extractions was documented in five of five (100%), either completed pre-operatively or at the time of exam under general anesthesia/TIVA. ▪ For five of the five cases, IV sedation/general anesthesia was used. ▪ From one to four teeth were extracted at a visit. This is informational only, ▪ Post-operative pain medication was provided in five of five (100%) cases. ▪ A follow-up dental note the following business day/morning in the Infirmary or a phone call to the residence (when not admitted overnight to the Infirmary) was documented in two of five (40%) cases. ▪ A follow-up exam was documented in five of five (100%) cases to determine healing or complications.	

#	Provision	Assessment of Status	Compliance
		Oral surgery consultation For five individuals that underwent oral surgery consultation, the dental record was submitted. The following findings were made: ▪ Reasons for consultation included: second opinion of impacted tooth, trauma with injury to oral cavity, review of radiographs, and extraction followed by slow healing. ▪ Zero of the five had prior refusals for dental appointments or unsuccessfully completed appointments. ▪ Five of five (100%) had completed IPN/DPNs in the record prior to referral to the oral surgeon indicating the need for the procedure. ▪ Five of five included a copy of the consultation note. ▪ Of the five consultations, there was one for which an oral surgery procedure was completed. ▪ One of one (100%) had a post procedure note by an ABSSLC Dentist at the Facility. Emergency Treatment Emergency treatment was reviewed for five individuals. The reasons for the emergency were as follows: swelling and redness of cheek, change in behavior (i.e., not eating), bleeding from mouth, and mouth ulcer. The following findings are made based on this review: ▪ Four of five records (80%) documented the presence or not of pain. ▪ Pain was treated in three of three (100%) cases demonstrating pain or for discomfort. ▪ Follow-up occurred for four of four (100%) individuals in which follow-up was indicated. ▪ There was documentation of closure of the dental emergency (either no further visit required or scheduled for procedure) in five of five (100%) cases. ▪ Length of time from when the complaint was first documented to the dental office visit could be determined in zero of five (0%) cases. It is recommended that the time of the initial complaint in the residence be recorded in the DPN, as well as the time of the dental visit to determine the response time by the Dental Department as an internal QA indicator. It is recommended that more clarity be consistently provided in the emergency DPN entries to include the reason for the emergency visit, whether the individual was noted or complained of pain, specifically whether the dentist elicited pain on exam, and whether/when the case was determined to be closed. The current brief narrative format at times was not as clear in providing this information. As the Dental Department strives towards substantial compliance with this subsection, 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 dental summaries should include a description of dental care over the previous year. ▪ At this time, there did not appear to be a program of tooth brushing training of employees or individuals in the residences. Although not a requirement for compliance, this should be considered, particularly for individuals with poor or fair oral hygiene.	

#	Provision	Assessment of Status	Compliance
		▪ For those that have a self tooth-brushing plan and have 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, and tracking progress through serial measurements of oral hygiene ratings. ▪ Identifying individuals who could floss and teaching individuals to floss their own teeth, with data that reflected results of flossing programs, was an area in which work remained. ▪ Several components of the oral sedation process and related documentation needed improvement. ▪ Documentation related to follow-up for extractions needed improvement. ▪ For dental emergencies, the Dental Department should clearly identify whether pain is present or not during the emergency examination.	
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,	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 interdisciplinary teams, 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> Policies developed and implemented since the last Monitoring Team visit included the following: The Dental Services Manual, "ABSSLC Dental Policy and Procedures," was reviewed and revised 9/24/13. The manual appeared to reflect the breadth of dental services. Additional policies are recommended for review of the dental visit record when a diagnosis of pneumonia occurs within a specified number of days of the visit, and a policy for steps to be taken when oral hygiene index ratings worsen for individuals. <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 records. This was used to assist in determining whether the IDTs received adequate/complete dental information for the individuals. Copies of relevant dental documents were submitted for 22 individuals. This totaled 183 documents. For the 183 documents submitted for review, 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 183 of 183 (100%) submitted documents, with one clerical submission discrepancy. For one of the documents submitted from the dental office, one page of a four-page document was missing, but the remainder of the document was consistent with the active record. Copies of the ten most recent annual dental summaries provided for the ISP process were submitted. The contents of these documents included the following components:	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	▪ Ten of the 10 (100%) summaries had an entry concerning cooperation, behavioral issues, and need for sedation/restraint use. ▪ Ten of the 10 (100%) summaries had entries for oral hygiene rating. ▪ Six of the six (100%) summaries for individuals with teeth had entries for periodontal condition/type. ▪ Of those with teeth, a periodontal chart or periodontal screening/probe record was completed/documented in six of six (100%) records. ▪ Four were edentulous. ▪ Zero of the 10 (0%) summaries had entries for oral cancer screening (i.e., intra-oral exam and extra oral exam screening)/soft tissue exam. ▪ Ten of the 10 (100%) summaries documented findings/treatment during the annual visit. ▪ A complete summary of findings/treatment during other dental visits could not be found in all summaries. There was documentation of other dental treatments/emergency visits in the prior year, with dates of service. There was notation of the number of missed appointments. There was no information about any other dental visits (i.e., preventive care, fluoride treatment, desensitization visits, etc.) in the summaries submitted. ▪ Ten of the 10 (100%) submitted summaries included a dental treatment plan, although it was not separately listed and did not include any information about preventive care treatments. All listed a follow-up appointment time, but at times this was only listed as part of the community placement information. A specific list of components under a dental treatment plan heading would assist the reader in understanding the needs of the individual in the future. ▪ Ten of the 10 (100%) submitted summaries documented oral hygiene recommendations. ▪ Zero of the 10 (0%) submitted summaries documented risk rating. ▪ Ten of the 10 (100%) submitted summaries documented community transition preparedness. Additionally, the following observations were noted. Of concern, the date of the annual dental exam appeared to be several months prior to the ISP meeting. The request was for a copy of the ten most recent summaries provided for the ISP. The dates of the actual exam varied up to one-year prior. If this was accurate, then the IDTs were basing decisions on outdated information. It is recommended that the annual dental exam be aligned in a timelier manner with the ISP to the team has the benefit of a current dental status when reviewing the needs of the individual. Additionally, the annual dental summary did not comment on an oral cancer screening (i.e., intra-oral or extra-oral), and did not list the actual risk rating for the IRRF as determined by the dentist to guide the IDT. For those with dentition, it is recommended that a statement include the trend of the oral hygiene: stable, worsening, or improving. A similar review of trend for periodontal type and probing would be	

#	Provision	Assessment of Status	Compliance
		valuable in guiding the team to determine whether adequate supports were in place for dental care. Refusals/Missed Appointments A review of information from a document entitled: "Absence Tracking Refusals for ABSSLC Dental Refusals" (document scan date of 10/2/13) for dental appointments for the prior six months indicated that 23 appointments were refused from April 1, 2013 through September 30, 2013. Twenty individuals refused 21 initial appointments and two follow-up visits, for a total of 23 refused appointments. Of the initial 21 follow-up appointments, 18 were subsequently completed. Three follow-up appointments for these individuals were still pending/remained incomplete as of the document scan date of 10/2/13. Up until 10/2/13, the range of days pending was from eight to 50 days. Two individuals refused more than one appointment. Reasons for the scheduled appointments that were refused included: recall prophylaxis with fluoride treatment (six appointments), recall monthly for prophylaxis with fluoride treatment (three appointments), recall every three months for prophylaxis with fluoride treatment (five appointments), annual exam (one appointment), annual exam with prophylaxis and fluoride treatment with x-rays (three appointments), admission exam (one appointment), x-ray films (one appointment), consult (one appointment), restoration (one appointment), and follow-up of oral surgery (one appointment). The individuals that refused appointments were from 14 residences, and one residence accounted for four refusals.	

Month 2013	Number of Refused Appointments	Number of Follow-Up Appointments Completed for Refused Appointments	Number of Follow-Up Appointments Pending for Refused Appointments
April	7	7	0
May	6	6	0
June	3	3	0
July	2	2	0
August	3	1	2
September	2	1	1
Total	**23**	**20**	**3**

For the 23 appointments that were refused, a follow-up appointment was completed in 20 cases.

- For 11 individuals, the completed appointments occurred from one to five days after the refused appointment.
- For three individuals, the completed appointments occurred from six to 10 days after the refused appointment.
- For three individuals, the completed appointments occurred from 11 to 15 days after the

#	Provision	Assessment of Status	Compliance
		refused appointment. ▪ For one individual, the completed appointments occurred from 16 to 30 days after the refused appointment. ▪ For one individual, the completed appointment occurred from 31 to 60 days after the refused appointment. ▪ For one individual, the completed appointment occurred more than 60 days after the refused appointment. ▪ Three individuals had a refused appointment for which a completed appointment had not yet occurred by the time of the printing of the document. For the time period April 1, 2013 through September 30, 2013, there were 15 missed/no show appointments, which were not categorized as refusals. Reasons for the scheduled appointments that were missed included recall monthly prophylaxis and topical fluoride (five appointments), recall every three months for dental prophylaxis and topical fluoride (three appointments), preventive treatment not otherwise specified (two appointments), annual exam with dental prophylaxis and topical fluoride and x-rays (two appointments), annual exam and dental prophylaxis and topical fluoride (one appointment), follow-up/bitewing x-rays (one appointment), and training in proxy brush use (one appointment). The missed/no show appointments occurred for individuals living in eight residences. One residence had five missed/no show appointments. The major reasons identified for missed appointments included: schedule conflict (nine), not scheduled on the calendar (five), and medical illness of the individual (one). **Month 2013** / **Number of Missed Appointments (Non-Refusals)** / **Number of Follow-Up Appointments Completed for Initial Missed Appointments** April: 0 / 0 May: 3 / 3 June: 8 / 8 July: 2 / 2 August: 0 / 0 September: 2 / 2 **Total: 15 / 15** For the 15 appointments that were missed, a follow-up appointment was documented in 15 cases. ▪ For seven individuals, the completed appointments occurred from one to five days after the initial missed appointment. ▪ For five individuals, the completed appointments occurred from six to 10 days after the initial missed appointment. ▪ For two individuals, the completed appointments occurred from 11 to 15 days after the initial missed appointment.	

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For zero individuals, the completed appointments occurred from 16 to 30 days after the initial missed appointment.
For one individual, the completed appointment occurred from 31 to 60 days after the initial missed appointment.

The Dental Department submitted information concerning whether the refused/no refusal missed appointments were followed by an IDT meeting with an ISPA created to address the no show appointment.

For 26 individuals that missed appointments, one or more ISPA was submitted addressing steps to prevent a recurrence of a missed appointment for 25 of the 26.
For one individual, the dental follow-up occurred prior to the IDT meeting and resolved the missed/refused appointment
For 12 of the 26, there was documentation of Dental Department attendance. For the remaining ISPAs, the documentation was not clear whether a Dental Department staff attended. Attendance rosters were not always included. One way to resolve this would be for the ISPA narrative to state when the Dental Department member attends.

Additionally, there were four individuals for whom an ISPA was not submitted, and was not located, but an IDT meeting was held.
Minutes of the 10/7/13 QA/QI Council documented the Dental Director had revised the corrective action plan to reduce missed appointments to reflect the recommendation from the State Dental Coordinator. A five-step process was reviewed, including: 1) the attendance tracking date was to be reviewed monthly, with findings provided to the Unit Directors; 2) all refusals were to be reviewed monthly with the QIDP and IDT, with an ISPA created to resolve the refusals; 3) on a quarterly basis, all missed appointments, that were not refusals, were to be reviewed with the QIDP, with development of an ISPA; 4) the Dental Department was to track progress and follow-up with the QIDP concerning effectiveness of the ISPA in reducing refusals; and 5) a quarterly report of dental attendance was to be presented to the morning medical meeting as well as the QA/QI Council.
From an untitled document, which listed three years of monthly data for missed appointments, completed appointments, and total appointments, the following information was obtained:
<table>
<tr><th>Month 2013</th><th>Percent Attendance of All Appointments (Completed Number/Total Number Appointments)</th><th>Month 2013</th><th>Percent Attendance of All Appointments (Completed Number/Total Number Appointments)</th></tr>
<tr><td>April</td><td>242/249=97%</td><td>July</td><td>247/251=98%</td></tr>
<tr><td>May</td><td>260/269=97%</td><td>August</td><td>226/229=99%</td></tr>
<tr><td>June</td><td>178/189=94%</td><td>September</td><td>144/148=97%</td></tr>
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#	Provision	Assessment of Status	Compliance

Total	1297/1335=97%		

Interventions to Minimize the Use of Sedating Medications and/or Restraints
Information was submitted concerning use of restraints for dental procedures. For the prior six months (April through September), there were 1297 completed appointments. The dental office did not use mechanical restraints. Six of 1297 (0.5%) of completed appointments utilized oral sedation. Per month, the percentage of dental appointments utilizing oral sedation ranged from 0.0 percent to 0.8 percent. Thirty-nine of 1297 (3%) completed appointments utilized general anesthesia (GA)/TIVA. Per month, the percentage of dental appointments utilizing general anesthesia ranged from two percent to six percent. The following provides this information per month:

Month 2013	Completed Appointments	Number of Appointments with GA	Percent Appointments with GA	Number of Appointments With Oral Sedation	Percent Appointments with Oral Sedation
April	242	5	2%	1	0.4%
May	260	6	2%	2	0.8%
June	178	7	4%	1	0.6%
July	247	6	2%	1	0.4%
August	226	7	3 %	1	0.4%
September	144	8	6%	0	0.0%
Total	**1297**	**39**		**6**	

Separately, a list of HRC-approved dental and medical restraints was submitted for the prior six months. Eleven individuals were approved for a medical restraint plan for dental procedures/care. Dates of the plans were 2/7/13 to 7/25/13. Dates of HRC approval ranged from 3/26/13 to 8/21/13. One individual was approved for a physical restraint only, four individuals were approved for a physical and chemical restraint, one individual was approved for a chemical restraint only, and five individuals were approved for a physical restraint, chemical restraint, and mechanical restraint. In summary, 10 of 11 were approved for a physical restraint, 10 of 11 were approved for a chemical restraint, and five were approved for a mechanical restraint.

The Dental Department submitted a "Dental Restraint and Sedation Log by Person." This dated back for approximately five years. For each chemical restraint administered, information included the date of administration, whether a physical or mechanical restraint was also used, the name of the medication, the dosage, the route of administration, the effectiveness, the reason for use, and the dental procedure during that visit.

Desensitization
A document entitled "Summary of Desensitization Programs as of October 1, 2013," was submitted

#	Provision	Assessment of Status	Compliance
		providing current information concerning desensitization and other behavioral programs to improve individuals' cooperation and compliance with dental visits. ▪ Seventy-five individuals had been identified as requiring a desensitization or other plan to reduce the need for restraint. ▪ Eleven of the 75 had assessments and were awaiting the next step in the desensitization plan process. ▪ Thirteen of the 75 had moved, and it was unclear why they had not been removed from the list. ▪ Five of the 75 (7%) had plans that were discontinued due to success. ▪ Seven of the 75 had plans that were discontinued due to failure or regression. ▪ Four of the 75 had other reasons for declining participation (i.e., edentulous condition, death, guardian refusal). ▪ Thirty-nine of 75 (52%) had formal plans (both active and inactive plans). ▪ Nineteen of 75 (25%) had formal active plans. ▪ Eleven of 75 had residential strategies, 10 of 11 of these were active residential strategies and one was considered non-active. ▪ Sixteen of 75 had office strategies. Thirteen of 16 of these were active office strategies and three were considered non-active. ▪ Nineteen of 75 had desensitization or strategy plans with revisions for both active and inactive plans of formal desensitization plans, residential strategies, and office strategies. ▪ From a submitted document entitled "OHI [Oral Hygiene Index]/Tissue Comparison Between Start Date and Current Period (April 1, 2013 thru October 1, 2013)," oral hygiene scores were compared prior to the implementation of the plan and the most recent period. For 14 of 75, there was no change in oral hygiene ratings. For 17 of 75, the oral hygiene rating showed a worsening trend. For 15 of 75, there was improvement. For 29 of 75, there was only one reading, indicating comparison could not occur. Of note, the scores were for all 75 individuals on the list for desensitization or strategy plans. However, only 19 (25%) had formal active plans. It is recommended that tracking of progress be done for those with active plans and active strategies (i.e., residence and office), as one would not expect a change for those for whom a plan or strategy had not been implemented. ▪ From this same document, level of gingivitis and periodontitis was recorded. For nine individuals, the level of gingivitis was unchanged. For four individuals, the level of gingivitis had worsened. For one individual, the gingivitis had improved. For the other 61 of 75 individuals, information was not available. ▪ From this same document, the degree of periodontitis was recorded. For 11 individuals, the degree of periodontitis was unchanged. For two individuals, the level of periodontitis had worsened. For one individual, the level of periodontitis had improved. For 61 of 75, information was not available. ▪ An updated document was submitted at the time of the Monitoring Team's visit, entitled "% of change in oral hygiene index levels." Data focused on the 42 current plans/strategies that	

#	Provision	Assessment of Status	Compliance
		were active, which was a different number than provided in other documentation. The oral hygiene rating prior to initiation of the plan or strategy was compared to the most recent score for the time period of 4/1/13 through 10/1/13. The summarized information indicated 40 percent improved, 29 percent maintained their starting oral hygiene score, and 31 percent regressed. ▪ Data was provided for each of the individuals for whom there was a formal active desensitization plan. This included a "dental monthly report" for each month since the Monitoring Team's prior visit, a copy of the training objective, data sheet (reflecting the date, time, task analysis step, criteria met, and comments for each dental desensitization encounter), and desensitization procedure data collection narrative notes. ▪ For the 19 with desensitization plans that had been successful, the level of progress at the office was listed (each of six levels had indicators that were measurable). The percentage of steps completed in the formal plans (initial or revised) was documented. ▪ Data was less available for individuals with residential strategies or office strategies. However, a document entitled: "Behaviors of active plans/strategies in regular dental office as of 10/17/13" listed 41 individuals in a format allowing progress to be recorded through the six levels. There were few entries in this document at the time of submission, but the dental staff is encouraged to continue documenting measurable progress. The desensitization program needed to have further review to ensure the measurements were sufficiently sensitive to capture progress. Additionally, desensitization for some individuals with sensory defensiveness needed expertise from psychology (within the Behavioral Health Services Department or consultants) to assist in developing and monitoring a successful desensitization program. Some individuals were being transitioned to the traditional/regular dental office, requiring further adjustments in the plan to reduce anxiety from the individual, because there were more staff, unfamiliar staff, and more/different equipment and noises in the traditional dental office. However, the dental staff in charge of desensitization plans and strategies for improved compliance appeared to have plans in place to be present while a different hygienist gained the trust of the individuals. <u>Quality Assurance/Improvement Initiatives</u> The Dental and QA Department used a monitoring tool entitled: "ABSSLC Texas Health Monitoring Instrument 11/1/2012." Monthly data was submitted from March through August 2013, along with a cumulative summary of results for those months. According to the Facility's data, areas identified as needing improvement/less than 100 percent compliance were identified by the following indicators: ▪ (3) The annual date of dental examination was within 365 days of admission and/or the last annual exam (97% compliance). ▪ (5.g) Dental summary is filed in the active record (99% compliance). ▪ (11.c) Developed strategies to overcome the individual's refusals to participate in dental appointments (88% compliance).	

#	Provision	Assessment of Status	Compliance
		▪ (11.d) Implemented the strategies that were developed (89% compliance). ▪ (13) If the individual uses pre-treatment sedation or restraints, there is a desensitization program and/or strategies to reduce the need for the use of pre-treatment sedation and/or restraints in place (80% compliance). ▪ (14) There is documentation that the desensitization plan and/or strategies to reduce the need for the use of pre-treatment sedation and/or restraints are being implemented (80% compliance). ▪ (16.a) If the individual is at risk for choking or aspiration, there is a Physical Nutritional Support plan addressing safe positioning for dental procedures (98% compliance). ▪ (16.b) If the individual is at risk for choking or aspiration, there is a Physical Nutritional Support plan incorporating safe positioning for dental procedures (98% compliance). The Quality Assurance Department also reviewed a sample of these records. The size of the sample and methodology in choosing the sample was not indicated. Inter-rater reliability ranged from 98 percent to 100 percent per month from March 2013 through August 2013. A Dental Monitoring Data meeting occurred monthly, at which time the Dental Director and the Program Compliance Monitor discussed the audit results and minutes were generated. Meetings occurred on 4/26/13, 5/31/13, 6/28/13, 7/30/13, 9/2/13, and 9/26/13. Specific questions indicating noncompliance were reviewed to determine the reason. Minutes reflected the findings and discussion. Some of the results indicated the need for changes in systems approaches or action plans, but the minutes did not reflect clear steps to resolve areas of noncompliance. As examples, from the 7/30/13 meeting minutes, there was the documentation that: "Dental indicates that it is difficult to interpret dental consults." There was no discussion or action plan created based on this finding. Additionally, from this same meeting, it was identified that the "tracking quarter is for April, May, and June, tracking quarter needs to be the same for both dental and QA. We will talk with the SAC [Settlement Agreement Coordinator] about quarterly designations." There was no follow-up documentation to show how this was resolved, whether a meeting occurred with the Settlement Agreement Coordinator about this, and the outcome. It is recommended that findings from one meeting be tracked until resolution/closure, with documentation in subsequent meeting minutes. Members of the group should be updated on progress related to concerns previously identified. The Dental Department needed to expand quality review beyond the monitoring tool currently used. Although it included numerous aspects of dental services, it did not provide the necessary breadth of measurement of quality and outcomes. Examples of areas that should be expanded to reflect the quality of dental services include clinical indicators for the completeness and adequacy of dental plans, tracking the rate of extractions or tooth loss (for non-traumatic reasons and excluding impacted wisdom teeth) per quarter, the rate of new caries in the quarter, the numbers of individuals	

#	Provision	Assessment of Status	Compliance
		per category of gingivitis/periodontitis (i.e., none, mild, moderate, severe) per quarter, the number of permanent fillings needing restoration/replacement at 12 and 24 months.	

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 Speech Language (SL) assessment for the following three individuals the Facility selected: Individual #162, Individual #334, and Individual #264; 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 Alternative or augmentative communication (AAC) Screening forms; o Speech language comprehensive assessments and updates (templates) used by SLPs along with any changes; o Tracking Log of SL 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; o Minutes for Speech Department meetings held since the Monitoring Team's last review; o List of all general common area communication devices; o Blank communication competency-based performance check-off for individual-specific communication programs; o Completed audits of SLP documentation; and o Behavior Support Committee minutes and attendance sign-in sheets for meetings held since the Monitoring Team's last review. ▪ **Interviews with:** o Bobbie Holden, OTR, Director of Habilitation Therapies; and o Leslie Riggins, SLP Assistant. ▪ **Observations of:** o Individuals in residences and day programs.

	Facility Self-Assessment: Facility Self-Assessment: The Facility submitted a Self-Assessment for Section R, dated 10/21/13. 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. ▪ Based on a review of the Facility Self-Assessment, as well as interview with the Director of HT, the following was found: o The monitoring/audit tool the Facility used to conduct its self-assessment included: Facility-developed audit tools and HT databases. The Director of HT indicated the State Settlement Agreement Monitoring Tool for Section R and/or the Facility-developed monitoring tool for Section R had not been used over the past six months. o The data presented in the Self-Assessment reflected the completion of additional activities and audits, such as tracking completion of SLP assessment spreadsheet, SLP assessment audit tool, and review of ISPs, etc. o The monitoring tool and audits did not include adequate methodologies (e.g., observations, record review, and staff interview), standards, and criteria. o The Self-Assessment identified the sample sizes, including sample sizes adequate to consider them representative. Section R samples were generated utilizing a Random Sample Generator; o The Facility-based audit tools (i.e., SLP assessment audit tool) did not have adequate instructions. o The following staff/positions were responsible for the monitoring tool for Section R: 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. o The Facility used some other relevant data sources, including, for example, the HT Department database(s); New Employee Orientation, veteran staff and annual refresher staff PNM training databases; and data related to ISPs. ▪ 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 not being in compliance with any subsections of Section R. This was consistent with 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 five full-time SLPs and one full-time SLA. The five SLPs were licensed to practice in the state of Texas and were certified by the ASHA. The SLPs had completed continuing education directly related to communication and transferrable to the population served.

	Five of seven newly admitted individuals since the last review received a SL/communication assessment within 30 days of admission or readmission. Review of the Facility-selected sample of three individuals' SLP/communication assessments revealed the Facility had made notable progress as evidenced by 17 of 23 assessment elements being present in each of the assessments reviewed. The Facility's Provision Action Information, Presentation Book, and staff interviews indicated that since the last review, no initiatives had been started for Section R.3 and R.4. However, if implemented, a number of the action steps in the Facility's action plans, should assist in moving the Facility towards substantial compliance.

#	Provision	Assessment of Status	Compliance
R1	Commencing within six months of the Effective Date hereof and with full implementation within 30 months, the Facility shall provide an adequate number of speech language pathologists, or other 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.	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., updates only) for this subsection, because the Facility had made limited progress due to the decision to prioritize other subsections. The noncompliance finding from the last review stands. **Samples for Section R:** ▪ **Sample R.1:** consisted of the following three individuals the Facility selected: Individual #162, Individual #334, and Individual #264. **Updates** The ABSSLC Provision Action Information, updated 10/21/13, reported the following for Section R.1: ▪ 5/6/13 – Previous SLP contractor returned and will stay through October; ▪ 6/17/13 – Experienced lead SLP began in New Employee Orientation; and ▪ 8/1/13 – Assigned caseload considering the various requirements of the job and the acuity of the individuals in relation to SLP needs. The Presentation Book for Section R.1 included an action plan with the following action steps and completion status: ▪ Analyze information from the self-assessment to identify potential causes for the issues and to connect the findings to actions put into place to correct the issues (completion status – in process); ▪ Revise/update SLP policy (completion status - not started); ▪ Revise monitoring/audit tool to include adequate indicators to allow the Facility to determine compliance with the Settlement Agreement (completion status - not started); ▪ Develop adequate instructions for monitoring/audit tool (completion status - not started); and	Noncompliance

#	Provision	Assessment of Status	Compliance
		▪ Designate a therapist to train so that inter-rater reliability will be established between the staff responsible for completing the tool (completion status - not started). These action steps were applicable to Section R. However, some of these action steps were not relevant to reaching compliance with Section R.1. For example, the development of adequate instructions for the monitoring/audit tool would be pertinent to Section R.4. The Facility should review the Monitoring Team's findings in its reports related to the Section R subsections to determine the appropriateness of action steps. 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. **Staffing** The Facility had five full-time SLPs and one Speech Language Assistant (SLA). There were no SLP vacancies. The Facility assigned caseloads based on the requirements of the job and the acuity of the individuals in relation to SLP needs (i.e., AAC systems). The SLP caseloads were: ▪ SLP #1 – 65 individuals. Based on interview, this SLP had a lower caseload, because these individuals had a higher acuity related to identified needs for behavioral health and AAC systems; ▪ SLP #2 – 59 individuals and also PNMT SLP; ▪ SLP #3 – 94 individuals. Individuals on this caseload did not have significant behavioral challenges; ▪ SLP #4 – 96 individuals. The caseload was higher as many of the individuals communicated verbally; and ▪ SLP #5 – 70 individuals. This SLP was employed in June 2013 and assumed the role of Lead SLP. The SLPs had additional responsibilities beyond their caseloads, which included attendance at Modified Barium Swallow Studies and follow-ups, conduct of staff in-services, eating assessments and follow-ups, direct therapy, work order generation, attendance at PNMP clinics and troubleshooting on equipment, and extended PNM duties including meal observations, etc. The SLA was supervised by SLPs and assisted with direct therapy, was the Educational Liaison for ABSSLC for school-aged individuals, and provided assistance with the Plan of Improvement.	

#	Provision	Assessment of Status	Compliance
		Qualifications: ▪ Five of five SLPs were licensed to practice in the state of Texas. ▪ Five of five SLPs had evidence of ASHA certification. **Continuing Education** Six of the six SLPs staff 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: ▪ Normal Aging and Hearing: An Update for SLPs (1/6/13); ▪ Video Technology: Reinventing Pragmatic Therapy (2/2/13); ▪ 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); ▪ A Behavioral Approach to Language and Social Skills Assessment (3/1/13); ▪ Swallow 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); ▪ Equipment Webinar – Mexia SSLC (3/14/13); ▪ Is This Ethical? Use of an Ethical Decision-Making Model to Address Ethical Issues in the Workplace (6/8/13); ▪ AAC and Aphasia (6/8/13); ▪ Professional Ethics in a Changing Professional Landscape (6/8/13); ▪ Siemens Earmolds: Your Connection for Best Sound (6/9/13); ▪ Microtia/Aural Atresis: A Parent's Perspective (6/9/13); ▪ Swallowing Physiology: Understanding Its Relationship to Traditional Swallowing Treatments (6/19/13); ▪ Conquering Pain (7/11/13); ▪ The MBSIMP [Modified Barium Swallow Impairment Profile] and Dysphagia Practice: Target Intervention Through Standardized Physiologic Swallow Assessment (9/28/13 to 9/29/13); and ▪ Habilitation Therapies Conference (10/31/13 to 11/1/13). **Facility Policy** The Facility submitted the following policies: ▪ SSLC Policy: Communication Services, Policy 016, implementation date 10/7/09.	

#	Provision	Assessment of Status	Compliance
		Based on interview and documentation submitted, the Facility had not started the revision of Facility-based SLP/communication policies. The Facility-based SLP/communication policy should include and/or reference the State communication policy and ensure the inclusion of the following elements: ▪ 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 R.4. In summary, the Facility had five SLPs and one SLA. The SLPs were licensed to practice in the state of Texas and provided evidence of current ASHA certification. SLPs had completed continuing education directly related to communication and transferrable to the population served. The Facility SLP policies had not been revised. Upon policy revision and final approval, the Facility should ensure the policy elements identified within this section are included in the Facility's revised policy and/or reference made within the Facility policy to elements contained in the State Communication policy. The Facility remained out of compliance with this subsection.	
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	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., a smaller sample the Facility selected) for this subsection. This was because the Facility had recently implemented a new assessment format and requested feedback on the newest assessments, recognizing that previous assessments needed improvement. The noncompliance finding from the last review stands.	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	**Updates** The ABSSLC Provision Action Information, updated 10/21/13, reported the following for Section R.2: ▪ 9/1/13 – Continuing to utilize assessment audit tool to ensure assessments contain all essential components, including collaboration between the SLP and Psychologist. The Presentation Book for Section R.2 included an action plan with the following action steps and completion status: ▪ Utilize assessment audit tool to ensure assessments contain all essential components, including collaboration between the SLP and Psychologist (completion status – in process); and ▪ Determine a timeline for completion of comprehensive SLP assessments to be completed (completion status – not started). These action steps were relevant to Section R.2, and should assist the Facility in working towards achieving compliance with Section R.2. **Assessment Plan** The Facility Evaluation Master Plan, revised 9/1/13, established the following priority levels for completion of communication assessments: ▪ Priority 1 –individuals with high risk for challenging behaviors, who did not communicate verbally; and ▪ Priority 2 – Everyone else. An Assessment Update of Current Status was to be completed yearly for individuals who were school-aged, if there was a change of communication status, or per HT policies/procedures. Individuals who were newly admitted and/or had a change in status were to be assessed immediately. However, Facility-based policies/procedures had not been completed and approved by the Facility policy review committee. **Communication Assessments Provided** Five of seven (71%) newly admitted individuals (i.e., Individual #298, Individual #336, Individual #354, Individual #455, and Individual #379) received an SLP/communication assessment within 30 days of admission or readmission. Individual #81 and Individual #299's SLP assessments were not completed within 30 days of admission. For individuals newly admitted to the Facility, SLPs completed a comprehensive assessment and not a SLP screening. **Communication Assessment** The Facility Self-Assessment reported 293 of 385 (76%) individuals had a comprehensive SLP assessment.	

#	Provision	Assessment of Status	Compliance
		The three SLP assessments reviewed for the individuals in Sample R.1 were current within the last 12 months. Based on review of the individuals in Sample R.1, the following provides the details of the comprehensiveness of the communication assessments: ▪ Three of three individuals' SL assessments (100%) were signed and dated by the clinician upon completion of the written report; ▪ None of two individuals' SL assessments (0%) (i.e., Individual #162 and Individual #334) were dated as completed at least 10 working days prior to the annual ISP. For the third individual, the Monitoring Team could not determine if Individual #264's SLP/communication assessment was completed 10 days prior to the annual ISP meeting; ▪ Three of three individuals' SL assessments (100%) included diagnoses and relevance of impact on communication; ▪ Three of three 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; ▪ Three of three 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 three individuals' SL assessments (100%) listed medications and discussed side effects relevant to communication; ▪ Two of three individuals' SL assessments (67%) (i.e., Individual #162 and Individual #264) provided documentation of how the individual's communication abilities impacted his/her risk levels. Individual #334's assessment indicated: "risk levels will be discussed at his ISP on 10/4/13." However, the SLP should have identified Individual #334's potential risk levels related to communication during the assessment process. ▪ Three of three individuals' SL assessments (100%) incorporated a description of verbal and nonverbal skills with examples of how these skills were utilized in a functional manner throughout the day; ▪ Three of three individuals' SL assessments (100%) provided evidence of observations by the SLPs in the individuals' natural environments (e.g., day program, home, work); ▪ Two of two individuals' SL assessments (100%) (i.e., Individual #162 and Individual #264) 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 #334 communicated verbally and did not require a Communication Dictionary;	

#	Provision	Assessment of Status	Compliance
		▪ Three of three individuals' SL assessments (100%) included discussion of the expansion of the individuals' current abilities. The SLP assessment discussed how an individual's current abilities could be enhanced; ▪ Three of three individuals' SL assessments (100%) provided a discussion of the individuals' potential to develop new communication skills. 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 two 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 (i.e., understanding and implementation of PNMP communication instructions). This clinical data should include the results of individual-specific compliance and effectiveness monitoring. Individual #334 was newly admitted to the Facility, and as a result, this assessment element was not applicable; ▪ Three of the three individuals' SL assessments (100%) 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; ▪ Two of three individuals' SL assessments (67%) (i.e., Individual #162 and Individual #264) offered a comparative analysis of health and functional status from the previous year. For these individuals, the SLP assessment provided an overview of an individual's health status over the past year. The therapist discussed the type of supports and services that had been implemented to minimize the impact on the individual's functional status; ▪ Two of three individuals' SL assessments (67%) (i.e., Individual #162 and Individual #264) gave a comparative analysis of current communication function with previous assessments. For these individuals, the SLP assessment provided an overview of the past assessment results with the current assessment data for communication function. The assessment analysis discussed if the individual's communication performance had remained the same, had improved, and/or had regressed; ▪ Three of three individuals' SL assessments (100%) identified the need for direct or indirect speech language services, or justified the rationale for not providing it; ▪ Three of three individuals' SL assessment (100%) had specific and individualized strategies outlined to ensure consistency of implementation among various staff; ▪ Three of three individuals' SL assessments (100%) had a reassessment schedule; ▪ Three of the three individuals' SL assessments (100%) supplied a monitoring schedule; ▪ Three of three individuals' SL assessments (100%) had recommendations for direct interventions and/or skill acquisition programs, including the use of AAC	

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		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; ▪ Three of three 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 needed were missing in the community; and ▪ Three of the three individuals' SL assessments (100%) defined the manner in which strategies, interventions, and programs should be utilized throughout the day. The SLP assessments provided suggestions for direct support professionals and other IDT members, as appropriate, to implement an individual's indirect programs (i.e., PNMP) and reinforce skills being learned in direct therapy interventions. The three SLP assessments reviewed indicated the Facility SLPs continued to make progress with SLP comprehensive assessments as multiple assessment elements were addressed in these individual's assessments. Seventeen of the 23 assessment elements were present in each of the three assessment reviewed. This was a significant improvement from the last review. **SLP and Psychology Collaboration** Based on interview with the Director of HT, SLPs were not attending the Behavior Support Committee at the request of the Director of Behavioral Services. Since the last review, the SLP assessment template, not dated, had been revised, and it provided instructions to the therapist for the completion of the Behavioral Considerations section. These instructions stated if the individual had a Behavior Support Plan with replacement behaviors that are communication related, then the therapist "MUST have a meaningful discussion with the psychologist that includes how those replacement behaviors are being addressed in direct and indirect supports." The addition of these instructions was a positive step in establishing collaboration between the SLP and the Behavioral Health Services Provider. During the Monitoring Team's next review, the following will be reviewed: ▪ ____ of ____ individuals' communication assessments and PBSPs reviewed (%) addressed the connection between the PBSP and the recommendations contained in the communication assessment.	

#	Provision	Assessment of Status	Compliance
		▪ ____ of ____ individuals' communication assessments (%) contained evidence of review of the PBSP by the SLP. ▪ Based on review of the Positive Behavior Support Committee meeting attendance sheets from ____ to ____, participation by a SLP was noted in ___ of the ___ meetings (%). As noted above, an abbreviated review was conducted of this section. However, the small sample of the most recently completed SL assessments showed notable improvements. In addition to continuing to address the areas of the assessments still needing work, the Facility is encouraged to expand the improved practices as additional individuals' SL assessments are completed. Although the Facility remained in noncompliance with this provision, significant progress had been made.	
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.	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., updates only) for this subsection, because the Facility had made limited progress due to the decision to prioritize other subsections. The noncompliance finding from the last review stands. **Updates** The ABSSLC Provision Action Information, updated 10/21/13, reported the following for Section R.3: ▪ 9/1/13 – No new initiatives started since last visit. The Presentation Book for Section R.3 included an action plan with the following action steps and completion status: ▪ Implement indirect communication supports/programs for those individuals with AAC (completion status – not started); ▪ Re-assess and make changes to the communication portion of New Employee Orientation (completion status – not started); ▪ Re-assess the functionality of general-use AAC devices in residences and other environments (completion status – not started); and ▪ Place pictures related to positioning of AAC on the mobility device/bed into the PNMP (completion status – not started). These action steps were relevant to Section R.3, and should assist the Facility in working towards achieving substantial compliance with Section R.3. **Integration of Communication in the ISP** During the Monitoring Team's next review, the following will be reviewed: ▪ ____ of ____individuals had an ISP Preparation meeting. ▪ ____ of ____ISPs reviewed (%) included a description of how the individual communicated and how staff should communicate with the individual, including	Noncompliance

#	Provision	Assessment of Status	Compliance
		the AAC system if he/she had one. ▪ ____ of ____ISPs reviewed (%)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. ▪ ____ of ____ISPs reviewed (%)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. ▪ ____ of ____ISPs reviewed (%) 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. **Development and Implementation of Functional Individual-Specific Assistive Communication Systems** During the Monitoring Team's next review, the following will be reviewed: ▪ ____ of ____observations (%) found individuals' AAC devices present in each observed setting and readily available to the individual. ▪ AAC systems for ____ of ____individuals (%) were noted to be in use in each observed setting. ▪ AAC systems for ____ of ____individuals (%) were portable. ▪ AAC systems for ____ of ____ individuals (%) were functional. ▪ For ____ of ____individuals (%), staff instructions/skill acquisition plans related to the AAC system were available. **General Use AAC Devices** It was reported that any changes to the Facility's general-use AAC devices was a low priority. **Direct Communication Interventions** Seven individuals (i.e., Individual #299, Individual #81, Individual #455, Individual #354, Individual #409, Individual #379, and Individual #83) were receiving direct speech therapy at the time of the review. This was an increase of five individuals from the last review.	

#	Provision	Assessment of Status	Compliance
		During the Monitoring Team's next review, the following will be reviewed: ▪ ____ of ____individuals' direct intervention plans were implemented within 30 days of the plan's creation, or sooner as required by the individual's health or safety. ▪ For ____ of ____individuals' records (%) reviewed, the current SLP assessment identified the need for direct intervention with rationale. ▪ For ____ of ____individuals' records (%) reviewed, there were measurable objectives related to individual functional communication outcomes included in the ISP. ▪ For ____ of ____individuals (%), information was present regarding whether the individual showed progress with the stated goal on a monthly basis. ▪ For ____ of ____individuals (%), a description was found of the benefit of the device and/or goal to the individual. ▪ For ____ of ____individuals (%), a report was found regarding the consistency of implementation. ▪ For ____ of ____individuals (%) 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. **<u>Competency-Based Training and Performance Check-offs</u>** Based on interview, a Facility SLP had developed a communication training curriculum, which included core competencies for communication. There were future plans to integrate this communication curriculum and performance check-offs into the NEO training schedule. If they do not already, the training materials should address the following content areas: ▪ Methods to enhance communication; ▪ Implementation of programs; ▪ Benefits and use of AAC; and ▪ Identification of non-verbal means of communication. PNMP Coordinators and Habilitation Techs were expected to provide the communication training instruction. No final date had been established for the integration of this training into the NEO schedule. **<u>Individual-Specific Competency-Based Training</u>** The Facility provided examples in the pre-document request of individual-specific communication programs competency-based performance check-offs for the following	

#	Provision	Assessment of Status	Compliance
		19 individuals: Individual #510, Individual #333, Individual #403, Individual #406, Individual #261, Individual #377, Individual #214, Individual #196, Individual #183, Individual #458, Individual #63, Individual #122, Individual #393, Individual #281, Individual #185, Individual #282, Individual #88, Individual #198, and Individual #5. These competency-based performance check-offs included staff demonstration components. During the Monitoring Team's next review, the following will be reviewed: ▪ ____ of ___individuals' staff (%) had received individual-specific training. The Monitoring Team will request individual-specific training documentation to identify the total number of staff (N) required to complete the training and the total number of staff (n) to have successfully completed individual-specific competency-based training and performance check-offs.	
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.	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., updates only) for this subsection, because the Facility had made limited progress due to the decision to prioritize other subsections. The noncompliance finding from the last review stands. **Updates** The ABSSLC Provision Action Information, updated 10/21/13, reported the following for Section R.4: ▪ 9/1/13 – No new initiatives started since last visit. The Presentation Book for Section R.4 included an action plan with the following action steps and completion status: ▪ Implement schedule for monitoring persons with AAC to ensure their equipment is functional and adaptable to a variety of settings and that such systems are readily available to them (efficacy monitoring) (completion status – not started); and ▪ Implement monitoring schedule for those with AAC for presence and condition of equipment (completion status – not started). These action steps were relevant to Section R.4, and should assist the Facility in working towards achieving substantial compliance with Section R.4. **Monitoring System** As noted above, the Facility had not yet finalized a policy. The Facility's policies/procedures should include the following elements related to monitoring: ▪ Monitoring for the presence of communication adaptive equipment or other AAC	Noncompliance

#	Provision	Assessment of Status	Compliance
		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 establishing inter-rater reliability; and ▪ A process for data trend analysis and utilization of findings to drive training and problem resolution (individual and systemic). **<u>Monitoring of Implementation of Communication Supports</u>** The Facility identified that the Compliance Monitoring form was used to monitor the implementation of communication supports for individuals. However, there was no established monitoring schedule for communication supports. The Facility reported that no individual-specific communication supports monitoring had been completed within the last six months. During the Monitoring Team's next review, the following will be reviewed: ▪ For ____ of ____ individuals (%), monitoring of communication supports was outlined in the assessment. ▪ For ____ of ____ individuals (%) monitoring of their communication supports occurred at the frequency established by Facility policy or ISP.	

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 11/4/13; o Section S Presentation Book; o Section S Self-Assessment, updated 10/21/13; o Individual Support Plans for: Individual #178, Individual #250, Individual #440, Individual #305, Individual #95, Individual #4, Individual #299, Individual #242, Individual #373, Individual #29, Individual #303, Individual #81, Individual #347, Individual #455, Individual #441, Individual #337, Individual #425, Individual #462, Individual #486, Individual #354, Individual #444, Individual #215, Individual #94, Individual #439, Individual #139, Individual #136, Individual #165, Individual #9, Individual #510, and Individual #177; o Skill Acquisition Plan for: Individual #178, Individual #250, Individual #440, Individual #305, Individual #95, Individual #4, Individual #299, Individual #242, Individual #373, Individual #29, Individual #303, Individual #81, Individual #347, Individual #455, Individual #441, Individual #337, Individual #425, Individual #462, Individual #486, Individual #354, Individual #444, Individual #215, Individual #94, Individual #439, Individual #139, Individual #136, Individual #165, Individual #510, and Individual #177; o Training materials developed by Kathy Theiss, BCBA; o Skill Acquisition Plan Data Sheets for: Individual #178, Individual #250, Individual #440, Individual #305, Individual #95, Individual #4, Individual #242, Individual #373, Individual #29, Individual #303, Individual #347, Individual #441, Individual #337, Individual #425, Individual #462, Individual #486, Individual #444, Individual #215, Individual #94, Individual #439, Individual #139, Individual #165, Individual #9, Individual #510, and Individual #177; o Monthly Reviews for: Individual #178, Individual #305, Individual #242, Individual #29, Individual #303, Individual #347, Individual #441, Individual #444, Individual #94, Individual #439, Individual #9, Individual #510, and Individual #177; o Plan for Addressing Inter-rater Reliability in Homes and Day Programs in the Areas of Engagement, Active Treatment, and Skill Acquisition, effective date 12/1/13; o Preferences and Strengths Inventory for: Individual #178, Individual #250, Individual #440, Individual #305, Individual #95, Individual #4, Individual #242, Individual #373, Individual #29, Individual #303, Individual #347, Individual #441, Individual #337, Individual #425, Individual #462, Individual #486, Individual #444, Individual #215, Individual #94, Individual #439, Individual #139, Individual #136, Individual #165, Individual #9, Individual #510, and Individual #177; o Functional Skills Assessment Summary for: Individual #178, Individual #250, Individual #440, Individual #305, Individual #95, Individual #4, Individual #299, Individual #242,

	Individual #373, Individual #29, Individual #303, Individual #81, Individual #347, Individual #455, Individual #441, Individual #337, Individual #425, Individual #462, Individual #486, Individual #354, Individual #444, Individual #215, Individual #94, Individual #439, Individual #139, Individual #136, Individual #165, Individual #9, Individual #510, and Individual #177; o Vocational Assessment for: Individual #178, Individual #440, Individual #305, Individual #95, Individual #4, Individual #242, Individual #303, Individual #441, Individual #425, Individual #462, Individual #486, Individual #444, Individual #215, Individual #94, Individual #439, Individual #139, Individual #136, Individual #165, Individual #9, and Individual #510; o List of individuals who received formal skill training in the community, undated; and o List of individuals identified as experiencing significant visual impairment or blindness. ▪ **Interviews with**: o Kristin Wyrick, QIDP Coordinator; Jeff Branch, Director of Active Treatment; and Jolene Willis, Assistant Director of Programs, on 11/5/13; o Direct Support Professionals, on 11/6/13; o Active Treatment Staff, QIDP Staff, and Program Compliance Monitors, on 11/7/13; o Candia Hallford, Director of Vocational Services, on 11/7/13; and o Ron Manns, Director of Behavioral Services, on 11/4/13 and 11/7/13. ▪ **Observations of**: o Residence 5961, Residence 5962, Residence 5971, Residence 5972, Residence 6330, Residence 6350, 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 Clara Campbell Center; o 5th Street Diner; o Incident Management Review Team meeting, held on 11/4/13; o Individual Support Plan meeting for Individual #397, held on 11/5/13 o Individual Support Plan meeting for Individual #233, held on 11/7/13; o Psychiatry Clinic for Residence 6350, held on 11/6/13.
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section S, dated 10/21/13. In its Self-Assessment, for each subsection, 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:

	○ 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 Training Monitoring Tool for SAP. ○ These monitoring tools included adequate indicators to allow the Facility to determine compliance with the Settlement Agreement. ○ The monitoring tools included adequate methodologies, such as record review, observation, and staff interview. ○ The Self-Assessment identified a sample size of 73 individuals whose records were audited using the "Section S" monitoring tool between 4/1/13 and 8/31/13. During this same time frame, 1861 audits were conducted using the PLACHECK monitoring tool. The sample size employed in the audit of skill acquisition training was not identified in the self-assessment. Lastly, the Facility reported monitoring 22 plans with regard to training in the community (Section S.3.b). ○ The monitoring tools did not yet have adequate guidelines to ensure consistency in monitoring and the validity of the results. It will be important that audits of SAPs address each individual habilitation program and do not result in one rating for multiple SAPs. Instructions should be expanded to clarify this point. It also will be important to ensure that staff completing the PLACHECK form are adequately trained in the core competencies of positive behavior support. If the staff completing the form have not been trained to competency, it might be best to omit this section. Questions relating to Section S.3.b were identified, but no guidelines for determining outcome were included. ○ The following staff were responsible for completing the monitoring: a) the "Section S" monitoring tool was completed by the QIDP Coordinator, the QIDP Educator, the QIDP Settlement Agreement Liaison, two QIDPs, two Active Treatment Coordinators, and the Director of Active Treatment; b) the PLACHECK monitoring tool and the Skill Acquisition Training Monitoring Tool were completed by Home Supervisors, QIDPs, Home Activity Specialists, and Day Program Managers; and c) six QIDP staff completed monitoring of training in the community. ○ Measurements of inter-rater reliability were collected using the "Section S" monitoring tool. A Program Compliance Monitor from the Quality Assurance Department was responsible for this monitoring. Additionally, a Quality Assurance Program Compliance Monitor completed "look behind" monitoring of eight of the 22 plans assessed for opportunities of community-based training. Inter-rater reliability was not assessed with the engagement or skill acquisition training monitoring tools. A plan for increasing the assessment of inter-rater reliability across all monitoring tools had been developed with an identified implementation date of 12/1/13. ▪ As noted in the last report, the Facility should consider an analysis of individual progress on identified SAPs as a key indicator. Also included should be data on the training that occurred in the community, including the dates and number of training opportunities. ▪ The Facility consistently presented data in a meaningful way with one exception. Compliance on each indicator was reviewed in the text of the Self-Assessment report. Data was presented in table and graphic format in the Section S Presentation Book for the audits completed in September. The

	one area in which data was not presented in a meaningful way was the report on Skill Acquisition Plans. As data were reported as one score on each of the identified indicators for the individual's SAPs, it was unclear whether each of his/her SAPs met the standard for each indicator. ▪ The Facility rated itself as being out of compliance with all subsections of Section S. This was consistent with the Monitoring Team's findings. ▪ In its Self-Assessment, the Facility did recognize the need for improved assessment of inter-rater reliability.
	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 QIDP Department now included four Facilitator QIDPs who were responsible for guiding the ISP process and meetings. In the meeting observed on 11/7/13, the Facilitator QIDP kept the group focused, drew participants into the discussion, and encouraged a lively exchange of ideas. Staff used data and referenced the rating scale when determining risk levels. Topics that required further discussion and follow-up were identified with meetings scheduled to ensure this occurred. ▪ Direct support professionals reported a very positive response to the mealtime management initiative. The plan to use a similar model to address engagement was a very positive step. ▪ Summaries of recently completed Functional Skills Assessment reflected more comprehensive reviews of individual strengths and needs. Although not evident yet, this should allow for more thoughtful and greatly expanded identification of habilitation programs that consider the individual's preferences and foster greater independence and a more enriched life. ▪ A staff member from the Behavioral Services Department continued to provide training and technical assistance to Active Treatment staff to address skill acquisition programs and engagement. Areas in which continued work was necessary include the following: ▪ Staff should use the Preferences and Strengths Inventory to create a vision for the future that extends beyond what is currently available at the Facility. ▪ Training objectives remained limited in scope with few identified opportunities for training. Community-based training was infrequent. ▪ Engagement remained quite limited. The dignity of the individual was not always considered, as adults were observed seated or lying on the floor of their homes. Activities were often the same from one setting to another with little consideration of individual interests. ▪ Direct support professionals also reported that skill acquisition plans sometimes were non-functional or addressed skills the person already demonstrated.

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S1	Commencing within six months of the Effective Date hereof and with	A total of 30 Individual Support Plans were reviewed. These had all been completed between 5/1/13 and 10/2/13. A summary of findings is provided below:	Noncompliance

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	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.	▪ All of the plans (100%) included a review of the individual's preferences and strengths. The breadth of these reviews varied across individuals. o Examples where the summaries provided a clearer profile of the individual's preferences and strengths included the following: • The summary of strengths for Individual #81 and Individual #354 outlined many of the functional skills each had demonstrated during assessment. • While less comprehensive than the plans identified above, the ISP for Individual #510 did provide a clearer profile of her preferences and strengths. o Examples where the summaries were brief and did not provide a clear profile of the individual included the following: • Individual #440 was noted to play sports. It was not clear which sports he played or which sports he preferred. • Individual #305 was noted to "avoid conflict" and have "fair motor skills." Neither of these described his strengths in observable terms. o The ISP for Individual #136 included skill acquisition programs that clearly addressed some of his preferences and strengths. These included learning to cook, learning to read maps, and learning to use the local bus system. For the majority of individuals, however, there was very limited incorporation of preferences and strengths into the design of habilitation programming. ▪ All of the plans (100%) included training objectives. A total of 148 skill acquisition plans were identified in the 30 ISPs, with individual totals ranging from two to nine. This computed to an average of 4.93 objectives per individual. Further discussion regarding SAPs is provided below. ▪ 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., work, hand washing, SAMS, communication skill). The ISP for Individual #441 reflected objectives that were written with greater clarity as observable behaviors were often described and conditions for learning were evident in at least one objective. ▪ A schedule of training for each skill acquisition plan was included in 25 of the 30 ISPs (83%). Schedules are summarized below: o Fifty-nine SAPs representing 13 individuals indicated training was to occur daily. In only one case (i.e., Individual #305), did the training schedule for three of his SAPs suggest multiple trials per day (e.g., at medication administration, after meals). o Forty-three SAPs representing 13 individuals indicated training was to	

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		occur weekly. o The seven SAPs for Individual #510 had an identified training schedule of "daily/weekly." o Training on four SAPs, representing two individuals, was to occur five times per week. o Three individuals had three SAPs each. Training schedules were identified as "ongoing," "annually and PRN," and "continuous." o Lastly, one individual had one SAP in which training was to occur three times per week. As has been noted in past reports, limited training opportunities will impede learning of new skills. ▪ The community was identified as a possible training site for at least one objective in 16 of the 30 ISPs (53%). While in many cases the community was clearly an environment where the individual could practice the identified skill, such as purchasing or pedestrian safety, other individual plans included objectives that were specific to the individual's home or the Facility, but included the community as a possible training site. Examples included the following: Individual #441 was to learn to move his wheelchair to the nurses area when it was time for his medication; Individual #425 was to learn to apply lotion to his body; Individual #165 had an objective to participate in the activity center; and Individual #510 was to develop her skills around medication administration. Staff should identify community-based training only when the skill is appropriate to the community. While the ISP meeting observed on 11/7/13 reflected thoughtful and comprehensive planning for Individual #233, the meeting observed on 11/5/13 was quite different. Individual #397 was engaged throughout his meeting. He often responded to questions and a review of his assessments reflected a number of very good skills. There were three areas that raised particular concerns. First, this individual recently had been required to quit smoking due to complications with his medication. He repeatedly asked for cigarettes. The behavior analyst suggested that this was no longer a biological issue, but rather was psychological in nature. While this might be the case, it is suggested that staff should make every attempt to support this individual as he deals with the absence of a habit that was apparently quite strong and of long duration. It was also concerning that when the individual responded that he preferred deep water as opposed to shallow water, a team member was overheard commenting that he had changed his mind, and stated: "imagine that." While it appeared that the staff member cared for the individual, this comment suggested a lack of respect that should be eliminated from the culture of the Facility. Lastly, only three SAPs were identified for this individual, two of which were continued from the previous year.	

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		A total of 45 Skill Acquisition Programs were reviewed. This represented one to two programs across 30 individuals. The format for 43 of these SAPs remained the same 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 QIDP to provide a monthly review of progress. The two exceptions were SAPs that had been introduced in 2012. A summary of the review of the 45 SAPs is provided below. ▪ In 44 of the 45 SAPs (98%) the Specific Target Behavior provided an objective that identified the conditions under which an observable and measurable behavior was to occur and the number of trials expected within the "reporting period." As noted in the last report, the criterion for mastery would be better indicated if the reporting period were clearly identified (e.g., 30 days, 60 days, etc.). In 37 of the 45 SAPs (82%) there was an indication as to whether the individual was to perform the skill independently or with a specific prompt. ▪ In 41 of the 45 SAPs (91%), a type of behavioral chain was identified under the General Instructions section. Sixteen of these 41 SAPs (39%) identified backward chaining as the teaching strategy. Although a forward chaining strategy was identified in 25 of these 41 SAPs (61%), 14 of these involved skills that were not behavioral chains. Some were discrete events, such as making a choice, while others involved shaping behavior, such as running for increasingly longer distances. Two of the 45 SAPs (4%) employed total task chaining and two (4%) utilized a discrete trial teaching format. An improvement noted since the last review were the instructions to staff to use hand-over-hand prompting to help the individual complete all the steps in the chain excluding the training step which he/she was expected to complete independently. This was evident in four of the SAPs that involved behavioral chains. This will allow the individual to learn the identified complex skill as a smooth routine, with each link in the chain serving as the discriminative stimulus for the next link in the chain. ▪ Where appropriate, a task analysis was identified in all of the SAPs (100%). ▪ Schedules of training varied across SAPs. Twenty-four of the 45 SAPs (53%) included daily training schedules. In other SAPs, training was to occur five days per week (five SAPs or 11%); two, three, or four times per week (one SAP each	

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		or 6% total); or one time each week (six SAPs or 13%). The remaining seven SAPs (16%) either did not identify the training schedule or used general descriptors, such as "anytime she is getting her nails painted," "when running," and "when his skin is dry." ▪ Training opportunities were clearly identified in only two SAPs (4%). The discrete trial program for Individual #354 noted that four trials should be conducted during each training session. Individual #177 was to have two opportunities daily to practice using an augmentative communication device to request a transition outside. It should be noted, however, that an additional seven SAPs (16%) implied multiple training opportunities each day, because the individual was to practice the skill during meals and snacks, during daily medication administration, or something similar. ▪ Twenty-eight of the 45 SAPs (62%) identified praise alone as the reinforcer to be provided contingent upon correct responding. Caution is advised when limiting reinforcement to praise alone, because its efficacy as a reinforcer might be very dependent on the person providing the praise. When teaching new and sometimes very complex behaviors, it might be necessary to combine praise with some other tangible reinforcer. Further concerns were raised in 14 of these 28 SAPs (50%), because praise was to be provided regardless of the level of prompting required to obtain a correct response. Without applying the reinforcer differentially, that is contingent upon the best performance observed up to that point in training, the person might not learn to perform the skill independently. On a positive note, this point was evident in the training materials one of the behavior analysts in the Behavioral Services Department developed. Ten of the 45 SAPs (22%) identified reinforcement as praise paired with an item or social interaction. In one program for Individual #462, the reinforcer was identified as her ability to categorize which was the skill she was learning. The other program, a slow eating routine, indicated that the absence of choking would serve as the reinforcer. Neither of these appeared to be thoughtfully designed reinforcers. A verbal prompt was the identified reinforcer to be delivered contingent upon Individual #139 correctly washing his hands. Prompting does not typically serve as a reinforcer. Staff are encouraged to conduct preference assessments to ensure that reinforcers identified in SAPs are individual specific. ▪ A clear description of staff response to incorrect responding or refusals to participate was found in 35 of the 45 SAPs (78%). ▪ Plans for ensuring maintenance of newly learned skills were found in 42 of the 45 SAPs (93%). The two plans developed earlier in 2012 did not address skill maintenance, and an incomplete description of maintenance strategies was included in the cooking SAP for Individual #136. The two SAPs for Individual #178 noted that he would learn to maintain the skill in response to a natural	

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		discriminative stimulus (i.e., waking up and arriving at a store). This was most appropriate, because it will increase the individual's ability to independently exhibit the skill. ▪ Plans for generalization of newly learned skills were found in 43 of the 45 SAPs (96%). ▪ All of the SAPs (100%) noted the ISP meeting date, and 34 (76%) included the implementation date. Ideally, the implementation date should be noted and should reflect initiation of training shortly after the ISP meeting. Data sheets for a total of 72 SAPs were reviewed. This represented between one and eight programs for 25 individuals. A summary of findings is provided below: ▪ Of the 72 programs reviewed, the date of program initiations was identified in 51 of the SAPs (71%). ▪ In data sheets for 13 of the 72 SAPs (18%), there was evidence of more than one daily training trial on at least some of the days during which data was recorded. This was most common for Individual #305 who had six SAPs with evidence of multiple daily training trials. ▪ Concerns remained regarding refusals or other impediments to learning. Individual #444 was scheduled to learn to shave. However, over 29 documented trials, he refused to participate 20 times. Individual #139 was learning to wash his hands at work. His data reflected a 50% refusal rate, with comments suggesting that he often refused to leave his bed following lunch. Lastly, Individual #510 was scheduled to learn to ambulate with a walker. She had refused to participate in this training activity for 31 of 36 trials. Individual #250 was scheduled to learn to place a telephone call to her family. Over a three-month period, only five data points were recorded. Each of these indicated that training had not occurred. Reasons included a lack of responding by the individual, a shortage of staff, and no response from the family. Individual #462 was scheduled to learn to make a purchase. Over a five-week period, she had no opportunity to learn this skill due to "no off campus activity." However, the SAP indicated that this activity could take place on campus. As has been noted in the past, it is critical that the individual's team meet to discuss impediments to habilitation training, with strategies designed to improve participation. The Monitoring Team requested three consecutive Monthly Reviews for the 30 individuals in the sample. The QIDPs complete these reviews to summarize progress on action plans and goals included in the individual's ISP. The Facility provided reviews or comments regarding the status of monthly reviews for all of the individuals. A summary of findings is provided below: ▪ The Facility reported that reviews had not been completed between August and October of this year for 17 of the 30 individuals (57%). Three of these	

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		individuals had been admitted during the summer months. ▪ Monthly Reviews from August through October were provided for nine of the 30 individuals (30%). One to two Monthly Reviews were provided for four of the 30 individuals (13%). ▪ None of the Monthly Reviews (0%) summarized data on SAPs. When comments were included, these often noted that the individual was making progress or was maintaining the skill. Several reviews noted the current step of the program and the level of prompting that was required for the individual to perform the skill. ▪ Individual specific concerns are addressed below: o In the October review (9/21/13 to 10/20/13) for Individual #441, there was a note that although four SAPs had been implemented on 9/12/13, there was not enough documentation to assess progress. o The August and September reviews for Individual #444 noted that he was refusing to participate in his money management SAP. This was to be discussed by the team on 8/28/13. This should have been resolved by the September review. o The October review for this same individual (Individual #444) was completed through 10/29/13. Although two SAPs were scheduled for implementation on 9/18/13, the review noted that the SAPs were not in the individual's I-Book. o Comments regarding progress were the same across three reviews for Individual #439. An additional note was recorded in the October review for a purchasing program. Although this was scheduled for implementation on 5/3/13, it had not been introduced. Further, it was noted that an ISPA had been recorded on 8/6/13 to revise this SAP. o Individual #510 was to learn to wash her cup. This program should have been introduced on 6/18/13. Yet, in the October review, it was noted that the team was going to discuss discontinuing this skill, because it was "not feasible at the home." It is unclear why this could not be implemented in the home setting. Staff should assess progress by reviewing the specific data that is collected during training. If changes are recommended, these should be addressed and implemented in a timely manner. At the time of the Monitoring Team's visit, graphic display of progress on SAPs was still not evident. Graphs provide a very clear display of an individual's progress or lack thereof in acquiring a new skill. When there is consistent evidence of a lack of progress, regression, or refusal to participate, members of the team should investigate the reason, and as appropriate, provide additional training to staff and/or revise the program to ensure that learning occurs.	

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		Engagement During this visit, PLACHECKS or measures of engagement, were collected in the homes and workshop areas only. A total of three PLACHECKS were collected in the three different workshop areas. Measures ranged from 80% to 92%, with a mean of 88% engagement. As has been noted in the past, work activities were limited to laundry care (e.g., separating, folding, and stacking facecloths, towels, or sheets) and shredding. A total of 18 PLACHECKS were collected in the homes. Similar to past reports, engagement varied markedly across homes. Engagement scores ranged from 0% to 100% with a mean of 37%. While some homes reflected leisure activities even in the early morning hours after breakfast, other homes revealed poor staff-to-individual ratios (e.g., one staff member supervising 14 individuals during the dinner hour), or large groups of individuals gathered in the central living area with limited materials or even furniture for them to sit in. In one home, one staff member was providing supervision to 11 individuals, all with complex needs. When he was asked to identify an individual, he explained that he was a "float" and did not know anyone. The Assistant Director of Programs explained an initiation was soon to be introduced focusing on engagement in the homes. This was to be modeled on the mealtime management initiative that had been reported as positively received by the direct support professionals. At the request of the Director of Active Treatment, a member of the Monitoring Team met with and conducted side-by-side PLACHECKS with Active Treatment staff, QIDP staff, and Program Compliance Monitors. There were high levels of agreement while conducting measures of individual engagement. One issue discussed was the length of the observation. At the time of the visit, the Facility was using a form with instructions describing a 10 second observation of each individual in the group. During this interval, an individual's engagement can change repeatedly. As PLACHECKS utilize a momentary time sample measurement, the Monitoring Team recommended that staff limit each observation to a maximum of three seconds. Staff could observe initially to determine the activity and then score the individual's participation in the activity at the final second. The Monitoring Team also recommended that staff rotate the pairing of staff when assessing inter-observer agreement. This will minimize and/or detect observer drift with regard to the operational definition of engagement. The goal is to ensure that all staff are employing a similar definition of engagement when collecting PLACHECK measures. As the Facility moves forward with its Plan for Addressing Inter-rater Reliability in Homes and Day Programs in the Areas of Engagement, Active Treatment, and Skill Acquisition, a rotation of auditors should be addressed. Since the last visit, Vocational Services had experienced some expansion of work and volunteer activities available to the individuals living at the Facility. The number of individuals involved in New Employee Orientation had expanded from one in March to five in September. Two individuals were taking photos for employee identification cards,	

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		Individual #303 was distributing packets to new employees, and Individual #8 and Individual #136 were presenting to new employees. Two new contracts for paper shredding had been procured, and some individuals were working in food services to prepare snacks for individuals living at the Facility. Volunteer activities had occurred with a local food bank, an animal shelter, and a community ministry. While this reflected an increased effort to identify a greater variety of vocational activities and sites, completing laundry skills in the workshop areas remained the primary employment opportunity for individuals residing at the Facility. There should be a continued focus on expanding vocational opportunities, both on campus and in the community, to ensure that individual preferences and strengths are being addressed. The Facility identified 113 people, or 30%, of the population as individuals experiencing blindness. Although it was noted that: "this is part of the Occupational Therapist's training," it is recommended the Facility consider working with an orientation and mobility specialist to ensure that the needs of these individuals are met and that staff are trained to best provide support. 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.	
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 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 was also expected to record the method used to identify the individual's 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 the 30 individuals in the sample were requested. As the Facility reported that a PSI had not been completed for four individuals (i.e., Individual #299, Individual #81, Individual #455, and Individual #354), the sample size for this section has been reduced to 26 individuals. Findings are summarized below. ▪ The completion date was identified in 20 of the 26 PSIs (77%). In the six remaining PSIs, there was a date on the last page paired with the staff member responsible for completing the form. ▪ Eighteen of the 26 PSIs (69%) had been completed prior to the individual's annual ISP meeting. One was completed on the same day as his meeting, and seven were completed after the individual's ISP meeting. ▪ The person guiding the process, his/her role, and signature were found in 18 of the 26 PSIs (69%).	Noncompliance

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		▪ Questions regarding future living options, employment, relationships, leisure skills, and independence were adequately addressed in only six of the PSIs (23%) reviewed. The remaining PSIs provided very limited information. For example, many of the questions were identified as not applicable for Individual #486. Other responses within the PSI suggested that the team was not providing thoughtful consideration to the individual's preferences. For example, when asked: "What do you like about your daily schedule?" the recorded response for Individual #95 was "yes." Similarly, responses to the questions: "What do you like/dislike about where you live now?" and "What would you change?" were recorded for Individual #303 as "yes" and "no" respectively. Further, his recorded response to the questions: "What would you like to learn?" and "Do you like to wake up early in the morning or sleep in?" were recorded as "not applicable" and "yes" respectively. There is no value in completing this form if every effort is not made to determine what is preferred and important to the individual. ▪ Fifteen of the PSIs provided an adequate summary of the individual's preferences and strengths. Two PSIs were missing this page, and the PSI for Individual #337 listed nothing under strengths. The preference summary for Individual #215 referenced another individual, and the strengths summaries for Individual #440 and Individual #425 included several identical points. ▪ The final section of the PSI guided teams to consider future planning for the individual. None of these (0%) adequately outlined individual visions for the future or steps necessary to achieve these visions. Although the PSIs for several individuals provided a more comprehensive review of their preferences and strengths, this information was not used to complete the final analysis for future programming. Examples included Individual #95, Individual #441, Individual #94, and Individual #9. As noted in previous reports, 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 future planning, with barriers to goals and accompanying action plans clearly outlined. Given that all individuals should have the opportunity to grow and develop as reflected in the language of Section S.1, consistent acceptance of the current living, working, and leisure activities and environments as the preferred goal for the individual without thoughtful efforts to look beyond the individual's current supports and status did not reflect any effort to provide the individual with an improved quality of life and greater independence. The Functional Skills Assessment Summary was reviewed for the 30 individuals in the sample. The results of this review are outlined below: ▪ The date of completion was identified in all of the reports (100%). In every case	

#	Provision	Assessment of Status	Compliance
		(100%), the assessment had been completed prior to the individual's ISP meeting. It is suggested that the assessment should have been updated for Individual #215, because it had been completed 10 months before his ISP meeting. ▪ Eleven of the summary reports (37%) included a more comprehensive review of the individual's strengths across the 13 areas assessed. Staff should provide a thorough profile of the individual to ensure that members of the team can make thoughtful decisions regarding habilitation planning. ▪ Between two and seven skill acquisition programs were recommended in the summary reports. This computed to an average of 3.97 programs per individual. Of concern was the restricted scope of habilitation planning. Plans were often limited to self-care skills or participation in domestic activities, such as laundry care. While these are important skill areas, consideration should be given to all domains identified in the FSA. ▪ In several cases, needs or acquisition plans were suggested on a skill the person reportedly already had learned. Examples included: o Although Individual #440 was reported to be able to engage in computer games, an identified need was his lack of computer skills. Further definition was needed, if other specific computer skills were seen as areas of need. o Although Individual #305 was able to button his shirts and pants, a SAP was suggested to develop this skill. o Included in a description of strengths displayed by Individual #444 was his ability to read and write simple words. However, included in his identified needs was his inability to read. Further definition was needed, if specific reading skills or a more advanced level of reading were seen as areas of need. ▪ All of the summaries (100%) were signed by the person completing the assessment. The Facility continued to employ a vocational assessment to outline an individual's vocational vision, work preferences, education/work history, strengths, barriers and supports necessary to overcome these barriers, ideas for the future, and recommendations. Twenty assessments were reviewed. A summary of the 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. ▪ Thirteen of the reports (65%) had been completed or updated in 2013. Four reports (20%) were completed in 2012, and three reports (15%) were completed in 2011. ▪ Six of the reports (30%) included information regarding expanded vocational	

#	Provision	Assessment of Status	Compliance
		opportunities as part of the individual's vocational vision. Some of these were very specific, (e.g., Individual #4 wanted to work at the Dollar Store or a grocery store, Individual #444 wanted to work preparing food or doing office work), while others described expanded opportunities to socialize (e.g., Individual #305, Individual #303), or to explore community-based work (e.g., Individual #136). The vision for eight individuals (40%) was to continue with their current jobs, or to explore other workshop jobs as these became available. It was suggested that work was of no importance to three individuals (15%), that work might be of interest to two individuals (10%), and the vision for one individual (5%) changed frequently. ▪ Recommendations regarding further assessment and/or job exploration were identified for 14 of the 20 individuals in the sample (70%). For 10 of these 14 individuals (71%), job exploration was limited to activities available in the workshops and/or on campus. Specific on campus sites outside of the workshop (i.e., the diner, central laundry, the recycling crew) were recommended for three of the 14 individuals (21%). Exploration of community-based employment was recommended for Individual #136 only. Regrettably, the same recommendations had been made the previous year, but had not been implemented. In no case (0%) was a due date identified. ▪ Five of the reports (25%) identified job exploration that had been completed during the previous year. In every case, this exploration took place on campus. In three of these five reports (60%), the individual's response to each job was described. As noted in the past, it will be important for the Vocational Services staff to focus on identifying a greater variety of jobs, with particular emphasis placed on matching individuals to jobs that meet their interests. This includes both situational assessments and actual job placement. Expansion should include environments beyond the workshop setting. All of the plans (100%) included the Integrated Risk Rating Form (IRRF). Behavioral health risk ratings were outlined in most cases and appeared to be appropriate to the individuals. It will be important for teams to consider this risk information, and develop SAPs and other programs, as appropriate, to reduce risks to the extent possible. Concerns are outlined below: ▪ Required behavioral health information was incomplete in the IRRF for Individual #4, Individual #303, Individual #215, and Individual #439. ▪ The rationale for the identified behavioral health risk rating was not documented on the IRRF for Individual #425, Individual #94, and Individual #136. ▪ The behavioral health risk rating for Individual #444 was identified as medium. However, the individual's primary care physician suggested that he was not a	

#	Provision	Assessment of Status	Compliance
		candidate for community placement due to his "severe problem with leaving without proper escort." Similarly, Individual #441 received a low behavioral health risk rating, yet he had a history of pica behavior. Finally, Individual #9 had received a medium behavioral health risk yet his crisis plan included protective mechanical restraint. In all three cases, it is suggested that further discussion should take place to determine whether the individual's behavioral health risk rating should be elevated. ▪ The IRRF for Individual #305 included documentation of two different support plans. It was concerning that his self-injurious behavior was addressed in the psychiatric support plan, but not in the behavior support plan. It is suggested that any aberrant behavior, particularly behavior that may cause harm to the individual or others, should be addressed in the behavior support plan to ensure that staff have guidelines to best prevent the behavior and consequences to apply following occurrences of the behavior. ▪ The IRRF for Individual #299 included a reference to multiple, daily occurrences of leaving without proper escort. Although his meeting was held in September, at the time of the Monitoring Team's visit, this behavior was still not identified in his behavior support plan. ▪ Lastly, staff should carefully proof all documents. An alternate name was used in the IRRF for both Individual #439 and Individual #9. Based upon the information reviewed above, the Facility remained out of compliance with this provision of the Settlement Agreement.	
S3	Within three years of the Effective Date hereof, each Facility shall use the information gained from the assessment and review process to develop, integrate, and revise programs of training, education, and skill acquisition to address each individual's needs. Such programs shall:		
	(a) Include interventions, strategies and supports that: (1) effectively address the individual's needs for services and supports; and (2) are practical and functional in the most integrated setting consistent with the individual's	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. And although there was evidence that the summaries of functional skill strengths and needs had been expanded, the individuals' habilitation programs remained limited in scope. Opportunities for instruction were	Noncompliance

#	Provision	Assessment of Status	Compliance
	needs, and	severely limited, reinforcement for correct responding was not individualized, and guidelines for error correction and maintenance and generalization of newly acquired skills were often the same across programs and individuals. During the onsite review 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.	
	(b) Include to the degree practicable training opportunities in community settings.	The Facility provided a list of individuals who had received formal skill training in the community. This list was not dated, the number of training sessions was not indicated, and the time frame during which training occurred was not identified. However, according to this list, a total of 18 individuals received formal training in community settings. Sixteen of these individuals received training in making a purchase, one individual used a computer at a local university, and one individual received training on learning to follow a recipe and shopping for the necessary ingredients. With a census of 378 at the time of the visit, this remained a very small percentage of individuals who had received training in the community. The Facility remained out of compliance with this provision of the Settlement Agreement.	Noncompliance

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 In response to the Monitoring Team's request for updated policies on the most integrated settings, the following statement: "Since the last monitoring review, there have been no changes to the State or Facility policies related to transition and discharge; o Presentation Book for Section T; o List of all individuals referred for community transition, since the Monitoring Team's last visit, undated; o List of individuals who have requested community placement but who have not been referred and reason, undated; o List of individuals who have not been referred solely due to Legally Authorized Representative's (LAR) preference, undated; o List of individuals transitioned to community, since the Monitoring Team's last onsite review, undated; o List of individuals who have had a Community Living Discharge Plan (CLDP) developed during the last six months; o Statement that no individuals had transferred to other SSLCs, undated; o Statement that no individuals had transferred pursuant to an alternate discharge, undated; o In response to request for description of how Facility assesses individual for placement: ISP Meeting Guide, dated 5/29/13; o List of individual (i.e., Individual #215) that returned to the Facility following transition to the community, including team review documentation; o Community Placement Report, as of 10/11/13; o List in response to request for the following: "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," undated; o Documentation for Individual #66 who had transitioned to the community, and recently

	died; o Total numbers of individuals and staff participating in Community Living Options Information Process (CLOIP) tours, since May 2013; o List and material related to training provided to individuals, families, and LARs; o Promoting Independence Living Options training slides, dated 11/1/13; o Training documentation and materials for staff related to most integrated setting, various dates; o Third Quarter Obstacle Report, March 2013 and May 2013; o Annual Report: Obstacles to Transition Abilene State Supported Living Center, Fiscal Year 2012; o Individual Support Plans, Sign-in Sheets, Assessments, Individual Support Plan Addenda (ISPAs), Preferences and Strengths Inventory (PSI), CLOIP worksheet, skill acquisition and teaching programs, Rights Assessment, monthly reviews, and ISP Preparation Meeting documentation for: Individual #158, Individual #246, Individual #253, Individual #390, Individual #306, Individual #145, Individual #183, Individual #476, Individual #237, and Individual #453; o CLDP, any associated assessments, and most recent ISPs for the following: Individual #215, Individual #289, Individual #384, Individual #483, Individual #87, Individual #534, and Individual #11; 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 #522, Individual #99, Individual #229, Individual #268, Individual #288, Individual #215, Individual #371, Individual #22, Individual #87, Individual #534, and Individual #483; o Monthly Meeting Notes Section T: Placement, dated 6/20/13, 7/31/13, 8/26/13, and 9/27/13; o Sample of Section T quality assurance monitoring tools the QA Department completed, and the Admissions/Placement Department completed, various dates; o In response to requests for analyses of data: ▪ Annual Report on Obstacles to Transition, completed November 2012; ▪ Section T Action Plans, updated 6/20/13; and ▪ Quarterly Obstacles Report for 3rd Quarter of FY 2013 o Updated list of current referrals, 11/7/13; o Updated list of individuals transitioned to the community, undated; o List of Provider in the Diner, May 2013 through October 2013; and o Draft CLDPs and ISPAs related to transition to the community for: Individual #33, Individual #318, and Individual #32. ▪ **Interviews with**: o Kerry Loveland, Admissions/Placement Coordinator; o Kristin Wyrick, QIDP Coordinator;

	○ Heather Vivoda, Post-Move Monitor; ○ Diane Jackson, Transition Specialist; and ○ Laura Wilford, Transition Specialist. ▪ **Observations of**: ○ Post-move monitoring visit for Individual #483, on 11/6/13; and ○ Pre-Community Living Discharge Plan meeting for Individual #165, on 11/5/13.
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section T, dated 10/21/13. 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: ○ The monitoring/audit tools the Facility used to conduct its self-assessment included: 1) Section T – Serving Institutionalized Persons in the Most Integrated Setting Appropriate to Their Needs; Sub-Section 1 – Planning for Movement, Transition, and Discharge – Review of Living Options; 2) Section T – Serving Institutionalized Persons in the Most Integrated Setting Appropriate to Their Needs; Sub-Sections 1 and 4 – Planning for Movement, Transition, and Discharge and Alternate Discharges – Review of CLDP; and 3) Section T – Serving Institutionalized Persons in the Most Integrated Setting Appropriate to Their Needs; Sub-Section 2 – Serving Persons Who Have Moved from the Facility to More Integrated Settings Appropriate to Their Needs – Review of Post-Move Monitoring. ○ Although these monitoring/audit tools included indicators relevant to the Facility's compliance with the Settlement Agreement, modifications had been made to the State's systems that were not reflected in the tools. 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. ○ 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. For example, for review of 13 CLDPs, the Facility's assessment of the indicators for T.1.a indicated 0% compliance with the referral being consistent with the determination of professionals, not being opposed by the individual or guardian, and being consistent with the ISP. It was unclear what methodology was being used, because the Monitoring Team found no evidence that individuals were being transitioned to the

	community against the advice of the professionals on the team, when they or their guardians opposed transition, or when their ISPs said they should not transition to the community. o The Self-Assessment identified the sample(s) sizes. However, it did not consistently 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 QIDPs 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. ▪ 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 included a recommendation from the Facility's team members with regard to whether or not community transition was appropriate. This was positive. However, a requirement of Section T is that: "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." Based on review of ISPs, a number of concerns were noted. For example, teams continued to make decisions not to refer individuals to the community, but often did not provide adequate justifications for their decisions, particularly when all assessments indicated the individual could be supported in a more integrated setting. ISPs reviewed did not include individualized plans to address guardians and/or individuals' need for further education about what was available in the community and/or the need for a well-planned transition process (i.e., time to explore options, slow transitions for individuals that need them, strong transition plans to ensure supports are made available, etc.), or even inform guardians and individuals that these were options. In some cases, teams appeared either to not have sufficient information to answer guardians' questions, or were found to discourage as opposed to encourage transition to the community. For example, for one individual in the sample, the ISP documented discussion of the team encouraging the family to obtain guardianship because: "although the team tries very hard to honor a family's wishes, there is increasing pressure to refer to the community if there are no obstacles to referral. The QIDP informed [the father] that if they feel strongly about [the individual] remaining at the ABSSLC, then guardianship would provide them with more control over the decision about community placement." On a more positive note, since the Monitoring Team's last review, 20 individuals had transitioned to the community, and 22 individuals were on the referral list. Despite the continuing problems noted above with regard to some teams' discussions and decisions about referrals, the Facility clearly had some initiatives in place that were designed to encourage individuals and their guardians to consider community transition, and to assist them in finding community providers that could meet their preferences and needs. For example, based on interview, a very important component of education was the discussions that the Admissions Placement Coordinator was having with individuals and their families at the time of admission about the need to think from the beginning about future plans for transition back to the community. The

	concept of "discharge/transition planning from the time of admission" can be a helpful one in ensuring that individuals and their guardians continue to consider the opportunity to transition to the most integrated setting as a viable one. Similarly, as noted in the last report, 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). During this most recent review, anecdotally, Facility staff reported some notable success stories. This illustrated that this individualized approach was helpful in ensuring that individuals and their guardians, as well as their teams were making more informed decisions based on information tailored to address their questions and/or specific support needs. This was an extremely positive development. Admissions and Placement Department staff and individuals' teams had continued to expand the scope and definition of pre-move and post-move required supports in individuals' Community Living Discharge Plans (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. However, the expanded supports in individuals' ISPs, particularly in the IHCP portion, were generally not incorporated into CLDPs. CLDPs continued to be missing a number of important pre-move and post-move required supports that the individuals needed to transition safely and successfully to the community. The Special Review Documentation for an individual that returned to the Facility as a result of significant behavioral concerns showed the team critically reviewed the behavioral aspects of his transition plan and its implementation. As a result of its review, the Special Review Team identified a list of action steps to take in developing and implementing CLDPs for other individuals with "more involved BSPs." These included, for example, ensuring provider staff successfully complete competency-based training on the BSP, requiring communication between the Behavioral Health Provider at the Facility and the community provider's equivalent, asking about the provider's ability to assure that treatment integrity can be maintained, and involving the ABSSLC Behavioral Health Provider in the seven and 45-day post-move monitoring visits to observe staff, review behavioral data, and provide recommendations or follow-up training, as necessary. Although based on the Monitoring Team's review of the CLDP, this was not a complete list, the Facility and this Special Review Team should be commended for conducting this critical review, and for developing meaningful recommendations that should assist in the development and implementation of future transition plans for this individual as well as other individuals. 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 remained 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 others with developmental disabilities.	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. The Monitoring Teams also were in the process of reviewing the State's very recently issued revised 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. For any transitions that were anticipated to take longer than the 180-day timeframe, justification needed to be provided. At the time of the previous review in May 2013, it appeared six individuals had exceeded the 180-day timeframe. Since the Monitoring Team's last review, 20 individuals had transitioned to the community, and 22 individuals were on the referral list. At the time of the onsite review, three of these individuals' referrals had exceeded the 180-day timeframe. A member of the Monitoring Team discussed each of these individuals with the representatives from the Admissions Placement Department. For all of them, the need to identify community providers that met their preferences and needs (e.g., guardians' preferences for areas of the state, or a specific provider; or medical or behavioral needs) was the reason for the delay. Facility staff reported that State Office was now requiring that individuals complete the transition to the community within 30 days of selecting a provider. As has been stated in the past, although it is important for transitions to occur at a reasonable pace, for	Noncompliance

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		transitions to be successful, it also is essential that thorough CLDPs be developed and implemented to ensure individuals' needs and preferences are met. The Facility appeared committed to trying to meet the goal State Office had set, but still taking the time necessary on an individualized basis to complete the planning and CLDP implementation process, which the Monitoring Team supports. In reviewing CLDPs of those individuals that were referred, none of them had opposed transition to the community. A requirement of this provision is that: "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." Based on review of ISPs, the following concerns were noted: ▪ As is discussed in detail with regard to Section T.1.b.3, Facility discipline members of teams still were not consistently justifying their recommendations when they concluded that individuals should not to be referred to the community. ▪ The following statement included in Individual #390's ISP was concerning, because it appeared to be the opposite of encouraging and assisting individuals to move to the most integrated setting: "The QIDP asked [Individual #390's father] if he or any other family members would be interested in obtaining guardianship. [Individual #390's father] stated that he felt like everything was going well just being [Individual #390's] advocate… The QIDP explained that, although the team tries very hard to honor a family's wishes, there is increasing pressure to refer to the community if there are no obstacles to referral. The QIDP informed him that if they feel strongly about [Individual #390] remaining at the ABSSLC, then guardianship would provide them with more control over the decision about community placement." Actions that would have encouraged and assisted this individual to move to the most integrated setting would have been for the team to work with the family to identify supports in the community that could meet his significant behavioral needs, developing plans at the Facility that could be transitioned to the community, addressing the family's questions and concerns about previous failed placements, and developing a strong and comprehensive transition plan to ensure that supports were in place for a successful transition. Rather, the team did not make a referral to the community, and as discussed with regard to Section T.1.b.3, the team's decision was not adequately justified. Moreover, the team did not develop an action plan to work towards identifying supports in the community that would meet Individual #390's needs and/or educate the family about community options. The team's approach of using the potential community transition as a mechanism to convince the family to pursue guardianship was very concerning.	

#	Provision	Assessment of Status	Compliance
		▪ For Individual #476, it did not appear that the team was equipped to answer the guardian's questions, and/or the team did not do a good job of explaining or documenting discussion about options that would be available to the individual in a community setting. The ISP stated: "The [guardian] asked for the Q to explain what exactly a less restrictive environment was. The Q asked the [guardian] if it was okay for [Individual #476] to take a tour just for exposure. The [guardian] stated [Individual #476] cannot make that decision himself. He wants to know the purpose of the trip. [The guardian] stated that he needs longer than 2 hours to see the reaction of [Individual #476]. [The guardian] stated he does not feel comfortable with [Individual #476] living in the community at this time. He wants him to get through what is going on medically now." The team did not discuss (or document discussion of), for example, the option of Individual #476 conducting visits lasting more than two hours to determine his preference, and/or conducting multiple visits over a period of time. They also did not discuss specific services that could be provided in a community setting to support Individual #476's medical as well as behavioral needs. On a more positive note, despite the continuing problems noted above with regard to some teams' discussions and decisions about referrals, the Facility clearly had some initiatives in place that were designed to encourage individuals and their guardians to consider community transition, and to assist them in finding community providers that could meet their preferences and needs. As is discussed in more detail with regard to Section T.1.b.2, the Admissions Placement Coordinator was working with newly-admitted individuals and their guardians to begin transition planning at the time of admission, and Transition Specialists were working with specific individuals and their guardians/families to successfully answer questions and identify options in the community that met their specific needs and preferences. 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	On 10/18/13, a couple of weeks prior to this onsite review, the DADS revised Most Integrated Setting Practices policy was issued. The Monitoring Teams will comment jointly as to whether the State policy adequately addresses all of the items in Section T of the Settlement Agreement. Facility staff indicated that they were in the process of reviewing the State policy, and revising Facility policies to reflect any changes. The parties agreed that the Monitors would rate T.1.b as just the development of an adequate policy. 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	Noncompliance

#	Provision	Assessment of Status	Compliance
	require that:	under T.1.b. Due to the fact that the Facility had not yet finalized an adequate policy related to transition and discharge processes, the Facility remained out of compliance with this provision.	
	1. The IDT will identify in each individual's ISP the protections, services, and supports that need to be provided to ensure safety and the provision of adequate habilitation in the most integrated appropriate setting based on the individual's needs. The IDT will identify the major obstacles to the individual's movement to the most integrated setting consistent with the individual's needs and preferences at least annually, and shall identify, and implement, strategies intended to overcome such obstacles.	The specific requirements of this provision are discussed below, including: 1) the identification in the ISP of the protections, services, and supports that need to be provided to ensure safety and the provision of adequate habilitation in the most integrated appropriate setting based on the individual's needs; and 2) identification of the major obstacles to the individual's movement to the most integrated setting, and identification and implementation of strategies to overcome such obstacles. <u>Identification in ISPs of Needed Protections, Services, and Supports</u> The first sentence of this provision states: "The IDT will identify in each individual's ISP the protections, services, and supports that need to be provided to ensure safety and the provision of adequate habilitation in the most integrated appropriate setting based on the individual's needs." Based on an agreement of the parties, 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	Noncompliance

#	Provision	Assessment of Status	Compliance
		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> The most recent 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 10 ISPs, teams generally had identified some obstacles. Of the 10 ISPs reviewed, 10 should have had obstacles defined (i.e., none of these individuals had been referred to the community). Of the 10 plans, four (40%) included an adequate list of obstacles (i.e., Individual #453, Individual #145, Individual #158, and Individual #237). The problems associated with the remaining 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 #253, Individual #246, and Individual #476); ▪ Some were not adequately justified (e.g., for Individual #476 list included medical concerns, but identified no specific medical issues that could not be supported in a community setting; for Individual #390, behavioral issues was one identified, but the team appeared to view the individual's behavioral issues as something that needed to change before referral would be made, as opposed to identifying these as supports that were not currently available in the community; for Individual #183, the team identified "Medical Issues" as the obstacle. The team listed his feeding tube, and the possibility of needing a PRN medication for seizures as the medical issues preventing his placement. Many individuals with feeding tubes live in the community successfully, and the team's conclusion that he had a "severe seizure disorder" that would prevent transition to a community setting was not supported in the IRRF or IHCP; or for Individual #306, the team indicated the obstacle was LAR Choice. However, the Rights Assessment indicated the guardianship had lapsed, so Individual #306 did not have a guardian); and ▪ One was missing. In the narrative of the ISP, Individual #253's team identified a lack of medical supports to address the individual's needs as a concern, but did not translate this into an obstacle, as should have happened.	

#	Provision	Assessment of Status	Compliance
		Moreover, action plans to overcome the obstacles to referrals were not adequate. ▪ Of the 10 ISPs, three (30%) included an action plan to overcome the obstacle(s) identified (i.e., one of Individual #158's obstacles, Individual #390, and Individual #237). ▪ Of these three, none (0%) were adequate. o The plans were not adequately individualized or detailed. For Individual #237, the obstacle identified was LAR Choice, with two issues checked, including "has been provided information, but not is interested," and "mistrust of providers." The team had some discussion about the LAR's concerns, including that the mother believed Individual #237 could be taken advantage of if she lived in a group home. It was positive that the team included an action step for the Transition Specialist to contact the mother. However, the ISP did not indicate why this was included or what the contact would involve. o At times, the plan did not address the stated obstacle or one of the obstacles (e.g., for Individual #253, Individual #476, and Individual #145, the plans did not address "LAR Choice;" and for Individual #158 and Individual #183, the plans did not address the "Medical Issues" obstacle), and/or the underlying issues (e.g., for Individual #158, although the team cited her inability to adjust to change as an obstacle, the team did not include any action plans to assist Individual #158 to adjust to changes, nor did it recommend a slow transition process; or for Individual #390, Individual choice - unsuccessful prior community placements was listed as the obstacle, but based on the plan, it was not clear how the team was planning to determine his choice, particularly because in other sections of the ISP, the team indicated he could not make informed choices). 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. o In one case, it did not appear that the team understood the concept of an obstacle to referral. For Individual #390, in the obstacle section, behavioral health/psychiatric needs appeared to be viewed as a characteristic of the individual that needed to change (i.e., the team noted: "These are being addressed through [Individual #390's] PBSP").	

#	Provision	Assessment of Status	Compliance
		Individuals with behavioral issues can be served in the community. For behavioral health/psychiatric issues to be identified as an obstacle, the team would need to determine that specific supports the individual requires to address their behavioral health concerns are not available in the community, or in the area of the state the individual wishes to live. No plan was included in Individual #390's ISP to identify services and supports to meet his needs in the community. o In another case, it appeared the team had made an error with regard to the individual's guardianship status. Specifically, for Individual #306, the team indicated the obstacle was LAR Choice. However, the Rights Assessment indicated the guardianship had lapsed, so Individual #306 did not have a guardian. As is discussed with regard to Section T.1.b.3, a referral should have been made. In any case, no plan was included to overcome the identified obstacle (i.e., LAR Choice, which appeared to be an error). 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 a positive note, the Admissions Placement Coordinator reviewed 31 ISPs to look behind data that showed high numbers of "Individual Choice" listed as the obstacle. Based on this review, only two of these were truly individual choice. It was positive that the Admissions Placement Coordinator took this initiative. Given the importance of this data in allowing the Facility and State to identify areas of concerns and act to make reasonable changes as well as the impact on referrals, the next step will be providing further education to teams to ensure that the obstacles identified are valid. The Admissions Placement Coordinator reported that since June 2013, obstacles to referral and transition had been entered into AVATAR. However, problems had been encountered in extracting the data from the system. The Data Analyst reportedly was working on the problem. At the time of the review, though, the Monitoring Team was not able to review an updated list of aggregate obstacles to referral or transition. 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, they 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.	

#	Provision	Assessment of Status	Compliance
	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**: As indicated in the last report, on Saturday, March 23, 2013, the Facility held a provider fair. Based on data the Facility provided, family member/LAR attendance remained low, with two family members attending the spring fair. Of note, one of the families that attended the spring fair decided to pursue a referral. Since then, on September 20, 2013, another provider fair was held. No family members attended the fall 2013 fair, but it was noted that the weather was very rainy. Individual attendance had fluctuated with 94 individuals attending the fair in March 2012, 52 individuals attending the September 2012 fair, 155 individuals attending in March 2013, and 102 individuals attending the September 2013 fair, despite bad weather. The Admissions Placement Department indicated that it was planning to focus on this as an annual event for individuals and staff, as well as to provide an opportunity for community providers to learn about the individuals that reside at ABSSLC. 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. This was part of the Facility's action plan for Section T, but was listed as "Not started." ▪ **Education about community options:** Individuals and their guardians also were provided information through the following: o Based on interview, a very important component of education was the discussions that the Admissions Placement Coordinator was having with individuals and their families at the time of admission about the need to think from the beginning about future plans for transition back to the community. The concept of "discharge/transition planning from the time of admission" can be a helpful one in ensuring that individuals and their guardians continue to consider the opportunity to transition to the most integrated setting as a viable one. 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	Noncompliance

#	Provision	Assessment of Status	Compliance
		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 below, the Transition Specialists had continued 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. o In addition, resource directories were available statewide to describe the services that community providers offered in various areas. ▪ **Tours of community providers**: Documentation indicated that educational community tours continued to be offered in collaboration with a Local Authority. The homes visited were both ICFs and Home and Community Services (HCS) providers. Based on review of individuals' ISPs, teams often 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. Data was provided to show that since May 2013, 47 individuals, and 42 staff had participated in CLOIP tours. However, 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 and Local Authority used the form entitled "Community Living Options Tour Attendance Sheet," and it included space to document the individual's reaction. However, the detail included varied. It also 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, the Facility had continued to take a number of steps to provide educational opportunities. However, Facility staff expected to develop a plan as part of the implementation of the revised State Office policy on the Most Integrated Setting.	

#	Provision	Assessment of Status	Compliance
		Since the last review, the Facility had added a component to New Employee Orientation on the most integrated setting. Based on a review of the PowerPoint presentation, it provided an overview of the *Olmstead* decision, as well as information about living options, obstacles to referral and transition, and the process for assisting individuals to transition to the community. It was a well-done presentation with succinct, but valuable and easily-understood information. Transition Specialists also were attending ISP meetings, which provided an opportunity for education of staff. In addition, the Local Authority offered annual training on community options on the same day as the provider fair. 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 September/October 2013 edition of the Maple Street Messenger included and article about an individual that had successfully moved to the community, and was working and enjoying his new home. 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, but they intended to play more of a role in facilitating it. The September/October issue of the Maple Street Messenger indicated that the Transition Specialists could provide a list to interested people; 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	

#	Provision	Assessment of Status	Compliance
		and documentation provided: o The Admissions Placement Department staff were offering education at Self-advocacy meetings. The Transition Specialists were on the schedule for at least two meetings a year. o The Facility also had continued implementing a creative idea entitled "Provider in the Diner." In July and August, 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. In June and October 2013, two other providers did not set up in the Diner, but went to homes on campus to meet individuals and staff. This also provided a good opportunity, particularly for individuals that might not frequent the Diner. 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:** The Monitoring Team did not specifically request information about the recent meetings with the Local Authority. However, as indicated in past reports, the Facility had previously maintained regular meetings with the Local Authority, and clearly from other information provided, a collaborative relationship continued to exist. ▪ **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 10 recently completed ISPs, none of the individuals had been referred to the community. For these 10 individuals, seven (70%) had a plan that addressed education about community options (i.e., Individual #253, Individual #145, Individual #158, Individual #390, Individual #237, Individual #183, and Individual #306). 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 plans generally included the same two action steps for all ISPs reviewed, including attending a community tour(s), and attending the Provider Fair. The action plans developed did not 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	

#	Provision	Assessment of Status	Compliance
		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 individuals had no plan for further education: Individual #246, Individual #453, and Individual #476. Although Individual #246 and Individual #476's plans included action steps for community activities, such action steps are important, but not relevant to the education process related to transition to community living and work settings. Individuals should have opportunities for community activities regardless of whether or not they live in a community setting. Therefore, such activities do not educate individuals or their guardians about what would be different if they were to transition to a community living or work environment. ▪ Seven of the 10 ISPs (70%) identified what happened with the previous year's plan (i.e., Individual #253, Individual #453, Individual #145, Individual #158, Individual #476, Individual #183, and Individual #306). However, a number of problems were identified: o Some of these summaries showed a failure to follow through on plans (i.e., Individual #253, who was sick on the day of the scheduled tour, but it was never rescheduled; and Individual #145, who was scheduled to go on a day that was "cool" outside, but the tour was not rescheduled) or to make the opportunities meaningful (e.g., for Individual #183, who attended a group home tour, but he was only able to see a portion of the house because it was not accessible);	

#	Provision	Assessment of Status	Compliance
		o At times, it was not clear what the plan was for the previous year, but some summary of activities was provided (i.e., Individual #453 and Individual #306). o For some individuals, minimal information was provided, making it difficult to use it in any meaningful way for planning purposes (e.g., Individual #158, and Individual #476). The Facility was continuing to complete some of the basic activities related to education, and some progress had been made in expanding these opportunities. Anecdotally, the Transition Specialists were working with teams, and some specific individuals and families to provide further education, which was very positive. However, based on review of individuals' ISPs, minimal progress had been made since the last review in individualizing the process. Although most individuals had a plan in their ISPs, 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.	As noted in the last report, in assessments prepared for annual ISP meetings, assessors' recommendations regarding transition to the community generally were included. Some assessments still did not include such recommendations, particularly recreation and sometimes, dental. In addition, based on review of a sample of ISPs, ISPs included a summary or conclusion with regard to the discipline team members' joint determination or recommendation with regard to whether or not community transition was appropriate. However, many concerns were noted with regard to the justifications teams provided for their recommendations, and in relation to the lack of reconciliation between recommendations included in the assessments and the final recommendation. Based on the review of the sample of 10 ISPs listed in the documents reviewed section: ▪ 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 10 ISPs reviewed, for none (0%), all of the assessments included the applicable statement/recommendation. Most assessments available in the packets included recommendations. However, recreation assessments never included a recommendation. Sometimes, dental assessments did not. In addition, for a number of individuals in the sample, assessments either were not submitted or old assessments were included in the packet (i.e., particularly for psychology, and to some extent, habilitation therapy). As a result, information had not	Noncompliance

#	Provision	Assessment of Status	Compliance
		been updated, including these recommendations. As also has been stated previously, ISPs did not clearly indicate the recommendations from all disciplines, particularly direct support professionals, residential staff, and the QIDP, who did not complete separate assessments. o Of the 10 ISPs reviewed, none of the individuals had been referred for transition to the community. For these 10 individuals, eight individuals' ISPs (80%) included a clear recommendation from the professionals on the team to the individual and LAR (i.e., those that did not were the teams for Individual #390 and Individual #453). However, for only five of these individuals (50%) was adequate justification provided (i.e., Individual #246, Individual #145, Individual #237, and Individual #476, whose teams recommended transition, but the guardians chose not to pursue transition, and Individual #306, for whom the team recommended transition, but mistakenly thought a guardian was involved, as discussed below). The following provide examples of inadequate justification for teams' conclusions and/or for whom one clear recommendation was not made: ▪ For Individual #390, the discipline members did not make one cohesive recommendation, and the team did not provide adequate justification for the conclusions it drew. Specifically, the team indicated: "The IDT considered all information and preferences identified. Based upon [Individual #390's] assessment recommendations, the facility discipline members determined that [Individual #390] could be served in a less restrictive setting. However, [Individual #390's] BCBA indicated in [Individual #390's] Behavioral Assessment that at this time [he] would not benefit from such an extreme change. He has just transitioned to a new home on campus, and he is still adjusting to new staff members. He has had a recent spike in target behaviors, and the team members agreed that it could be very dangerous for [Individual #390] to move again so soon because of how severe his SIB can be." This was not consistent with other information provided in the ISP. Although his IRRF indicated that he had had a spike in SIB, no specific data was provided, and the team concluded that he was at medium risk for Behavioral Health. The IRRF stated: "Behavioral data indicates a decreasing trend for SIB. There has been a slight increase in the frequency of SIB in the past 4 months. Level of severity is low. Has not had a serious injury related to SIB since 6/26/12." It also appeared from the IRRF that there were a number of factors that could have led to the "slight increase,"	

#	Provision	Assessment of Status	Compliance
		including a move to another home, but also a change in programming and a decrease in level of supervision. Also of concern, the assessment off of which this concern was taken was out-of-date (i.e., approximately a year old), and the Behavioral Health Services Specialist was not in attendance at the meeting, despite being a required member of the team. It is unclear how the rest of the team reconciled the recommendations from their assessments with the one included in a year-old psychological assessment. ▪ For Individual #253, although there were discrepancies between the discipline members' recommendations, no reconciliation of these discrepancies was described in the ISP narrative. More specifically, the PCP recommended against community transition, and although the nurse indicated Individual #253 could be supported in the community, the assessment indicated this was with "reservations." A list of supports was then articulated in the nursing assessment that Individual #253 required, many of which were not included in the IHCP. Despite the fact that the remaining team members included recommendations in favor of community transition in their assessments, the discipline members of the team concluded: "The facility discipline members (independent of the resident and LAR/family) determined that [Individual #253] cannot be served in a less restrictive setting at this time. This determination is based on the need for 24-hour nursing and multiple medical concerns. [Individual #253] is not able to express where he wants to live, but the LAR states that they want [him] to live at the AbSSLC." In addition to this not being independent of the individual and LAR, it did not explain how the majority of team members changed their minds. ▪ The team for Individual #453 made two incongruent statements, and, as a result, it was not clear they had made an independent recommendation to the LAR and individual. The first indicated that Individual #453's supports and services could be provided in a less restrictive setting. The second indicated that: "Without the guardian, there would be no referral today as we are not sure what [Individual #453's] true preferences are." ▪ For Individual #183, although all of the assessments indicated that assessors believed he could be supported in a less restrictive setting, the team concluded: "The Team decided that	

#	Provision	Assessment of Status	Compliance
		[Individual #183] cannot be served in less restrictive environment because he requires 24 hour nursing care due medication [sic] administration, severe seizures, and his enteral feedings. Anyone fed via G-tube or receive [sic] medications via G-tube has to have their residual levels checked prior to administration or feedings. Also, if he requires seizure medication that is injectable which should [sic] only be done by a nurse and most group homes do not provide 24 hour nursing staff." No discussion was included in the ISP to reconcile the difference between team members' recommendations in their assessments and this conclusion. In addition, the team's conclusion that he had "severe seizures" and might require an injectable medication for his seizures were not supported in the medical assessment, IRRF, or IHCP. In fact, these documents did not indicate he was prescribed or had used an injectable medication for seizures, and according to the IRRF and IHCP, he had had 15 generalized tonic/clonic seizures ranging between five and 25 seconds. He was being seen by the neurologist every six months, and was prescribed one medication for the control of his seizures. Moreover, supports can be provided to individuals requiring nursing services in community settings, and both individuals with seizures and G-tubes live successfully in community settings, so it was unclear on what the team was basing its conclusion. o In ten of the ten (100%) written ISPs reviewed, a statement regarding the overall decision of the entire IDT, inclusive of the individual and LAR, was included. However, of these, six (60%) included appropriate justification (i.e., Individual #246, Individual #145, Individual #453, Individual #253, Individual #476, and Individual #237, whose guardians chose not to pursue transition). Examples of concerns included: ▪ For Individual #306, the team chose not to make a referral due to "LAR Choice." However, the Rights Assessment indicated the guardianship had lapsed, so Individual #306 did not have a guardian. Right above the decision not to refer due to LAR Choice, the team had identified the need to pursue guardianship for Individual #306. It appeared he should have been referred. ▪ For Individual #158, the discipline members of the team appeared to make two recommendations. The first was that Individual #158 could be supported in a less restrictive setting, and the team indicated that this was based on their	

#	Provision	Assessment of Status	Compliance
		assessments. The second was that the entire team including the individual did not recommend referral to the community. On the page prior, the team indicated that the individual could not make decisions and had a Priority Level 1 need for a guardian. In other words, the team and/or Facility Director currently needed to make decisions for Individual #158, so the second recommendation was the discipline members' decision, not the individual's decision. As its reasons for the decision not to make the referral, the team cited the individual's lack of understanding of community living options, and the team stated: "The team feels that while [Individual #158] may do well in the community setting, it is questionable as to whether or not moving to the community would improve her quality of life. The team expressed genuine concerns regarding [Individual #158's] heart defect and how she has responded to stressful situations in the past. The AICD [Automatic Implantable Cardioverter Defibrillator] has shown increased activity during stressful periods, including moves on campus. The team feels that [Individual #158] needs more exposure to community living options and would also like to have the cardiologist's input as to whether or not he feels that [Individual #158] could benefit from moving to a less restrictive environment." No data was provided in the ISP or IRRF to justify the statement that her AICD showed increased activity during stressful periods, nor was it clear why none of the team members had included this in their assessments and/or recommended against community transition. It also showed a lack of understanding on the team's part about the possibilities of a slow transition that would not result in and "extreme environmental change." ▪ For Individual #390, the team indicated the individual's preferences were not known, but it was not clear whether the individual could express a specific preference with regard to living options. In addition, his father, who was not his guardian, wanted him to remain at ABSSLC. The concerns of the BCBA listed above also were noted as part of the rationale for not making a referral. As discussed above, the data and other information in the IRRF and ISP did not support this position. ▪ Individual #183 is discussed above. In past reports, the Monitoring Team had recommended that for some individuals for	

#	Provision	Assessment of Status	Compliance
		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. As noted in the last report, 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). During this most recent review, anecdotally, Facility staff reported some notable success stories. This illustrated that this individualized approach was helpful in ensuring that individuals and their guardians, as well as their teams were making more informed decisions based on information tailored to address their questions and/or specific support needs. This was an extremely positive development. Facility staff indicated that they intended to formalize the process further through the development of more action plans that are incorporated into individuals' ISPs, as well as documentation of the effort toward completing the action plans. The Monitoring Team strongly supports such efforts. The Facility had made some progress in this area. Specifically, with some limited exceptions, 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, or the team as a whole recommended against transition. 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	Since the last review, some progress continued to be made with regard to teams' development of CLDPs. The Admissions Placement Department and the teams of individuals that had transitioned to the community clearly had worked hard to continue to broaden scope of pre-move and post-move required supports, and provide more	Noncompliance

#	Provision	Assessment of Status	Compliance
	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:	detail. However, team members needed to continue 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. Importantly, now that ISPs were improving and including more of the supports individuals required, teams should use the ISPs as a starting point when developing CLDPs and define how the protections, services, and supports would transition to the community. It was very positive that at the CLDP pre-planning meeting a member of the Monitoring Team observed while on site, the team reviewed the IHCP and discussed the specific supports the individual would continue to need after he transitioned. However, evidence of such review and incorporation of supports from ISPs into CLDPs, and particularly the IHCP portion of ISPs, was not found in the CLDPs reviewed. Based on a list the Facility updated while the Monitoring Team was on site, since the Monitoring Team's last review, 20 individuals had transitioned to the community. Community Living Discharge Plans were reviewed for six of these 20 individuals, representing 30% of this group of individuals. The CLDPs reviewed were for Individual #289, Individual #384, Individual #483, Individual #87, Individual #534, and Individual #11. With regard to the timeliness of the Community Living Discharge Plans, the plans themselves included little documentation to show that they were developed sufficiently prior to the individual's transition. Based on the dates included in the plans, they all appeared to have been developed only a few weeks prior to the individuals' transitions. However, summaries were provided of some of the teams' activities in the selection process. What was unclear from the CLDPs themselves was whether teams were developing pre- and post-move supports sufficiently prior to the time of transition to assist during the selection process in ensuring that providers could meet individuals' needs. Based on interview, teams were meeting shortly after the referral to begin this process. However, given the change to the CLDP format, it will be important for teams to clearly document their efforts with regard to transition planning between these meetings. These efforts should be documented in ISPAs or other documentation. The Facility remained out of compliance with this provision.	
	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	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 six 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	Noncompliance

#	Provision	Assessment of Status	Compliance
	coordinating the community living discharge plan with provider staff.	examples of the general strengths and weaknesses included: ▪ All of the plans identified the need for training for community provider staff. This had been improved by providing more information about what would be included in the training. However, none of the plans clearly defined which community provider staff needed to complete the training (e.g., direct support professionals, management staff, clinicians, etc.). The language generally read: "training of home staff and day program staff," with only occasional reference to a specific staff member such as the nurse or regional director. ▪ Similarly, as noted in the last report, the CLDPs had begun to identify what level of mastery of the information was required (i.e., verbal or performance mastery). However, for none of the individuals, 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. For example, Individual #384's plan required verbal and performance mastery for a list of supports related to his psychiatric and behavioral needs, but it was not clear which applied to which of the supports, or what tool would be used to measure the community provider staff's competence. ▪ Although present in some (e.g., Individual #87 for nursing), 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 where it appeared necessary (e.g., Individual #11, Individual #384, and Individual #87 for other clinicians). ▪ Similarly, very little coordination was specified as needing to occur between current and future residential or day/vocational staff, which for many individuals would be appropriate. A good example of where this had occurred was for Individual #384 for whom the CLDP included a post-move support for the Behavior Coach to attend the seven and 45-day monitoring and monitor for competency on the BSP, and provide additional training if needed. ▪ None of the plans described ABSSLC's staff's involvement in evaluating potential sites at which individuals would be served (e.g., Habilitation Therapies staff to ensure adequate accessibility and/or equipment, Behavioral Services Department staff to determine if safety issues could be addressed in specific settings, and/or if modifications needed to be made to existing plans to address changes in environment), and for some individuals it appeared necessary (e.g., Individual #87 related to safety issues due to behaviors, and Individual #289 related to physical support needs). ▪ Only one of the plans addressed any role that ABSSLC staff or community provider staff might play in assisting the individual to make the transition. As noted above, the Behavior Coach was identified in the CLDP as a support	

#	Provision	Assessment of Status	Compliance
		following the transition. However, other than this 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. 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.	The parties agreed the Monitoring Team would not monitor this provision because the Facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding stands.	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.	The parties agreed the Monitoring Team would not monitor this provision because the Facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding stands.	Substantial Compliance
T1d	Each Facility shall ensure that each individual leaving the Facility to live in a community setting shall have a current comprehensive assessment of needs and supports within 45 days prior to the individual's leaving.	This requirement of the Settlement Agreement includes two components, including the timeliness of assessments (i.e., within 45 days of the individual leaving the Facility), and the comprehensive nature of the assessments. The Facility had made progress with regard to obtaining timely assessments. Although some improvement was seen, the quality (i.e., comprehensiveness) of the assessments continued to be lacking. The following information is repeated here from Section M and exemplifies the issues related to inadequate assessment processes for individuals transitioning to the community. A review of the nursing notes and Nursing Discharge Assessment	Noncompliance

#	Provision	Assessment of Status	Compliance
		Summaries for four individuals including: Individual #295, Individual #87, Individual #22, and Individual #371 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. The process the Facility had put in place to improve compliance with the timeliness of assessments appeared to have been successful. For all six of the individuals' CLDPs reviewed (100%), it appeared that assessments had been updated within the 45-day timeframe. However, the quality of these assessments was lacking. None of the six 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, this review continued to find 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 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	

#	Provision	Assessment of Status	Compliance
		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 the assessments occasionally included recommendations about the need for ongoing involvement of therapist/clinician (e.g., most of the psychological assessments, and often the nutrition assessments), but they generally did not define specifically the various roles that such a person would play. ▪ 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 supports identified in the comprehensive assessment that are determined by professional	The CLDPs reviewed included pre-move and post-move required supports. In the last several reports, the Monitoring Team noted that progress had been made, and the Facility continued on this track. 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.	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	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. However, as noted above with regard to Section T.1.c, with some of the improvements in ISPs, it would be expected that teams would use the ISPs, including the IHCPs to structure discussion at CLDP planning meetings. At this point in the improvement processes for ISPs, teams would still need to supplement this information, but the CLDPs should reflect at least what is in the ISPs with plans to transition the protections, supports, and services to the community. As noted above, it was very positive that at the CLDP pre-planning meeting a member of the Monitoring Team observed while on site, the team reviewed the IHCP and discussed the specific supports the individual would continue to need after he transitioned. However, evidence of such review and incorporation of supports from ISPs into CLDPs, and particularly the IHCP portion of ISPs, was not found in the CLDPs reviewed. In summary, 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. These deficits 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 six 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 CLDPs should identify how they will be provided in the community, by whom, when, with what frequency, and for how long. ▪ As noted in previous reports, sometimes, supports related to the clinical services were referenced in the CLDPs. However, this seemed to vary across disciplines. Psychology/Behavior Supports, PCPs, and psychiatry were routinely included in CLDPs (e.g., Individual #11, Individual #87, Individual #289, and Individual	

#	Provision	Assessment of Status	Compliance
		#384). Sometimes dietary (e.g., Individual #289) and medical specialists were identified as necessary. However, a concerning trend was to leave it up to the community PCP to identify which clinical services and specialties were needed. This is not consistent with the Settlement Agreement requirements, and will not ensure that the individuals' needs are met. Also missing was generally any mention of nursing or Habilitation Therapists for individuals that had been receiving such supports at ABSSLC (e.g., Individual #11, Individual #534, Individual #87, and Individual #289). ▪ Some brief requirements (e.g., qualifications and frequency of review of the individual) were included (e.g., for some, but not all of the behavior supports required, for example, for Individual #384, or less so for Individual #87 or Individual #289), but this generally did not comprehensively describe the supports or ensure that similar supports to those the individual required at the Facility were transitioned to the community, unless clear justification for discontinuing them was provided. This definition is necessary for all of the clinicians involved with the individual, and needs to address issues such as staff training, review of data, monitoring of the implementation of programs, etc. This was a significant missing piece for one or more of the clinical supports in all of the plans reviewed. ▪ In addition, many clinical supports that ABSSLC was providing, based on assessment information, were not included in the CLDPs, and no justification was provided for not identifying a functionally equivalent support. For example, nursing care plans/IHCPs were largely missing from CLDPs. 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. Although the Facility had begun to include some of the specific components of PNMPs in CLDPs, the related supports, such as monitoring of plan implementation, and oversight of the fit, function, and availability of adaptive equipment was not included. Behavior Support staff's role in communicating with Psychiatrists was not transitioned to community programs. Therapists at ABSSLC played a number of roles, including staff training, provision of direct therapy, monitoring of programs, monitoring of equipment, etc. In general, 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 #11, Individual #87, and Individual #534). 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	

#	Provision	Assessment of Status	Compliance
		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 had been maintained was in the inclusion of various plans to be implemented (e.g., PNMPs, diets, PBSPs, etc.). However, this was an area that required continued attention. As mentioned above, some plans were generally not included (e.g., IHCPs/nursing care plans), or there was not a plan to transition the plan (e.g., counseling plan for Individual # 534). ▪ 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 (e.g., Individual #483 for constipation), this was not consistently done (e.g., Individual #483 for weight, Individual #11, Individual #87, and Individual #534). 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. ▪ Of those reviewed, the only CLDP that identified a crisis intervention plan was the one for Individual #87, and it was only referenced as part of the training for community provider staff. No indication was provided and no post-move support included to ensure that community provider staff were certified in physical management techniques. For a number of individuals crisis strategies/plans should have been identified as pre- and/or post-move supports, but they were not (i.e., Individual #11, Individual #534, and Individual #384). ▪ 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 (e.g., Individual #87). 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	

#	Provision	Assessment of Status	Compliance
		describing an appropriate ratio), as well as in different situations (e.g., in the home, in the community, at a day or work site, at night, etc.), as well as the qualifications of staff (e.g., specific training requirements for staff, competencies or certifications needed, etc.). ▪ In reviewing assessments, albeit incomplete, most recommendations were specifically addressed in CLDPs, but some still were not (e.g., for Individual #11, the need for weight bearing exercise). However, in a number of instances, the justifications for not following recommendations was not sufficient (e.g., for Individual #534, related to an appointment with a dietician that was referred to the PCP in the community; or for Individual #87, the recommendation related to minimizing the availability of objects with which someone could get hurt, for which the team said the BSP addressed it, but review of the BSP did not identify such strategies). ▪ Generally, day and vocational supports were not well defined, and in some instances, individuals that had been working did not have adequate supports included to ensure this continued (i.e., Individual #534, and Individual #87). ▪ Supports that needed to be provided across day and vocational programs, as well as residential programs (e.g., nursing, psychology, therapy, etc.) were not included as part of the day/vocational component or other post-move supports. As noted above, the CLDPs continued to show incremental improvement. 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 six individuals' pre-move site visit documentation (i.e., Individual #483, Individual #229, Individual #99, Individual #288, Individual #215, and Individual #22). 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 responsible party of the corrections needed, and to confirmed 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	The Facility was conducting monitoring of CLDPs using the tool that had been modified	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	based on the Monitoring Teams' original audit tools. However, the data being collected were not relevant and valid. As discussed with regard to the Facility Self-Assessment, 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. In addition, not all requirements of the Settlement Agreement related to CLDPs 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. In addition, since the Monitoring Team's last review, a new Program Compliance Monitor had been assigned to Section T, and inter-rater reliability had not yet been established. Data were summarized. For example, graphs were presented to show that the Facility had the ability to display the data for analysis purposes. However, based on review of the Monthly Meeting Notes for Section T the Admissions Placement Coordinator and PCM met monthly, but no discussion was documented regarding review of data related to audits of the CLDPs. As a result, no analysis was completed of the data, and as noted above, because the Facility was not collecting valid data regarding the quality of CLDPs, little meaningful analysis could be completed. The Facility had action plans to address Section T.1.c, but not to address Sections T.1.d or T.1.e. The action plan for T.1.c did not directly address problems with the quality of the CLDPs. It had four action steps related to training QIDPs on the CLDP process and timeliness, completing monitoring tools "to verify the completion of CLDP in timely manner," reviewing information gathered at meetings with the Admissions Placement staff, and reporting findings at the QA/QI Council meetings. Again, as a result of invalid and/or incomplete data, the Facility was not correctly identifying the problems that continued to exist with CLDPs. Therefore, although the Admissions Placement Coordinator was presenting to the QA/QI Council, appropriate data were note being presented and necessary action plans to address outstanding issues had not been developed. 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 19 individuals that had transitioned to the community between 5/1/13 and 10/2/13. Of these 19 individuals, a total of six individuals experienced potentially negative outcomes. The following summary is provided. However, it is important to note that further	

#	Provision	Assessment of Status	Compliance
		analysis would need to be completed to draw conclusions from the data. Such an analysis should be part of the Facility's QA system: ▪ One individual returned to the Facility after his behaviors escalated, and a decision was made for him to return due to "concerns for his safety." This individual also had had police contact, a psychiatric hospitalization, and an ER visit. ▪ Another individual was taken to the ER due to an elevated temperature and lethargy. He was admitted with a diagnosis of pneumonia. ▪ Another individual became upset at home, began breaking dishes, and was aggressive towards staff. Police were called when "staff could not get her to calm down." She then "attacked a police officer," and was taken to a psychiatric hospital. She was released the following day. ▪ One individual called 911, and was admitted to the hospital, and then, a rehabilitation hospital, but was returned home after attempts to have her comply with a C-Pap machine were unsuccessful. Due to problems at the IV site after this stay, she returned to the ER shortly after her return home, and was admitted for close to three weeks. The day after she returned home from this second hospitalization, she fell, and returned to the hospital, where she was admitted for close to a week. ▪ One individual was taken to the hospital for a known condition, and treatment was provided. ▪ An individual originally moved to a family member's home, but after complaining of being bored, moved to an HCS home to provide more opportunities to make friends and be involved in activities. In addition, the Facility provided information about an individual that transitioned to the community in April 2010, and died in July 2013. Due to the family's directive that the hospital not provide the community provider with information, limited information was available related to his death. In correspondence to the Facility, the community provider indicated: "We know that he went into the hospital due to aspiration and was put in ICU [Intensive Care Unit] due to colon issues and possible illius (sp) [sic]. His organs were shutting down and he was put on a vent[ilator]… we do not have a death certificate nor do we know the exact cause of death." For one of these six individuals, information was presented showing that the Facility had conducted a critical analysis. This review was completed for Individual #215, who had returned to the Facility after behavioral issues were considered to have placed him at significant risk. The Special Review Team consisted of the Admissions Placement Coordinator, a representative from the Local Authority, the Director of Behavioral Services, the Human Rights Officer, the Assistant Director of Programs, the Chief Nurse Executive, the Quality Assurance Director, and a Program Compliance Monitor. The	

#	Provision	Assessment of Status	Compliance
		Special Review Documentation for Individual #215 showed the team critically reviewed the behavioral aspects of his transition plan and its implementation. The team identified some of the important activities that had been initiated when problems began to occur shortly after the transition, such as the community provider coming to ABSSLC to obtain feedback and more training from the BCBA at the Facility, as well as the ABSSLC psychiatrist providing guidance. However, the team also identified missing supports, such as more thorough training initially on Individual #215's PBSP, including role playing, and opportunities for staff to show mastery of the appropriate techniques, and the need for the Facility BCBA to have gone to the individual's community home when issues began to arise. Based on the Monitoring Team's review of the CLDP, there were other missing supports [e.g., a crisis intervention plan, better definition of the role of the community provider's psychologist or behavior analyst, too lengthy a time for the behavior supports to be put in place, incomplete requirements related to his healthcare, etc.], but it was positive that the team had identified a number of the supports that were missing. In addition, the Special Review Team identified a list of action steps to take in developing and implementing CLDPs for other individuals with "more involved BSPs." These included, for example, ensuring provider staff successfully complete competency-based training on the BSP, requiring communication between the Behavioral Health Provider at the Facility and the community provider's equivalent, asking about the provider's ability to assure that treatment integrity can be maintained, and involving the ABSSLC Behavioral Health Provider in the seven and 45-day post-move monitoring visits to observe staff, review behavioral data, and provide recommendations or follow-up training, as necessary. In addition, the group discussed the need to ensure that they provide community providers with the complete picture of an individual, and that the community provider understands the nature of the potential challenging behaviors, particularly, if the individual has not exhibited them during the pre-move visits. The Facility and this Special Review Team should be commended for conducting this critical review, and for developing meaningful recommendations that should assist in the development and implementation of future transition plans for this individual as well as other individuals. The Facility is encouraged to both implement the resulting recommendations, and continue to conduct such reviews when potentially negative outcomes occur for individuals that transition to the community. 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 development and implementation of CLDPs. The Facility should continue to improve its monitoring activities in this area, analyze information resulting from monitoring activities, and, as appropriate, develop, implement, and monitor action plans to address	

#	Provision	Assessment of Status	Compliance
		concerns identified. Such plans should include action steps, person(s) responsible, timeframes for completion, and anticipated outcomes. In addition, the Facility should implement the actions identified in the critical review conducted for Individual #215, and conduct other similar critical reviews for other individuals for whom potentially negative outcomes have occurred after their transitions to the community.	
T1g	Each Facility shall gather and analyze information related to identified obstacles to individuals' movement to more integrated settings, consistent with their needs and preferences. On an annual basis, the Facility shall use such information to produce a comprehensive assessment of obstacles and provide this information to DADS and other appropriate agencies. Based on the Facility's comprehensive assessment, DADS will take appropriate steps to overcome or reduce identified obstacles to serving individuals in the most integrated setting appropriate to their needs, subject to the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities. To the extent that DADS determines it to be necessary, appropriate, and feasible, DADS will seek assistance from other agencies or the legislature.	On February 26, 2013, DADS issued an Annual Report: Obstacles to Transition Statewide Summary. It included data as of 8/31/12 from all 13 Facilities. In its last report, the Monitoring Team provided detailed comments on the Obstacles report, which explained both the positive aspects of this report, as well as the reasons for ongoing noncompliance. The annual obstacles report had not yet been updated since the time of the previous monitoring review, and, therefore, no new comments are provided here. As noted in the Monitoring Team's last report, improvements in data collection and analysis, implementation of revised ISP processes, and actualization of the planned activities to overcome or reduce obstacles will be necessary for substantial compliance to be obtained.	Noncompliance
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	The parties agreed the Monitoring Team would not monitor this provision because the Facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding stands.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	listing: those individuals whose IDTs have determined, through the ISP process, that they can be appropriately placed in the community and receive community services; and those individuals who have been placed in the community during the previous six months. For the purposes of these Community Placement Reports, community services refers to the full range of services and supports an individual needs to live independently in the community including, but not limited to, medical, housing, employment, and transportation. Community services do not include services provided in a private nursing facility. The Facility need not generate a separate Community Placement Report if it complies with the requirements of this paragraph by means of a Facility Report submitted pursuant to Section III.I.		
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	<u>Timeliness of the Checklists</u> Post-move monitoring documentation was reviewed for six of the 20 individuals (30%) that had transitioned to the community since the Monitoring Team's last review (i.e., Individual #483, Individual #229, Individual #99, Individual #288, Individual #215, and Individual #22). Due to the numbers of individuals that had transitioned and only one Post-Move Monitor, other staff had sometimes conducted monitoring. In selecting the sample, the Monitoring Team ensured that all of the staff that had had responsibility for conducing post-move monitoring had conducted some of the reviews (i.e., the Post-Move Monitor, the two Transition Specialists, and the Admissions Placement Coordinator). For	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	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.	the six individuals during the time period reviewed, ABSSLC staff should have conducted 13 reviews. Of the 13 required visits, 13 (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/vocational 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 include information regarding the methodology used to conduct the reviews, including the interviews conducted, the documents reviewed, and the observations made. 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. 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 13 reports reviewed, 12 of them had needs identified for which follow-up was necessary to ensure supports were implemented. ▪ Of the 12 reports for the six individuals for whom follow-up was indicated, documentation was present to show that for 12 (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. The Post-Move Monitor made clear requests of the community providers, and the providers generally followed-up quickly. There also was documentation in the Post-Move Monitoring forms, and in ISPAs that the teams had met and discussed relevant issues. In a number of cases, the Post-Move Monitor then communicated	

#	Provision	Assessment of Status	Compliance
		information the team felt was important back to the community provider. In some instances, teams determined the need for direct follow-up between the ABSSLC staff and community provider staff. Completion of these steps often was documented in the next post-move monitoring report. 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 remained 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 date.	During the week of the onsite review, a member of the Monitoring Team accompanied the Post-Move Monitor on post-move monitoring visits for Individual #483, 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 #483 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. Due to the thorough and accurate post-move monitoring observed, the Facility remained 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.	Substantial Compliance
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		

#	Provision	Assessment of Status	Compliance
	a juvenile court proceeding. The provisions of this Section T do apply to individuals committed to the Facility following the court-ordered evaluations.		
T4	**Alternate Discharges -**		
	Notwithstanding the foregoing provisions of this Section T, the Facility will comply with CMS-required discharge planning procedures, rather than the provisions of Section T.1(c), (d), and (e), and T.2, for the following individuals: (a) individuals who move out of state; (b) individuals discharged at the expiration of an emergency admission; (c) individuals discharged at the expiration of an order for protective custody when no commitment hearing was held during the required 20-day timeframe; (d) individuals receiving respite services at the Facility for a maximum period of 60 days; (e) individuals discharged based on a determination subsequent to admission that the individual is not to be eligible for admission; (f) individuals discharged pursuant to a court order vacating the commitment order.	The parties agreed that in addition to the categories listed in the Settlement Agreement, other circumstances of an individual moving from a SSLC might fall under the category of "alternate discharges." For example, reasons such as a LAR choosing to discharge an individual from the Facility without formal transition planning occurring, or an individual transferring to another SSLC would be considered alternate discharges. These would be situations in which the Facility would be expected to follow the Centers for Medicare and Medicaid (CMS) discharge procedures. However, since the previous review, there had been no alternate discharges of individuals served by the Facility. As a result of no alternate discharges having occurred, this provision of the Settlement Agreement was not rated.	Not Rated

SECTION U: Consent			
#	Provision	Assessment of Status	Compliance
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.	The parties agreed the Monitoring Team would not monitor this provision, because the Facility had made limited to no progress due to the lack of a functional capacity assessment. The noncompliance finding from the last review stands.	Noncompliance
U2	Commencing within six months of the Effective Date hereof and with full implementation within two years, starting with those individuals determined by the Facility to have the greatest prioritized need, the Facility shall make reasonable efforts to obtain LARs for individuals lacking LARs, through means such as soliciting and providing guidance on the process of becoming an LAR to: the primary correspondent for individuals lacking LARs, families of individuals lacking LARs, current LARs of other individuals, advocacy organizations, and other entities seeking to advance the rights of persons with disabilities.	The parties agreed the Monitoring Team would not monitor this provision, because the Facility had made limited to no progress due to the lack of a functional capacity assessment. The noncompliance finding from the last review stands.	Noncompliance

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 or Revisions for the following: 1) Recordkeeping Policy; and 2) Archive instructions;" o List of persons responsible for filing and purging in the Active Records and for monitoring records, including names and titles, undated; o ABSSLC Active Record Order and Maintenance Guidelines, revised 7/18/13; o Individual Notebook and Guidelines for Filing and Purging, revised 8/26/13; o Minimum Documents Included in Master Record, undated; o Procedure for Section V Monitoring, revised 7/15/13; o Completed review tools for last 10 records reviewed, various dates; o Plans of correction resulting from records audits for the last three full months prior to the compliance visit, including: ▪ Correspondence or other documentation confirming completion of plans of correction resulting from these records audits, along with documentation of follow-up for corrective actions not completed; and ▪ Documentation of any follow-up checks to confirm completion of these corrective actions, various dates; o Description of Electronic Record, undated; o List of SSLC Policies, dated 10/1/13; o Lists of staff trained on Policy for Procurement of Medication After Hours; o In response to request for exception reports for training on policies, the following response: "At this time exception/delinquency reports are not available. Policy tracking system under development. Will have the ability to provide exception/delinquency reports as requested in the near future;" o CAP for Recordkeeping – Inter-Rater Reliability, revised 3/22/13; o CAP for Recordkeeping regarding quality of the records, revised 3/22/13; o CAP for Recordkeeping – Identified Systemic Issues, revised 7/15/13; o Training records for CAP on systemic recordkeeping issues; o Competency Training Department (CTD) training slides for: a) supervisors, Unit Directors, etc. regarding recordkeeping; and 2) staff identified with issues related to recordkeeping; o Training records for in-service on policy tracking form; o Menus for AVATAR CWS; o Section V Action Plans, updated 10/21/13; 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 10/21/13. 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. As discussed on site with the Records Department staff, the presentation of the information in the Self-Assessment for Section V was very clear, and showed a good understanding of the requirements of the Settlement Agreement, and the Facility's status with these requirements. 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 interview tool, and indicators within 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, as well as the standards for review. 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. However, since the last review, the Facility had adopted a new methodology for the record reviews. It narrowed the focus of the review of notes within the records to 30 days. This made sense as a sampling technique, and allowed for a thorough review of the most recent notes. o The Self-Assessment identified the sample(s) sizes. It also 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). 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. 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 Inter-rater reliability scores were noted for each of the various indicators included in the Self-Assessment. For some indicators, 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 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 included data related to the training of staff on new or revised policies. This would be an area where key indicators/outcome measures could be developed to measure compliance. ▪ The Facility presented some, but not all of the data in a meaningful/useful way. Specifically: o The Facility presented the findings based on specific, measurable indicators. 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. For these areas, the Facility identified or referenced action plans it had put in place 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. Although recent data was showing some improvements, 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. In addition, a formal corrective action plan was in place that involved the Competency Training Department (CTD) re-training supervisory staff on recordkeeping requirements. On 10/14/13, this training had begun, and at the time of the review, it reportedly was in the final stages of completion. Supervisory staff would then be expected to play a role in overseeing recordkeeping practices, and intervening when they noted problems. The Unified Records Coordinators had sent a list of the first group of staff that had been identified through record audits as failing to comply with recordkeeping guidelines. The next phase of the training was for CTD to provide them with competency-based training. 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 updated, and a number

	of department heads had been retrained. A focus of the training was ensuring that when policies were revised, the revisions were clearly identified, as well as the staff that would require training. CTD was finalizing a system to track training on policies, including the production of reports that would allow easy identification of staff that still needed to complete specific training. This represented significant progress. 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. Progress had been made in establishing inter-rater reliability. 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, significant 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. For example, multiple observations showed staff completing data for the entire shift at the end of the shift, and in some cases, prior to the time periods for which documentation was entered.

#	Provision	Assessment of Status	Compliance
V1	Commencing within six months of the Effective Date hereof and with full implementation within four years, each Facility shall establish and maintain a unified record for each individual consistent with the guidelines in Appendix D.	Progress had been made and/or sustained with regard to the establishment and maintenance of a unified record consistent with the guidelines in Appendix D of the Settlement Agreement. Positive developments included: ▪ According to staff, all of the individuals at ABSSLC continued to have Active Records, Individual Notebooks, and Master Records. ▪ The Facility's Records Committee continued making changes, as appropriate to the content of the records. ▪ As noted during the last review, 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 continued to address them, and revise the CAP, as necessary. 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. Although recent data was showing some improvements, the Facility continued to identify issues with the quality of the records. Its plan was for CTD to re-train supervisory staff (i.e., Supervisors, Unit Directors, Lead staff) on recordkeeping requirements. According to the meeting	Noncompliance

#	Provision	Assessment of Status	Compliance
		minutes for the monthly meeting with the QA Department, training had begun on 10/14/13. At the time of the review, this reportedly was in the final stages of completion. Supervisory staff would then be expected to play a role in overseeing recordkeeping practices, and intervening when they note problems. Once supervisors are trained, when record audits identify staff who fail to comply with recordkeeping guidelines, they will be referred to CTD for competency-based training. Shortly before the onsite review, the Unified Records Coordinator already had sent a list of the first group of staff requiring training. ▪ As discussed during the exit meeting, an ongoing issue with the accuracy of the information included in the records was the timely documentation of data related to the implementation of plans, such as PBSPs. A number of the Monitoring Team's observations showed staff completing data for the entire shift at the end of shifts, and even filling in data for time periods that had not yet occurred. Appendix D of the Settlement Agreement prohibits falsification of records, and provides an example of falsification as: "Entries are made prior to administering a service…" In addition, one of the goals of the Individual Notebook is described in Appendix D as: "to ensure… when possible, immediate documentation of significant events." The observations evidenced poor recordkeeping practices. Data that direct support professionals collect is used to make important clinical decisions. Efforts should be made to identify and correct problems with the accuracy of their documentation. It was good to see that the topics of falsification of records, as well as timely and accurate recordkeeping were included in the training that CTD was expected to provide staff for whom recordkeeping concerns were identified. 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 continued to implement the policy on Dissemination, Training, and	Noncompliance

#	Provision	Assessment of Status	Compliance
		Implementation of New/Revised Policies and Procedures, and in October 2013, had updated it. 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 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 Facility had updated its Policy Tracking form, and retrained a number of the department heads. The in-service training focused on the need to complete the form, and provide specific information, such as which staff required training and the level of training required. ▪ The Facility provided a list that showed the State Office policies related to the Settlement Agreement with a crosswalk to the Facility policies. Of the 19 State Office policies, including nine that had been issued/updated since the last review, the Facility reported that it had localized all of them, or adopted them in full. ▪ When staff were delinquent in completing training on policies, staff from the Records Department, QA Department, and CTD played roles in following up to work with the other departments to ensure completion of the training. 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. ▪ Although significant progress had been made, the Facility was still finalizing its system for tracking training related to policies. CTD was able to produce lists of staff that had completed training, but was in the final stages of being able to produce exception reports to identify staff that still required training. Based on some limited examples, it appeared the system the Facility was developing would be capable of presenting summaries showing the number of staff that had successfully completed the training (n) over the number of staff that required the training (N) to show the percent compliance with completion of the training (n/N). Once this information was regularly available, the Facility's Action Plan for Section V appropriately included action steps related to presentation of the data at the QA/QI Council meetings, and analysis and action based on the findings.	

#	Provision	Assessment of Status	Compliance
		Although the Facility continued to make progress in updating and/or developing policies to address the various requirements of the Settlement Agreement and training staff, it was not yet in compliance with this provision.	
V3	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall implement additional quality assurance procedures to ensure a unified record for each individual consistent with the guidelines in Appendix D. The quality assurance procedures shall include random review of the unified record of at least 5 individuals every month; and the Facility shall monitor all deficiencies identified in each review to ensure that adequate corrective action is taken to limit possible reoccurrence.	Progress had been made and/or sustained with this provision of the Settlement Agreement. Positive developments included: ▪ At ABSSLC, the Unified Records Coordinators were conducting reviews of at least five records each month as the Settlement Agreement requires. In fact, they often were conducting 10 per month, except when legitimate reasons, such as leave from work. The QA Department also was conducting reviews of a subsample of records, as was the Medical Records Coordinator/Supervisor. ▪ As described in the Monitoring Team's previous reports, to accomplish this, the Facility was randomly selecting a sample of 10 records. The tools used to complete these 10 record reviews included: the Settlement Agreement Section V – Recordkeeping and General Plan Implementation review tool, the Individual Notebook Monitoring Tool, and the Master Folder Table of Contents review tool. The Interview Tool was conducted for two of the 10 records. In addition, using the Section V Document Filing Monitoring Tool, the Unified Records Coordinators tracked temporary copies using a list of the 10 most recent medical reports/documents routed to the residences to determine whether they were filed timely. ▪ Since the last review, the Facility had taken steps to improve the inter-rater reliability between the various auditors. The Facility had a CAP related to inter-rater reliability for Section V, which had been initiated on 4/1/12, and revised on 3/22/13. The goal was to reach 80% inter-rater reliability. Specifically, the Facility reduced the time between audits of the same record. They also revised some of their monitoring instructions/guidelines. This included reducing the timeframe for the review of notes in the files (e.g., IPNs, observations notes, physician's orders, etc.) to 30 days. This allowed them to more easily identify differences in ratings for issues such as legibility. Between April 2013 and August 2013, inter-rater reliability estimates were between 74% and 82%. Monthly meetings were still occurring between the QA and Records Departments in which differences were discussed. ▪ 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.	Noncompliance

#	Provision	Assessment of Status	Compliance
		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. As noted with regard to Section V.1, the accuracy of the data being collected regarding the various plans being implemented was questionable, and this was an area that required a consistent effort across the Facility to correct. All of these indicators might not be reviewed by the Unified Records Coordinators, but might be distributed in other monitoring tools. ▪ As noted with regard to Section V.1, the Facility was in the process of implementing a CAP related to the quality of the records. The first phase involved the training of supervisory staff, and this process was underway. CTD then would train specific staff for whom issues had been identified as a result of record audits. The Records Department had begun to submit lists of such staff to CTD. It will be important to track the outcome of this training to determine if it has the desired impact on improvement in the quality of the records. If not, it will be important to determine if other actions are necessary. Although progress continued to be made with regard to this provision of the Settlement Agreement, the comprehensiveness of the monitoring efforts for Section V.4, as well as the full implementation of CAPs and assessment of their effectiveness was necessary. 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.	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. ABSSLC had not incorporated the entire structure into their internal monitoring. The following represent the Monitoring Team's findings: ▪ **Records are accessible to staff, clinicians, and others**: Although ABSSLC was not yet self-assessing this, the Monitoring Team observed that: o On a positive note, in an effort to ensure accessibility of certain documents that teams needed to develop ISPs and engage in related activities, Personal Folders for each individual were maintained on the shared drive. The Records Department also had developed a naming	Noncompliance

#	Provision	Assessment of Status	Compliance
		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 previous reports, 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" had been implemented. This policy clearly identified roles and responsibilities, and set timelines for completion of specific activities. The Records Department also had incorporated a sample of records into its monitoring to measure timely 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. In addition, during the onsite review, the Monitoring Team observed staff engaging in practices that likely resulted in inaccurate data, such as recording significant amounts of data at the end of shifts, and recording data for time periods that had not yet 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. ▪ **Observation at meetings, including ISP meetings, indicates the unified record is used as per this provision item:** As noted in the Monitoring Team's last report, 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 regard to Section V.3, this also 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	

#	Provision	Assessment of Status	Compliance
		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.	

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
AMA	Annual Medical Assessment
ANA	Annual Nursing Assessment
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
CIP	Crisis Intervention Plan
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

COS	Change of Status
COTA	Certified Occupational Therapy Aide
CPE	Comprehensive Psychiatric Evaluation
CPR	Cardiopulmonary Resuscitation
CRIPA	Civil Rights of Institutionalized Persons Act
CT	Computed Tomography
CV	Curricula Vitae
DADS	Texas Department of Aging and Disability Services
dc'd	Discontinued
DD	Developmental Disabilities
DEXA	Dual energy x-ray absorptiometry
DFPS	Department of Family and Protective Services
DISCUS	Dyskinesia Identification System: Condensed User Scale
DNR	Do Not Resuscitate
DOA	Date of Admission
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
EPRC	External Peer Review Committee
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
IHCP	Integrated Health Care Plan
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
IPRC	Internal Peer Review Committee
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
MTC	Mealtime Coordinators
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
PTP	Psychiatric Treatment Plan
Q	Quarter
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
QIDP	Qualified Intellectual Disabilities Professional
QMRP	Qualified Mental Retardation Professional
RAPPORT	Risk Analysis of Psychiatric Plan and Other Reasonable Treatments
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
TB	Target Behavior
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